QUEENSLAND
COURTS

CORONERS COURT OF QUEENSLAND

Non Inquest Findings

CITATION:	**Investigation into the death of C, a child aged 14**
TITLE OF COURT:	Coroners Court
JURISDICTION:	BRISBANE
FILE NO(s):	2015/2605
DELIVERED ON:	10 September 2016
DELIVERED AT:	Brisbane
FINDINGS OF:	John Lock, Deputy State Coroner
CATCHWORDS:	Coroners: investigation, death in care, child, person with a disability, foetal alcohol syndrome, intellectual impairment, swallowing difficulties, death due to choking, Child Protection, Public Advocate

Counsel Assisting:	Ms Emily Cooper

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Introduction

C was a 14 year old girl who choked on her food in the presence of her carers – she was transferred via QAS to the Lady Cilento Children's Hospital, but later died on 9 July 2015. C had multiple disabilities, including:

- Foetal alcohol syndrome;
- Autism; and
- Intellectual impairment and associated behavioural issues.

C had been in the care of the State, through various foster carers, since she was three months old. C was mostly fed via a tube to her stomach, however had been beginning to eat orally in the days prior to her death. She had been in the care of the disability facility 'House with No Steps' since 7 January 2013. Prior to that, C had been in the care of various foster carers and other disability care facilities. She was noted to have irregular contact with her mother, who was known to consistently miss scheduled appointments, or request to re-schedule.

Circumstances leading up to death

On 27 June 2015, C was on an outing with her carers and some other children. Both of the carers involved provided statements. The carers had purchased some McDonalds, and placed the food in the front seat of the car while they loaded the other items and the other children into the car.

Even though C was in the back seat of the car, she managed to access the food in the front seat and started to eat it. She was then seen to choke, before becoming red, then blue in the face, before eventually collapsing. Resuscitation was commenced, and the QAS were called at 11:24am.

QAS arrived at 11:37am, at which time resuscitation was ongoing, but no signs of life had returned. A large amount of food was located in her mouth above the vocal cords, and this was removed. QAS continued resuscitation efforts and C eventually responded. She was then transferred to the Lady Cilento Children's Hospital for further treatment.

Whilst at the hospital, C underwent an endoscopic procedure of her airways, during which more food was removed. A similar procedure was conducted the following day so as to clear some fluids and secretions from her airways. A CT scan and MRI scan of the brain showed changes consistent with significant damage to the brain due to the period of impaired blood and oxygen supply (hypoxic-ischaemic encephalopathy). Discussions were made with the family and the Adult Guardian was also involved. A decision was made to cease active treatment, and C was removed from the ventilator machine at 11:36am on 9 July 2015. She died shortly after at 12:02pm.

Autopsy results

Dr Nathan Milne conducted a full internal autopsy examination on 13 July 2015. He concluded the cause of death was:

1(a) Hypoxic-ischaemic encephalopathy, due to or as a consequence of;

1(b) Choking on food; due to or as a consequence of;
1(c) Foetal alcohol syndrome.

Department of Communities, Child Safety and Disability Services

Given that C was a child under a guardianship order (since infancy), a full Systems and Practice Review was conducted by the Department after C's death. The SPR provides a history of C's care, as follows:

- C came to the attention of the Department at birth when concerns were raised in relation to her mother's mental health, her ability to provide appropriate care and also previous her child protection history interstate.

- Whilst in hospital, C's mother was unable to acquire the necessary skills to look after C, despite weeks of daily support and education by hospital staff.

- On 17 April 2001, a Child Protection Order (CPO) granting the Department short-term guardianship of C was granted.

- C had two placements prior to being placed with two foster carers in March 2001 – over the following months, concerns continued to be raised about her mother, who had presented to hospital to give birth to her eighth child, which ultimately resulted in her being admitted to a psychiatric care facility under an Involuntary Treatment Order.

- On 22 September 2003, a CPO granting long-term guardianship of C was granted – she was noted to have special needs including brain damage, failure to thrive, developmental delay, lung disease and congenital cataracts – these needs required C to be fed via gastronomy button, needing overnight oxygen and requiring intensive medical support.

- C's mother was, once again, assessed to not have the required ability to look after C, due to her mental health.

- In November 2006, one of C's foster carers passed away – the remaining foster carer continued to look after C until March 2012, with support from Xavier Children's Support Network so as to meet C's complex needs.

- The remaining foster carer ceased care in March 2012 due to her inability to manage C's increasingly difficult behaviours (aggressive behaviour towards others, smearing faeces and defiance) – despite relinquishing care, the foster carer remained in regular contact with C.

- Initially, C was placed temporarily with House with No Steps on 15 April 2012, however this option soon became more permanent and was the subject of grants-funding – she was eventually moved to the grants-funded home located in Forestdale, where she remained until her death.

During her time at House with No Steps, C was noted (despite her disabilities) to be a child with many abilities and interests. She enjoyed cheerleading and dancing, and was encouraged by staff to engage in those activities. C loved dancing to music, riding her trike and helping out with household chores. She was described as the 'queen bee' within her home environment and thrived on routine. She was largely unable to communicate verbally, and got around this by using sign language – approximately 30% was Auslan/Makaton whilst the rest was made up by C. C required regular follow up with paediatricians, dieticians, paediatric dentists, and specialists in relation to her spinal and respiratory issues.

The SPR is noted to have reviewed the care provided to C for the two years prior to her death. Given the CPO in place, the SPR noted that to meet Departmental standards, a case of C's calibre would require six-monthly case planning and review, including the completion of a child strengths and needs assessment, six-monthly placement meetings, monthly home visiting and annual Education Support Plans. The SPR considered the extent to which these requirements occurred and the quality of the service provided to C. This involved an analysis of C's 'main needs', which were:

- physical health needs (general health, kyphoscoliosis, dental, eyes, hearing, bowel issues, menstruation issues and her end of life medical treatment)
- child development, intellectual ability and education
- behaviour
- relationship with her biological mother
- other social relationships (non-family).

The Review Team considered the Departmental officers overseeing C's case during the two years before her death had a good understanding of C's needs and documented them comprehensively. The main needs identified for C were all met by the Departmental officers appropriately. The Review Team did not identify any concerns with C's placement with House with No Steps and its ability to meet C's needs. It was noted that House with No Steps worked hard to normalise C's life by linking her with social activities such as cheerleading. The Review Team was impressed with the facility's commitment to meeting C's needs and advocating for her best interests. Supervised contact with C's mother was facilitated by the Department, and even after long periods of time where there was no contact, Departmental officers were always receptive at re-kindling the relationship. C had an ongoing relationship with her previous foster carer, and this contact was encouraged and supported by the Department. The contact was facilitated by House with No Steps. The foster carer was considered to be a mother to C, given the length of time she had been in her care.

The overall goal of case planning for C was the provision of long-term out of home care. Overall, the Review Team concluded that the departmental service delivery was sound. As a specialist disability service provider, House with No Steps provided a placement for C that recognised and addressed her needs whilst also encouraging her development and involvement as a member of the broader community. The following matters, whilst not necessarily impacting on C's death, were identified as areas for improvement in the SPR, which were accepted by the individual departmental officers during the review process:

- the importance of exploring and engaging extended family in casework for children on long-term orders
- the value in undertaking stakeholder meetings in those cases where children have complex medical/support needs
- the importance of undertaking case management functions including home visits and placement agreements in ensuring that children's needs are met and relationships are developed with children in care
- the importance of including parents in review processes.

The Review Team noted the Child and Family Reform agenda will change the way child protection services are delivered in Queensland, and will build a new support system for children and their families. The SPR report was provided so as to inform that agenda in the following ways:

- Child health passports
- Information and Communication Technology (ICT replacement strategy including the sharing of case plans)
- Placement services and residential care review (Hope and Healing project)
- National Disability Insurance Scheme (NDIS) will bring a significant shift in how the Department navigates cases where children have disabilities.

The SPR made one recommendation, namely that 'staff from Child and Family Practice and Service Improvement (Practice Leadership), Child Protection and Adoption Design Commissioning, Child Safety Training Branch, in partnership with the South-East Region, will review resources currently available to staff in relation to home visiting children in Out of Home Care to ensure that they are providing staff with the best guidance.'

Domestic and Family Violence Death Review Unit (DFVDRU) review

Given that C's death occurred while the subject of a CPO, the Domestic and Family Violence Death Review Unit within the Coroners Court of Queensland provided assistance and reviewed the material. That review looked at the Child Death Case Review report, but they also looked at the implications of the Public Advocate's recent report 'Upholding the right to life and health: A review of the deaths in care of people with disability in Queensland', which focuses on key issues and systemic recommendations which are relevant to C's death. This report was tabled in Parliament in March 2016.

With respect to interdisciplinary approaches, the Review Panel's broad recommendation to strengthen interdisciplinary approaches, collaboration and communication between relevant entities, including (specific to C's case) child safety services, disability services, placement services and schools is an ongoing tenet of child safety reforms in Queensland following the Child Protection Commission of Inquiry (2013) and the introduction of the National Disability Insurance Scheme.

The Public Advocate report recommended collaboration between relevant agencies to ensure optimum treatment and care of individuals living with a disability and other health conditions in residential care and ensuring there was a dedicated person responsible for coordinating treatment.

With respect to health records, the Review Panel recommended that current, accessible health records were necessary in dealing with children experiencing complex health conditions and/or disability and this is certainly an issue that would be of significant benefit and aid in proactive treatment, care and support. There is no evidence that this was a specific factor in C's death, however it is a clear need for children with disabilities involved with the child protection system. It was noted that recommendations from the Public Advocate report also included practical solutions such as using hand-held health records to ensure continuity and foster better communication between health service providers and people responsible for the every-day care of these individuals; which is of relevance to the Panel's findings.

The DFVDRU review also conducted a review of C's eating plans and various risk assessments conducted. It was noted that C's eating plan did indicate that she had a tendency to take food from others and should be supervised to eat; however the incident was not in a controlled environment where the eating plan might reasonably be expected to apply. C's carers said they were able to sight C and the other children in the van whilst they were unpacking the groceries, however it is apparent that C did get out of her seat and take the food from the front passenger seat.

The Public Advocate Report

The Public Advocate's report considered the deaths in care of people with disability in consideration of the significant health inequities faced by people with a disability. The Report made a suite of systemic recommendations to strengthen the system of support available to this group. It acknowledged that many people with disability who live in residential care had complex health conditions with limited communication skills and noted that their primary health care was generally overseen by support workers with minimal or no medical expertise. It recommended that people with a disability who live in residential care should have a designated person/role to take responsibility for coordinating and reviewing their health care (in consultation with the person themselves and/or their decision maker). It also advocated for the use of hand-held health records that ensure all relevant health information resides with the individual and should be used to promote communication between health care providers and those responsible for the person's every day care.

The specific issue of choking/food asphyxia was also considered in recognition that many people with intellectual or cognitive disability have difficulty with swallowing and eating. The Report found that, of the five people in their review sample who died due to food asphyxiation, swallowing assessments had been conducted and mealtime management plans developed for only three; and that, notably, there appeared to be a lack of compliance with those plans.

The Report concluded that:

- Service organisations and support staff must be alert to risks that indicate the need for further investigation of eating, drinking, swallowing and/or breathing difficulties.
- Support staff must work closely with health practitioners to ensure that risks are appropriately assessed, and that mealtime management plans are developed, the resultant plans strictly complied with, and regular reviews undertaken. Factors such as resourcing and rostering must be considered and addressed in developing plans.
- There is a clear need for increased understanding and training in relation to: the preparation of food; physical positioning, prompting and pacing during meals; maintaining close supervision; and in administering emergency care.
- The potential for legal liability should diagnosed conditions or identified issues not be appropriately managed is an important matter for organisations and staff alike.

Amongst its systemic recommendations, the Report contains recommendations aimed at:

- The development of a Framework to Improve Health Care for People with Intellectual or Cognitive Impairment
- The establishment of local, regional and state-wide networks, led by Health and Hospital Services in partnership with QCIDD to provide clinical leadership, education and support to enhance the provision and coordination of health services to people with disability.
- The National Disability Insurance Scheme (NDIS) Code of Conduct and/or registration/accreditation requirements must include minimum standards in relation to:
    - Health management guidelines (premised on Article 25 of the Convention on the Rights of People and available evidence)
    - Risk management policies and practices
    - First aid and health observation training
    - Critical incident reporting and review.

Conclusions

The frequency of home visits by the Child Safety Officers (CSOs) in this case was considered and it was acknowledged in the SPR that these did not meet with departmental standards. The CSO agreed the number of visits did not meet the requirements, however reported that they had visited more often than was reflected in the records though could not explain why these were not captured. It was noted that despite this, the quality of the interaction was high and the CSO maintained good contact with the placement service and was well informed about C’s welfare. Records provided would generally confirm this. Overall, it appears that C’s health needs were met however appointments were occasionally missed. I am satisfied that the residential service always responded quickly if notified of any missed appointments.

In a general sense, it is clearly critical that that the provision of care and support that is provided to a child subject to departmental intervention is appropriately recorded to ensure the appropriate provision of care, and that irrespective of what case officer is working with the child or family; they are able to quickly and accurately assess both current and future client needs. Whilst this is an area that requires continuous focus and improvement by the Department, I am unable to definitively determine that this led to any detrimental outcomes to C, or in any other way may have contributed to her death.

The residential care facility, House with No Steps (HWNS), provided their care plan in relation to C which included meal plans and guidance for support workers. In relation to eating, the care plan stated:
“C loves all food but can tend to take food from others. C requires guidance with eating with a knife and fork (previously PEG fed) and can tend to overfill her mouth. Staff to prompt C to slow down and to use her knife and fork instead of her hands to help slow her down.”

C’s latest Eating and Drinking Plan (dated 1 March 2015) provides that C should eat a balanced diet at a table with water. Carers were required to cut her food into small pieces as she was unable to do so without assistance. It was noted that she should have a utensil in each hand to prevent her from using one hand to push food into her mouth. Based on the incident reports that have also been presented it is clear that, overall, C’s eating was well managed by staff and she enjoyed preparing and eating a variety of food with her carers and co-tenants.

One of C’s carers stated an inability to recall if there was a formal plan in place for C’s eating and drinking. This in itself strengthens the case presented in the Public Advocate’s report about the need to increase understanding and capacity within the disability services sector about the increased potential for choking on food; and to improve understanding and compliance with individual eating plans.

For the purposes of s .9 of the *Coroners Act 2003*, C’s death is a ‘death in care’ as categorised by the following:

‘9 Death in care defined
(1) A person’s death is a death in care if, when the person died –
(d) the person was a child who was—

(iv) the subject of a child protection order granting long-term guardianship of the child to—
…
(B) another suitable person, other than a member of the child’s family, nominated by the chief executive.”

With respect to whether I am required to hold an inquest into this death, I note the application of s.27 of the Coroners Act 2003:

"27 When inquest must be held

(1) The coroner investigating a death must hold an inquest if—
(a) the coroner considers the death is—
(i) a death in custody; or
(ii) a death in care, in circumstances that raise issues about the deceased person's care;"
….

The circumstances surrounding this death are that C had taken food that was not intended for her and unfortunately choked. One of the carers who was responsible for C said that both carers were unloading a trolley full of groceries when the incident occurred. One of the carers reported that the food was in the foot well of the front passenger's seat and that they were able to observe each of the children whilst unloading the groceries. It remains unclear how C managed to access the food from where she was in the back seat, however I am satisfied that the carers took reasonable steps in the circumstances by asking C to stop and remove the food; and then providing medical assistance and calling 000 when it became apparent that C was having difficulties.

I am satisfied that the implementation of recommendations from the Public Advocate's report will improve the provision of care to children with complex disabilities in the care of residential facilities across the service system. I am of the view that the circumstances of this case do not warrant an inquest. Whilst this is a death in care for the purposes of s. 27 of the *Coroners Act 2003*, I have not been able to identify any significant systemic shortcomings, or missed opportunities for intervention with respect to the provision of care by the Department of Communities, Child Safety and Disabilities Services.

I close the investigation.

John Lock
Deputy State Coroner
BRISBANE
10 September 2016