ORDER:
Restricting the publication of any report of the matter which disclosed the deceased's name, the names of her carers and the names of two (2) employees of Territory Families.

CITATION: *Inquest into the death of Baby S* [2017] NTLC 014

TITLE OF COURT:	Coroner's Court
JURISDICTION:	Alice Springs
FILE NO(s):	A0021/2015
DELIVERED ON:	9 June 2017
DELIVERED AT:	Alice Springs
HEARING DATE(s):	9, 10 and 11 May 2017
FINDING OF:	Judge Greg Cavanagh
CATCHWORDS:	**Death in Care, Aboriginal baby, appropriate care and attention, kinship arrangements, sudden death.**

REPRESENTATION:

Counsel:

Assisting:	Jodi Truman
Territory Families	Tony Whitelum

Judgment category classification:	A
Judgement ID number:	[2017] NTLC 014
Number of paragraphs:	83
Number of pages:	26

IN THE CORONER'S COURT
AT ALICE SPRINGS IN THE NORTHERN
TERRITORY OF AUSTRALIA

No. A0021/2015

In the matter of an Inquest into the death of
BABY S
ON 25 APRIL 2015
AT INTENSIVE CARE UNIT
ALICE SPRINGS HOSPITAL,
ALICE SPRINGS

FINDINGS

Judge Greg Cavanagh

Introduction

1. "Baby S" (whose name has been restricted from publication) was an Aboriginal female born on 25 September 2014 at the Alice Springs Hospital ("ASH"), in Alice Springs in the Northern Territory of Australia. Her mother is Natasha Ruth Charra (aka Tarsha Lebois) and her father is Reece Shane Swan. Ms Charra and Mr Swan commenced a relationship in or about May 2013, but it appears their relationship quickly deteriorated and eventually there were domestic violence orders ("DVO's") in place against them both with respect to one another.

2. Although Baby S was the only child born to Ms Charra and Mr Swan; Ms Charra had two (2) other children from previous relationships. Both those children however were no longer in her care; with one child having been placed into the care of extended family members by way of a private arrangement, and the other child having been removed from Ms Charra's care by the Department of Families in South Australia ("SA") in January 2014 due to chronic substance misuse and domestic violence. That child was also then placed by the SA Department with the same extended family members. It is with that family that both children remain.

3. It was this prior involvement by the SA Department that resulted in Ms Charra coming to the attention of the Northern Territory Government Department known as "Territory Families" on 28 March 2014. Notification had been made to Territory Families by their SA equivalent by way of an "interstate alert" with respect to Ms Charra's then unborn child (i.e. Baby S) and concerns relating to her ability to care for the child after its birth. As a result of this alert, Territory Families opened a Family Support Case file.

4. In the meantime, relations between Ms Charra and Mr Swan continued to deteriorate and on 19 September 2014 Mr Swan was arrested and charged with assaulting Ms Charra whilst she was 37 weeks pregnant with Baby S. At that time Ms Charra alleged she had been assaulted by Mr Swan and was admitted to the Hermannsburg Health Clinic before being transferred to the ASH. Mr Swan denied the allegations made against him, but was remanded into custody. This is where he remained at the time of the death of Baby S.

5. Ms Charra subsequently gave birth to Baby S at the ASH on 25 September 2014. Both Ms Charra and Baby S were subsequently discharged on 29 September 2014. Unfortunately during her very short life thereafter, a number of notifications were made to police and Territory Families concerning the care provided to Baby S by her mother. These notifications will be addressed in more detail later in these findings.

6. On 7 April 2015, as a result of one of these notifications, Baby S was taken into Provisional Protection under s.51 of the *Care and Protection of Children Act* ("CAPC Act"). Upon being taken into care, Baby S was placed with Mrs MS; a registered educator with Alice Springs Family Day Care ("ASFDC"). This was via a "purchased home-based care" arrangement between Territory Families and ASFDC.

7. On 22 April 2015 however, some 15 days after being placed into the care of the Chief Executive Officer ("CEO") of Territory Families, Baby S was found lifeless and not breathing in her cot by Mrs MS. She was conveyed to

the ASH, but was eventually declared deceased in the Intensive Care Unit ("ICU") at 8.33pm on 25 April 2015 after life support systems were ceased. She was only seven (7) months of age.

8. This death was reportable to me pursuant to s.12 of the *Coroners Act* ("the Act") because it was a death of a person who immediately before their death was a "person held in care". A person held in care is defined under s.12 of the Act to include a child who is in the CEO's care as defined under the *Care and Protection of Children Act*. As a result of being a person held in care immediately prior to death, this inquest is mandatory pursuant to s.15(1) of the *Act*.

9. Pursuant to s34 of the *Act*, I am required to make the following findings:

> "(1) A Coroner investigating:
>
> a. A death shall, if possible, find:
>
> (i) The identity of the deceased person.
>
> (ii) The time and place of death.
>
> (iii) The cause of death.
>
> (iv) Particulars required to register the death under the *Births Deaths and Marriages Registration Act*"

10. I note that section 34(2) of the *Act* also provides that I may comment on a matter including public health or safety connected with the death being investigated. Additionally, I may make recommendations pursuant to section 35 as follows:

> "(1) A Coroner may report to the Attorney General on a death or disaster investigated by the Coroner.

(2) A Coroner may make recommendations to the Attorney General on a matter, including public health or safety or the administration of justice connected with a death or disaster investigated by the Coroner.

11. The Coroner's Court can also impose certain restrictions on the publication of reports of the proceeding. The power to do so is found in s43 of the *Act* as follows:

"43. Restriction on publication of reports

"(1) A coroner shall order that a report of an inquest or of part of the proceedings, or of evidence given at an inquest, shall not be published if the coroner reasonably believes that, to publish the report, would -

(a) be likely to prejudice a person's fair trial;

(b) be contrary to the administration of justice, national security or personal security; or

(c) involve the disclosure of details of sensitive personal matters including, where the senior next of kin of the deceased have so requested, the name of the deceased.

(2) A person shall not publish a report in contravention of an order under subsection (1).

Penalty for an offence against this subsection: $10,000 or imprisonment for 2 years."

12. In these proceedings, I made an order restricting the publication of any report of the matter which disclosed the deceased's name, the name of her carers and/or anything that may identify those carers. I also made an order

restricting the publication of the name of two (2) employees from Territory Families. Those orders remain in place.

The Conduct of this Inquest

13. Counsel assisting me at this inquest was Ms Jodi Truman. Mr Tony Whitelum was granted leave to appear on behalf of Territory Families. A total of ten (10) witnesses were called to give evidence, namely; Detective Senior Constable Brett Wilson, Mrs NR, Erica Johansson, Dr Sheena Gune, Emma Davis, Dr John Rutherford, Mrs GB, Bronwyn Thompson, Mrs MS and Mr MS. I also note that the father of Baby S, namely Mr Reece Swan, and her maternal aunt, namely Mrs Priscilla Larkins, attended each and every day of the inquest. I thank them for the respect they showed these proceedings in what were clearly still very difficult and distressing circumstances concerning the death of their loved one.

14. A brief of evidence containing various statements, together with numerous other reports, medical records, police documentation and documentation held on the case file belonging to Territory Families was tendered at the inquest. Public confidence in Coronial investigations demands that when police (who act on behalf of the Coroner) investigate deaths that they do so to the highest standard. I thank Detective Senior Constable Wilson for his investigation.

15. Because Baby S was in care at the time of her death, the quality and appropriateness of that care and the training provided to the persons responsible for her care became a central focus of this inquest; together with attempting to ascertain the precise cause of her death.

Circumstances leading up to Baby S coming into the care of Territory Families

16. As noted earlier although an interstate alert was received by Territory Families on 28 March 2014, it appears this was not the first involvement

that Territory Families had in relation to Ms Charra. According to the evidence; on 30 December 2013 Territory Families received notification from NT Police concerning allegations made by Ms Charra about sexual assaults perpetrated upon her by an extended family member in SA and concerns she had with respect to her two (2) children. Territory Families forwarded this information to their SA counterparts for investigation.

17. Subsequent to this; the first formal notification concerning Baby S was the one previously referred to occurring on 28 March 2014 as an interstate alert. The information received by Territory Families was that Ms Charra's other children were no longer in her care due to chronic substance misuse and domestic violence. Territory Families were also informed that Ms Charra had been diagnosed with borderline personality disorder, depression and anxiety disorder and refused to take her medication, whilst continuing to abuse alcohol and other drugs during her pregnancies. Following receipt of this alert, Territory Families opened a Family Support Case file.

18. I received evidence that this was done in accordance with policy that was in place at the time. However there appears to have been no contact made with either Ms Charra or Mr Swan following receipt of that notification and therefore no family support services were actually provided. A further notification was then received from ASH on 22 September 2014 after Ms Charra was admitted following the events of 19 September 2014 where she alleged she was assaulted by Mr Swan. Notification was also made at that time of an incident on 17 September 2014 where Ms Charra alleged Mr Swan assaulted her.

19. At the time of this second notification, Territory Families were advised that Mr Swan had participated in an electronic record of interview ("EROI") and denied all the allegations made against him, claiming that Ms Charra had been hitting herself in the stomach with a rock and drinking alcohol throughout her pregnancy. Due to Mr Swan's denials, Territory Families

determined there was insufficient information to proceed and no further action was taken at that time.

20. On 10 November 2014 the original Family Support Case file was closed. However on 28 December 2014 Territory Families received their third notification after family members had taken Baby S after seeing Ms Charra extremely intoxicated and nearly falling over whilst holding her. It was also alleged that Ms Charra had threatened to self-harm on a number of occasions. Although it was noted that Baby S was unharmed during these events, a child protection investigation was commenced and determined that neglect and physical abuse were substantiated.

21. As a result the matter was assessed as a "Priority 2" which meant a response was required within three (3) days. A decision was made to commence a Child Protection Investigation. Several attempts were made to locate Ms Charra and Baby S but these were unsuccessful and on 29 December 2014 Territory Families requested a "Concern for Welfare" check by NT police who also commenced looking for the pair.

22. On 2 January 2015 Ms Charra and Baby S were located by police and their details passed on to Territory Families. Workers made contact with Ms Charra and Baby S on 5 January 2015 at their accommodation. It was noted that the house was overcrowded; Ms Charra stated she had little money and Baby S had bites on her from bed bugs. Ms Charra also complained that she was receiving "payback" from family members of Mr Swan as a result of her reporting him to police.

23. Agreement was therefore reached that Ms Charra would be provided with support by Territory Families to help improve her circumstances. A safety plan was developed which included Ms Charra not drinking alcohol and accommodation being found at the Alice Springs Women's Shelter. A Family Risk Assessment was conducted which assessed Baby S as being at "high" risk.

24. On 6 January 2015 Families SA provided further information to Territory Families and the following day a Case Consultation was conducted. At that time it was assessed that Baby S was safe to remain with Ms Charra whilst further information was obtained. An alert was also placed on the Community Care Information System ("CCIS"); being the electronic record system of Territory Families, advising that if there were concerns reported that evening that Ms Charra was intoxicated or unable to care for Baby S then the child was to be taken into Provisional Protection.

25. In accordance with this plan; Mr Swan was interviewed on 8 January 2015 at the Alice Springs Correctional Centre ("ASCC") and provided information as to the couple's history and relationship, together with family contacts. Baby S was also assessed at the Healthy Kids Clinic that day and Ms Charra attended at the Territory Families office for a meeting. Territory Families advised Ms Charra that she was required not to drink, not to fight and to stay in stable accommodation in order for Baby S to remain in her care. Ms Charra agreed to stay at Akangkentye Hostel for the next two (2) months.

26. The Case Consultation reconvened and determined that at that time Baby S was not at "immediate risk of harm" and was therefore safe to remain with her mother whilst intensive family support was provided. A referral was completed by Territory Families to Congress Intensive Family Support Service ("Congress") to assist Ms Charra in the caring of Baby S. I received evidence that the role of Congress was to do the "practical work" in offering intensive support to Ms Charra whilst the Territory Families "Strengthening Families Team" monitored and assessed her progress. The Child Protection Investigation was substantiated for emotional abuse and neglect.

27. On 9 January 2015 Ms Charra was scheduled to meet Congress however Territory Families staff were unable to find Ms Charra to take her to the appointment. Nevertheless a meeting still occurred between Territory Families and Congress staff where Congress agreed to provide Ms Charra

with assistance. Ms Charra was subsequently located by Territory Families that day and agreed to attend an appointment with Congress the following week to discuss her arrangements.

28. On 12 January 2015 Ms Charra met with Congress and Territory Families staff. Ms Charra stated she would work with Territory Families and Congress as she did not want to lose the care of Baby S and would do "anything" to keep her in her care. Thereafter Congress attempted to contact Ms Charra a number of times between 16 and 23 January 2015 but was unsuccessful. It was also discovered that Ms Charra had moved out of her accommodation at Akangkentye Hostel without a forwarding address. As a result Congress passed this information on to Territory Families.

29. On 27 January 2015 Ms Charra was eventually located at Abbotts Camp by Territory Families staff. At that time she had an injury to her face which she stated had been caused by an aunt of Mr Swan hitting her with a rock. Ms Charra was told to attend at the Territory Families office to discuss her situation and she attended later that day. Discussions were held surrounding her accommodation and Ms Charra stated that despite the rock incident she felt safe at Abbotts Camp and wished to remain. Ms Charra was advised to re-engage with Congress and this subsequently occurred to some extent.

30. On 27 February 2015 Territory Families received their fourth notification. This time from ASH after Baby S had been brought to the Emergency Department ("ED") by her paternal grandmother who wanted Baby S medically assessed and emergency accommodation provided. The grandmother alleged that she had removed Baby S from Abbotts Camp as "everyone" in the house was drunk and Ms Charra was at that time in protective custody with police.

31. Unfortunately this notification was not correctly documented in accordance with Territory Families policy and was recorded as a "case note" on CCIS, rather than as a new Child Protection report. This meant that the Case

Manager was not automatically alerted to the new information that had been received and therefore no follow up was conducted by Territory Families.

32. On 14 March 2015 at 3.45am however a fifth notification was received by Territory Families reporting that Baby S had been dropped off by Ms Charra the previous evening so she could go drinking but she had not returned to collect her. It was reported by the notifier that they did not even know the name of the baby or the mother's last name, but a subsequent search of the bag left with Baby S revealed paperwork providing those details. It was also stated that Baby S had been crying for two (2) hours, there was no food for her, the notifier did not know when she had received her last feed, was not able to afford formula and they did not even know if Baby S was still being breast fed or was on formula.

33. This notification was screened in for neglect and assessed as a "Priority One" requiring a response within 24 hours. Territory Families Alice Springs On Call staff attended at 4.15am and took Baby S to the ASH. Ms Charra was also subsequently located and brought to the ASH. Ms Charra claimed to staff that she was "sober" at that time but was breathalysed at ASH and returned a reading of 0.19%. Baby S was medically examined and found to have an ear infection, but was otherwise well. Territory Families staff subsequently transported Ms Charra and Baby S to the Visitor Park Hostel with Baby S remaining in her mother's care.

34. A new child protection case was opened and a Safety Assessment completed which determined that Ms Charra had made arrangements for Baby S to be cared for by a family member whilst she went out drinking, but that the nominated family member had not complied with that arrangement. Ms Charra had been observed as very attentive to the needs of Baby S at the ASH and there were therefore no immediate threats to her safety and wellbeing. As a result she was determined by Territory Families to be "safe" and remained with her mother.

35. On 17 March 2015 however a sixth notification was made to Territory Families. This time by NT police following a verbal argument between Ms Charra and the paternal grandmother outside the Memo Club. It was reported that the paternal grandmother was upset upon hearing that Ms Charra was drinking a lot. The report also stated that Ms Charra was sober and Baby S was not harmed.

36. Unfortunately this notification was also not correctly documented in accordance with Territory Families policy and was screened out as having been assessed as "no risk of emotional harm" to Baby S, despite the fact that she was reported to have been present.

37. On 18 March 2015 Congress contacted Territory Families and advised they had attended at the Visitor Park Hostel and been informed that Ms Charra had moved out on 14 March 2015 and was "agitated and anxious", leaving no forwarding address. Congress advised they had made attempts to locate Ms Charra but had been unsuccessful.

38. On 19 March 2015 the seventh notification was received by Territory Families from both ASH and police. Although the first recording of a report was from ASH, the timing of the events relating to this notification were as follows:

    38.1 Police were called to Todd Street at about 5.00pm where they found Ms Charra highly intoxicated and standing in the middle of the road. Baby S was being held by another female on the footpath. Ms Charra was spoken to by police and taken to Old Timers Camp to be cared for by family. A referral was subsequently made by police to Territory Families about this incident.

    38.2 At about 8.00pm that same day, police were called back to the road outside the entrance to Old Timers Camp where Ms Charra was found sitting in the middle of the road in a highly intoxicated state with Baby

S in her lap. It was alleged that Ms Charra had been seen to slap Baby S, almost drop her on the ground and then sat on the highway breastfeeding causing traffic to swerve to avoid hitting them both. As a result police took both Ms Charra and Baby S to the ASH where Ms Charra was recorded as having a blood alcohol reading of 0.253%.

38.3 Shortly after arrival at the ASH; staff there made a notification to Territory Families concerning Baby S. As part of this notification it was reported that Ms Charra was observed at the hospital to physically fight with others whilst still holding Baby S in her arms with punches being thrown.

39. ASH medical staff examined Baby S and she was found to have no obvious physical injuries. Ms Charra was reported to have said that she had drunk two (2) bottles of Chardonnay and had been assaulted at the Old Timers Camp by an unknown man who had physically pulled Baby S from her, but that she had got her back from him. Ms Charra denied that she had fallen over or dropped Baby S.

40. ASH advised Territory Families that Ms Charra and Baby S would be admitted overnight and a safety plan was entered into whereby ASH would regularly monitor Ms Charra and Baby S and notify security, police and Territory Families immediately if attempts were made to remove Baby S. Shortly thereafter police made their reports to Territory Families of the events described above and had also allocated the matter to the Southern Child Abuse Taskforce for further investigation.

41. This seventh notification was screened in for physical harm and significant risk of emotional harm and neglect and was assessed as a “Priority One” requiring a response within 24 hours. The plan by Territory Families was to attend the ASH the next morning.

42. On 20 March 2015 Territory Families workers attended ASH to speak to Ms Charra and conduct an assessment. Territory Families staff were advised by the ASH that both Ms Charra and Baby S were fit to be released and discussions were held with Ms Charra where she gave her version of events. Ms Charra stated she wished to stay with her grandmother, Ingrid Ginarri, at Karnte Camp. As a result Territory Families transported Ms Charra and Baby S to Karnte Camp and Mrs Ginarri agreed to assist. Ms Charra was advised that Territory Families would return again on 23 March 2015 for a follow up visit.

43. A Safety Assessment was conducted finding no "immediate danger of serious harm" to Baby S. It was noted that whilst there were historic and current concerns as to Ms Charra's alcohol usage, these did not meet the threshold of impacting on the "immediate" safety of Baby S. Further there were no reports of injury to Baby S and no reports of family violence at Mrs Ginarri's home. In addition Ms Charra had been observed as "very engaging" with Baby S and a decision was therefore made to continue the Strengthening Families casework.

44. On 23 March 2015 Territory Families staff attended Karnte Camp but were unable to locate Ms Charra and Baby S. Attempts were made again the following day, but again they were unsuccessful. On 25 March 2015 a meeting was held between Territory Families and Congress to discuss concerns about Ms Charra and Baby S. Again the action plan developed was aimed at providing further assistance to Ms Charra to help with the care of Baby S. On 26 March 2015 Territory Families and Congress staff attended jointly at Karnte Camp and located and spoke with Ms Charra who agreed to continue to work with Territory Families.

45. I received evidence that in the meantime, the Southern Child Abuse Taskforce had continued their investigations into the events of 19 March 2015. As a result, on 6 April 2015 Ms Charra was arrested and charged with

Aggravated Assault, Recklessly Endangering Life and Endanger Life of Child by Exposure. She was subsequently bailed to appear before the Local Court on 29 July 2015. I note that Ms Charra failed to appear and as a result a warrant was issued for her arrest. Detective Senior Constable Wilson made attempts to locate Ms Charra concerning this inquest however it appears that her warrants have resulted in her refusing to return to Alice Springs.

46. Following the arrest of Ms Charra, police submitted a further Child Abuse Report Form ("CARF") to Territory Families about the events of 19 March 2015. As a result of the police charging Ms Charra Territory Families determined that it was necessary to remove Baby S from her care assessing she was at imminent risk of harm. On 7 April 2015 Territory Families located Ms Charra and Baby S at Karnte Camp and Baby S was taken into Provisional Protection under s.51 of the CAPC Act.

47. At the time of taking Baby S into care, the Territory Families workers noted that she had a "rattly" chest and "marks" which they considered suspicious on her back, shoulders and buttocks. As a result arrangements were made for Baby S to return the following day for a review by a Paediatric Consultant. Having been taken into care, it was also necessary for Territory Families to find a placement for Baby S. Subsequently Baby S was placed in a "purchased home-based care" placement by the Placement Unit (Darwin) of Territory Families Out of Home Care Division. This placement had been procured through ASFDC and Baby S was placed with a registered full time educator employed by ASFDC, namely Mrs MS, and her husband Mr MS who was also a registered educator's assistant.

48. I received evidence as to the process for outsourcing a placement and the policy surrounding such placements. It is clear that at the time of Baby S being taken into care there were no Territory Families "authorised" carers available, although care arrangements with ASFDC educators are made in

line with the *Care and Protection of Children Act* and ASFDC is an approved care giver provider registered with Territory Families. In fact, at the time of Baby S's placement; Mrs MS also had two (2) other children in her care who were the subject of care orders with Territory Families and were aged 5 and 6 years respectively, together with her own 5 year old child.

49. After Baby S was placed with Mrs MS, she was taken by Mrs MS to her medical review the next day. Mrs MS identified the rattly chest and marks to staff. A review was conducted and Baby S was assessed as "thriving with weight", "happy and smiling and neuro developmentally appropriate". The paediatrician considered there was evidence of "very mild" bronchiolitis which accounted for her rattly chest, but recommended it simply be monitored. As for the marks on her back, it was the opinion of the Paediatric Consultant that these were "Mongolian blue spots". I was informed that these are a type of birthmark and not associated with any conditions or illnesses. A review was planned for four (4) weeks' time.

50. Territory Families continued their child protection investigation and determined that neglect and physical abuse were substantiated with Ms Charra believed responsible. Baby S was deemed unsafe to be in her mother's care and on 10 April 2015 Territory Families obtained a two (2) week Temporary Protection Order ("TPO") via the Local Court of Alice Springs. The plan at that time was to meet further with family to discuss the future care for Baby S and referral had been made for Kinship Carer Assessment with respect to the placement of Baby S. In the meantime supervised contact between Ms Charra and Baby S was facilitated by Territory Families and contact occurred between Territory Families staff and Mrs MS.

51. On 22 April 2015 an application was made in the Local Court for a 2 year Protection Order. The application was adjourned to 20 May 2015 for Ms

Charra to provide instructions to her lawyers and for service to be effected upon the father (Mr Swan). Daily care and control for Baby S was given to the CEO in the interim. Tragically this was the very same day that Baby S was found not breathing and unresponsive in her cot.

Discovery of Baby S on 22 April 2015

52. On 22 April 2015 at around 4.00pm Mrs MS placed Baby S into her "day time cot" in the study area for a nap that she had developed as part of her routine. Mrs MS gave details of the routine she had established with Baby S and her home routine more generally. Mrs MS described the study area as an open alcove area of the home where she generally placed Baby S because she could "hear and keep an eye on her better". Mrs MS detailed the events of that day describing how Baby S had appeared, the food she had received and how she had fed. There appeared to be nothing out of the "normal" in the behaviour of Baby S and according to Mrs MS she had fed and slept well.

53. Mrs MS described the day time cot as one she had purchased new only two (2) years prior, but that it had no mattress. As a result she had placed "multiple" large pillows into the cot to make an improvised mattress, namely:

    53.1 Two turtle animal pillows turned upside down;

    53.2 A large white continental square pillow; and

    53.3 A large green continental square pillow with a frill trim on the cover.

54. As noted at about 4.00pm Mrs MS put Baby S into that day time cot for a nap. She put her down with her bottle which Baby S drank from and left approximately 60mls. Mrs MS said she did not burp Baby S, but she never had and she had not experienced Baby S as being prone to vomiting after feeds. Mrs MS recalled placing Baby S on the green pillow on her right

side. The air conditioner and lights were off but the temperature that day was generally cool.

55. Mrs MS described Baby S as being unsettled for about 8-10 minutes, but that there was nothing unusual in her cry and it was something that she usually did just before falling asleep. Mrs MS checked on her at about 4.15pm when the crying stopped and found Baby S in basically the same position that she had placed her down in, although tilted further over on her tummy, but still on her side. Baby S appeared to be sleeping and she could see her body moving with her breath, her hands next to her face and her legs out flat and straight.

56. The next time Mrs MS entered that room was at about 5.15pm. She had not seen anyone else enter that room in the meantime. She stated that she went into the room with the intention of waking Baby S so she did not oversleep. When she entered the room she recalled Baby S was laying on her back, with her legs and arms out flat and she thought she was sleeping. However, when she picked up Baby S she immediately realised she was lifeless and ran with her into the kitchen.

57. Mrs MS stated that she put Baby S down on her back on the kitchen bench and could see that her lips were a light blue colour and her chest was not moving. She thought her temperature felt normal and she yelled at her then 5 year old daughter to "run next door and ask for help". Her daughter immediately ran out the door.

58. Mrs MS stated that she began CPR on Baby S. She heard a gurgling sound and noticed a discharge from her mouth and nose which she wiped away. She then noticed that her neighbour was present and on his mobile phone, yelling instructions to her. Mrs MS continued with the CPR until St John Ambulance ("SJA") officers arrived and took over before they took Baby S in the ambulance to the ASH. Mr MS also gave evidence of the actions he

took that day upon arriving home and his evidence accords with the evidence given by his wife.

Events at the Alice Springs Hospital

59. Baby S arrived at the ASH via ambulance at approximately 5.55pm. At that time she was unresponsive, her pupils were fixed and she had a weak pulse. She was commenced on adrenaline and placed on a breathing machine. Doctors reported noticing "matter" around her nostrils and airway which appeared to be "aspiration" (aka vomit).

60. A CT scan of Baby S's brain was undertaken within 3 hours of her admission and it showed brain oedema (or swelling), but no evidence of skull fracture or intracranial bleeding (i.e. bleeding inside the brain). The CT scan did show however "loss of grey-white differentiation" which was "consistent with catastrophic hypoxic-ischaemic injury", i.e. Baby S's brain had been catastrophically injured as a result of being deprived of blood and oxygen. This was as a result of Baby S having suffered a cardiac arrest.

61. Baby S was transferred to the ICU under the care of paediatrician, Dr Sheena Gune and ICU consultant, Dr Raj Goud. Dr Gune stated that during the entire time that Baby S was admitted she did not display ***any*** signs of recovering neurological function and that her prognosis from almost the time of her arrival was "extremely poor". Dr Gune stated that discussions were held between herself, Dr Goud and two (2) paediatric intensive care specialists in Adelaide about Baby S's condition. Because of her history, clinical findings and radiology consistent with severe hypoxic-ischaemic injury with very poor prognosis, and a high likelihood of progressing to brain death, the decision was made not to transfer Baby S to Adelaide.

62. From her admission; Baby S remained in an ongoing coma with no response to painful stimuli. She had shown no brainstem reflexes and was haemodynamically unstable requiring significant support, amongst other

difficulties. Her circumstances were showing no signs of change and she was not improving. On 25 April 2015 doctors were of the firm opinion that Baby S had suffered irreversible loss of brain function and considered it appropriate to conduct testing to determine whether she was clinically brain dead. That testing was conducted and as a result Baby S was declared deceased at 8.33pm on 25 April 2015.

Cause of death

63. As noted earlier, the cause of death was a central focus during this inquest. Dr John Rutherford, Forensic Pathologist, conducted an autopsy upon Baby S on 28 April 2015. His report formed part of exhibit 1. Within his report Dr Rutherford detailed his extensive external and internal examination of the body and the musculoskeletal system of Baby S. Dr Rutherford stated that at autopsy there were "no naked eye findings to suggest a definitive cause of death". He also concluded that there was "no pathological evidence of injury externally or internally".

64. Dr Rutherford therefore conducted further investigations which revealed:

    64.1 The presence of enterovirus/rhinovirus RNA in a lung swab;

    64.2 Changes in the brain corresponding with hypoxic-ischaemic encephalopathy; and

    64.3 Pneumonia in the lung at the right lower lobe.

65. Dr Rutherford opined that there were two (2) possible interpretations of his findings:

    65.1 That the pneumonia could have been a consequence of weakness as a result of the hypoxic-ischaemic encephalopathy following a cardiac arrest. He stated that in this scenario it was unknown as to what caused the cardiac arrest (but possibly suffocation); or

65.2 A respiratory virus infection which could have predisposed Baby S to pneumonia which then resulted in a cardiac arrest and consequent hypoxic-ischaemic encephalopathy following resuscitation procedures.

66. Within his report, Dr Rutherford opined that it was this second possible that "would seem more likely" and he was "satisfied that death can be attributed to hypoxic-ischaemic encephalopathy complicating cardiac arrest as a consequence of respiratory viral infection and pneumonia".

67. Before discussing the additional evidence subsequently received in relation to the cause of death, I wish to pause here and make clear that there was ***no*** evidence found at autopsy to support any finding that the death of Baby S was caused by any intentional or reckless conduct on the part of her carers Mr and Mrs MS. In particular there were ***no*** injuries found on her body.

68. With respect to cause of death my office sought a further opinion from Senior Specialist Forensic Pathologist, Professor Roger Byard. Professor Byard is a world expert in his field and conducted a review of the evidence in relation to the death of Baby S and provided a report. Within his report he also noted there was no external trauma and "no evidence of inflicted injury". In relation to the potential cause of death relating to respiratory virus infection and pneumonia; Professor Byard noted that whilst it was "much more usual" for there to be "marked symptoms and signs, such as fever with chills, productive cough, malaise, vomiting and loss of appetite – this is not always the case in very young children, and particularly infants, who can be mortally ill and have very minimal evidence of illness". Professor Byard also set out his own experiences in this regard.

69. With respect to the findings of Dr Rutherford that the most likely cause of death was "pneumonia complicating viral respiratory infection", Professor Byard stated:

> "This would be in keeping with the identification of entero/rhinovirus on post mortem virological testing. Enterovirus infection has been linked to sudden and unexpected death in childhood. Although no bacteria were found on post mortem culture, this is not uncommon."

70. In relation to those known medical issues, Dr Rutherford referred to the respiratory virus and pneumonia that Baby S had been suffering and gave evidence as follows:

> "…there are multiple components to it, your Honour including what was noted on the first CT scan when the infant was taken into hospital and that is widespread sinus disease. In other words the infant had sinusitis as well. And as we all know, infants are nose breathing organisms and that is because it's an evolutionary advantage to be able to breathe through your nose whilst you're suckling. So if your nasal passages and your sinuses are in trouble then that makes it easier for you to die as a consequence of that. So there is that. Then there is the rhinovirus, enterovirus issue. As I've said, the enterovirus component of it, which is a pretty important component, that the virus may give rise to all manner of things including innocent rashes, cold-like symptoms, but may give rise to serious things like paralysis, pneumonias, myocarditis, all of which may cause cardiorespiratory arrest leading to pneumonia and hypoxic-ischaemic encephalopathy".

Having considered this evidence very carefully, whilst I agree that the sleeping surface of the makeshift mattress for Baby S was not in accordance with the recommendations for "ideal" surfaces for babies, I find that the medical, or what may also be referred to as the "pathological", evidence leads me to the conclusion that the death of Baby S was caused by a respiratory illness and pneumonia that caused her heart to stop and then to suffer brain damage. Furthermore, the evidence established that there was very little indication (obvious or otherwise) of this serious illness which might have been picked up by

the carer. Indeed, what little evidence that was present was noticed by the carer who reported the baby's "wheezy chest and cough" at a medical appointment in the several days prior to her death. I agree with the opinion reached by Dr Rutherford in his report (and subsequent evidence) as to cause of death I reject the possibility that suffocation caused the baby's heart to arrest.

The care provided to Baby S

71. Given that the possibility of accidental suffocation was raised during this inquest, I consider it important to comment upon the care provided to Baby S during the period she was with Mr and Mrs MS from 7 to 22 April 2015. In my view, the evidence established that Baby S was well cared for by Mr and Mrs MS who were both clearly devastated at her passing and clearly remain so.

72. I received evidence that Mrs MS had been registered as an Alice Springs Family Day Care Educator for 3 years by the time of this death. She had attained (relevantly) a Certificate III in Child Services and a "Red Path" First Aid Certificate which had only been renewed on 18 April 2015. It is clear that she took her role of providing 24 hour care and protection to children (note just those who had been placed with her by Territory Families) **very** seriously. I had tendered before me photographs of the home of Mr and Mrs MS and it appeared to be clean and well-kept.

73. As previously noted, not only did Mr and Mrs MS have Baby S in their care; they also had 2 other children who were under the care of Territory Families, along with their own daughter who was 5 years and 8 months at the time of this death. Of the 2 other children under the care of Territory Families; one of those children had been in the care of Mrs MS for approximately 2 and ½ years and had significant medical needs which were being well provided for by Mr and Mrs MS. The other child had been with Mr and Mrs MS for approximately 12 months.

74. Further, it is clear that when Baby S was required to attend her follow up medical appointment on 8 April 2015; it was Mrs MS who took her for that check up and pointed out the marks on Baby S together with her wheezy chest and cough. It is clear that Mrs MS was very attentive to the needs of Baby S.

75. In terms of her training to become a Family Day Care Educator with ASFDC, I received evidence from Mrs Erica Johansson, who was (at the relevant time) the Scheme Manager of ASFDC. Mrs Johansson gave evidence that ASFDC facilitates in home care for children and provides training and support to their registered educators. Mrs Johansson noted that in order to become an educator with ASFDC, applicants were required to complete an induction course, undertake police checks, obtain an OCHRE card, have first aid qualifications, be anaphylaxis and asthma trained, trained in mandatory child reporting, food trained and occupancy trained.

76. Mrs Johansson stated that Mrs MS had completed all the training and risk assessments and had undertaken successfully a house inspection. Mrs Johansson noted that Mr MS had also completed all the checks and training required to be registered as an educator's assistant. With respect to her experience of Mrs MS, Mrs Johansson stated that in "all my dealings" she was "lovely, caring and competent". Ms Johansson stated:

> "She meets the children needs and loves them unconditionally. She sets boundaries for the children, but is flexible with them when needed. She is firm but fair. Any children that she cares for are like part of her family. She has even taken them on family holidays with her, with permission from Territory Families. **She is one of our best educators**". (My emphasis added).

77. It is also apparent from the evidence given by Mr and Mrs MS themselves that they were appropriate and qualified educators (aka carers) doing their absolute very best to provide for the care and protection of little Baby S. I

have no doubt this was their priority and they took it seriously. As I stated at the conclusion of the evidence, I do not consider there is any basis to criticise the actions taken by Mr and Mrs MS, in particular Mrs MS, in relation to the care of Baby S. The cause of death of Baby S was not as a result of anything that was done, or should have been done and was not done, by Mr and Mrs MS.

78. I have also carefully considered the evidence with respect to the arrangements made by ASFDC in relation to the care of Baby S. I note that ASFDC conducted its own review of its arrangements and I commend them for taking such a proactive approach. It is clear there was nothing done by ASFDC that was inappropriate or inadequate with respect to Baby S and I make no criticism of their conduct.

79. In relation to Territory Families, I gave very careful consideration to the actions taken by that Department given the significant role that must be undertaken by Territory Families whenever a child is placed under the care of the Chief Executive Officer ("CEO"). I note that Territory Families also conducted its own review of actions taken by them; not just from the time of when Baby S was taken into provisional protection, but in relation to each and every notification in the lead up. Again, I commend Territory Families for their proactive approach. Their review was a very careful and considered analysis of the decisions made throughout. Whilst it is true that there were occasions when certain administrative actions were not undertaken in accordance with policy then in place, I do not consider that any of those actions impacted in a negative manner to such an extent that Territory Families can be criticised for their conduct.

80. A specific concern was raised on behalf of family during the course of this inquest in relation to the time taken for Territory Families to conduct a kinship assessment with a view to the placement of Baby S with a member of her family. In relation to this issue, I consider it important to keep in

mind that Baby S was only under the care of the CEO for a period of 15 days. Further, prior to the removal of Baby S from the care of her mother, it is clear that Territory Families were using every endeavour to provide assistance and support to Ms Charra to enable Baby S to remain in her care. This was not an unreasonable approach given that there was an obvious bond observed between Baby S and her mother and all medical assessments in the lead up to the making of orders, noted that despite the conduct of the mother from time to time, Baby S was in fact "thriving". I therefore do not consider that Territory Families acted inappropriately in attempting to ensure that it had "done all that could be done" before making the serious and significant decision of taking Baby S into care.

81. In my view, I do not believe that the department was taking an unreasonable period of time to conduct their assessment of possible kinship placements. It is clear that such placements are complex and therefore take time. Here the assessment of kin was made all the more complex by virtue of continued allegations by the mother against her family, but also her stated desire to do all that she could to have Baby S returned to her care, which included undertaking rehabilitation. This agreement to enter into rehabilitation was a significant change in circumstances and it is clear that the department were also appropriately attempting to support Ms Charra with a view of returning Baby S to her mother.

Formal Findings

82. On the basis of the tendered material and oral evidence received at this Inquest I am able to make the following formal findings:

    i. The identity of the deceased person was Baby S born 25 September 2014 at the Alice Springs Hospital in Alice Springs in the Northern Territory of Australia.

ii. The time and place of death was approximately 8.33pm on 25 April 2015 at the Intensive Care Unit of the Alice Springs Hospital.

iii. The cause of death was hypoxic ischaemic encephalopathy complicating cardiac arrest as a consequence of respiratory viral infection and pneumonia.

iv. Particulars required to register the death:

a. The deceased was a female.

b. The deceased's name was Baby S.

c. The deceased was of Aboriginal descent.

d. The death was reported to the Coroner.

e. A post mortem examination was carried out by Dr John Rutherford who investigated and discussed the possible causes of death.

f. The deceased's mother is Natasha Ruth Charra and her father is Reece Shane Swan.

g. The deceased lived at a known address in Alice Springs in the Northern Territory of Australia.

RECOMMENDATIONS

83. I have no recommendations in relation to this death.

Dated this 9th day of June 2017.

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GREG CAVANAGH
TERRITORY CORONER