OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Felix Jake STILLER-SMITH**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Brisbane
FILE NO(s):	COR/03 0193
DELIVERED ON:	10 August 2007
DELIVERED AT:	Brisbane
HEARING DATE(s):	12 February, 12 April, 13 & 14 June 2007
FINDINGS OF:	Ms Christine Clements, Deputy State Coroner
CATCHWORDS:	CORONERS: Inquest – infant death, undetermined cause, presence of amphetamines in breast milk, contact with the Department of Families

REPRESENTATION:

Ms K McMillan of Counsel – appearing to assist the Coroner

Mr K Parrott of Counsel – representing Department of Child Safety; instructed by Crown Law

Ms L Evans of Counsel – representing Royal Children's Hospital instructed by Crown Law

Mr B Farr of Counsel – representing Ms Angela Stiller, instructed by Minter Callaghan Lawyers

CORONERS FINDINGS AND DECISION

Introduction

1. I record at the outset of these findings that the inquest proceeded in the absence of the mother, Angela Stiller. She was served with documentation informing her of the inquest as was the father. Neither parent attended the pre-inquest conference but the father, Paul Smith has attended throughout the course of the inquest. Ms Stiller attended the first day of the inquest. She was accompanied by a support person but that person was not a legal representative. It was apparent from Ms Stiller's presentation on the day and information available on the material before the inquest that it was advisable that Ms Stiller obtain independent legal advice and representation. The evidence of the attending police officer and pathologist who performed the autopsy was taken on that first day but the inquest was adjourned after that evidence to enable Ms Stiller to obtain legal advice and representation. The court was then advised that Mr Farr of counsel would be representing Ms Stiller. A transcript of the proceedings to that point and access to the material was facilitated.

2. Unfortunately, when the inquest resumed on 13 June 2007, Mr Farr appeared but his client Ms Stiller was not present. Inquiries indicated Ms Stiller was unable to attend court due to illness but no advice had been given to her legal representative. No application for further adjournment was made and Mr Farr sought and was given leave to withdraw.

3. In all the circumstances of the matter it did not appear to be warranted to further adjourn the matter.

Coroners Act 1958 applies

4. The inquest was conducted pursuant to section 26 of the *Coroners Act 1958* ("the Act") because the death occurred before 1 December 2003, the date on which the *Coroners Act 2003* was proclaimed. It is therefore a "pre-commencement death" within the terms of s100 of the latter Act, and the provisions of the *Coroners Act 1958* are preserved and continue to apply in relation to the inquest. I must deliver my findings pursuant to the provisions of that Act. I do so, reserving the right to revise these reasons should the need or the necessity arises.

5. The purpose of this inquest, as of any inquest under the Act, is to establish, as far as practicable –

    - the fact that a person has died;
    - the identity of the deceased person;
    - whether any person should be charged with any of those offences referred to in section 24 of the Act;
    - where, when and in what circumstances the deceased came by their death.

6. It should be kept firmly in mind that an inquest is a fact finding exercise and not a method of apportioning guilt. The procedure and rules of evidence suitable for a criminal trial are not suitable for an inquest. In an inquest

there are no parties; there is no charge; there is no prosecution; there is no defence; there is no trial. An inquest is simply an attempt to establish facts. It is an inquisitorial process, a process of investigation – see *Annetts v McCann* (1990) 170 CLR 596 at 613-617, per Toohey J.

7. A Coroner's inquest is an investigation by inquisition in which no one has a right to be heard. It is not inclusive of adversary litigation. Nevertheless, the rules of natural justice and procedural fairness are applicable. Application of these rules will depend on the particular circumstances of the case in question.

8. In making my findings I am not permitted, under the Act, to express any opinion, on any matter which is outside the scope of this inquest, except in the form of a rider or recommendation.

9. The findings I make here are not to be framed in any way which may determine or influence any question or issue of liability in any other place or which might suggest that any person should be found guilty or otherwise in any other proceedings.

Summary of evidence

10. Felix Jake Stiller-Smith was born on 30 December 2002. His parents are Angela Stiller and Paul Smith. They have an older child named Indigo Emilio Stiller-Smith.

11. Mr Smith and Ms Stiller had a volatile relationship. They lived together at 189 James Street, New Farm but by March 2002, they were living separately. Mr Smith continued to reside at James Street. Ms Stiller moved to a New Farm address and then to a housing commission unit at 28/56 Farm Street, Newmarket from about November 2002, shortly before the birth of Felix.

12. On 30 December 2002, Felix was born at the Royal Women's Hospital. Mother and baby stayed in hospital for a very short period of time and left the hospital the day after the birth. Angela and baby Felix stayed with Paul Smith for a couple of days after discharge. Felix was breast fed and was also supplemented with formula. He attended the Spring Hill Medical Centre on 10 January, 2003.

13. Ms Stiller's first statement of 6 February, 2003 records that on 15 January, 2003 Felix was dozy. She breast fed him and gave him a bath. She stated he coughed up some mucus. Her mother attended and they took Felix locally to Dr Costello who referred them to the hospital. Felix was admitted to hospital. Ms Stiller indicated the diagnosis was a viral infection and that Felix was gravely ill with septicaemia. She admitted that the hospital detected amphetamines in the baby's urine but sought to explain this as an inadvertent contamination of her breast milk. She said she had been at a friend's home and had taken a bottle of iced tea home which she believes had amphetamines in it. Felix was released from hospital on 28 January, 2003 after thirteen days. The information about the presence of

amphetamines in Felix's urine was discussed with the mother by a hospital social worker, Mr Clements. He kept this information confidential because she provided some innocent explanation of how this might have occurred. The father of the child, Paul, only visited Felix once during the hospitalization. He was not informed that amphetamines had been detected until after Felix's death.

14. Ms Stiller's statement records that on 30 January, 2003, she was at her home unpacking and cleaning. She "arranged to get some amphetamines" that day from someone she knew in the Valley. She stated she breast fed Felix at 6.00pm and then fed him expressed milk at about 8.30pm before putting him to bed. She says she then took little bits of speed and fell asleep.

15. She told police that she had used amphetamines (speed) recreationally for ten years. According to her statement to police, the last occasion she took amphetamines prior to Felix's death was on 30 January, 2003.

16. She and Felix stayed with Paul Smith on 31 January, 2003 and also 1 and 2 February, 2003 before returning to her home with Felix. The older child, Indigo stayed with his father. Ms Stiller was still in the process of unpacking. Her statement continues that she was at the unit on 5 February, 2003 unpacking and looking after the baby. She stated she breast fed him every two to three hours and later in the evening, with a bottle of formula.

17. At about 4.30pm on the afternoon of 5 February, 2003, she met Paul Smith with Felix and went to his house at James Street. The child, Indigo was also present. Paul Smith went out for a short time with Indigo to shop during which time Ms Stiller breast fed the baby. She recalls Felix being apparently well and that photos were taken. He was fed some formula at about 9.30pm and then put to bed in the papoose wrapped in a bunny rug at the end of the mattress on the floor. The baby went to sleep and Ms Stiller says she also went to sleep in the second room on a mattress on the floor. Her first statement refers to two cushions, a pillow and a doona being on the bed. Her second statement suggests she thinks Paul brought in a pillow after she was asleep and put her head on it and moved the baby up to it.

18. Ms Stiller told police she woke up to hear Felix crying at about 12.30am. She removed him from the papoose and laid him next to her on the mattress where she breast fed him lying side by side. She said the baby was still wrapped in his bunny rug.

19. Ms Stiller's statement says she woke up about 2.30am or 2.45am. She recalls the light being on and rolling over to her left to face Felix. She saw some blood on the sheet in front of his face and blood coming from his nose. He was still and lying on his right side. She states his blanket was wrapped around him a little. She picked him up and ran towards Paul's room crying out that she thought he was dead. Paul took the child from her

and placed him back on the mattress and started resuscitation attempts and told Angela to ring the ambulance. Efforts at resuscitation were unsuccessful.

20. Constable Damian Houston was the first police officer in attendance in the early morning when Felix died. He confirmed that Mr Smith told him he found Felix in the back bedroom. By the time he arrived Felix was being held in the arms of his paternal grandmother, Dorothy Smith who had arrived at her son's house.

Autopsy

21. Dr Guy Lampe performed a complete autopsy on Felix on the same day that he died, 6 February, 2003. Another pathologist, Dr Olumbe had attended the house where Felix died and observed the child's body in situ. No injures were detected on Felix. There was some dried blood in his nostrils which the pathologist remarked was of little significance.

22. Dr Lampe was aware of Felix's medical history including the serious septicaemia illness and the presence of amphetamines detected in urine samples during that hospital admission. He noted old haemorrhage in the lungs and organising (healing) fibrosis in the liver. He considered that these were explicable on the basis of the previous exposure to drug effect when Felix was exposed to amphetamine. He referred to literature that documented such effects in other cases in the past. There was a sample of breast milk that was tested. This revealed a very low level of methylamphetamine. He could not say that this level of amphetamine caused Felix's death. The literature is simply insufficient to quantify at what levels such drugs are toxic to a baby of Felix's age. The possibility of amphetamine toxicity could not be excluded.

23. There was no evidence presented to the inquest to suggest that Felix was demonstrating some of the more distressing symptoms of exposure to amphetamine, such as agitation, irritability, vomiting, eye movements or seizure.

24. The exact mechanism of death could not be determined. The heavy and congested internal organs could be due to either a drug effect or to hypoxia or asphyxia. This could be consistent with a SIDS death. I note that nominating this to be a SIDS death would be precluded on the basis of other possible explanations for the death.

Parent's actions and responsibility

25. Felix's parents were of course the primary carers for Felix with the ultimate responsibility for his welfare. On review of all the information available, it is clear that Felix's mother was experiencing serious difficulties coping with a new born child. The father, Mr Smith was contradictory in terms of whether Ms Stiller was coping with Felix and her use of illicit drugs. He suggested to the inquest that he suspected that she was using prescribed and non prescribed drugs at various times but wasn't really sure. He also acknowledged that from time to time, when the opportunity

arose, he would use marijuana. He hastened to add that this was not at such times that he had care of Indigo. It seems that his focus of attention was on the older child, Indigo although he made some efforts to assist Ms Stiller and the baby.

26. Broadly speaking, this family unit of two young separated parents with two young children was struggling to cope. Again, I note that the cause of Felix's death remains undetermined and no blame for Felix's death is implied in my remarks. The focus of my remarks is that this family needed help to protect its most vulnerable members.

Findings

27. Felix Jake Stiller-Smith was born on 31 December, 2002 and died at New Farm on 6 February, 2003. He was co-sleeping with his mother, Angela Stiller at the time. A full autopsy was unable to determine the cause of death. No natural disease process was identified. The pathologist considered that heavy, congested, internal organs could be due to either drug effect or to hypoxia or asphyxia. The effects of breast milk from the mother passing methylamphetamine to the child were considered by the pathologist to be significant in contributing to, but not causing, the child's death.

28. No person is committed for trial in relation to the death of Felix Stiller-Smith.

Issues commented upon pursuant to section 43 (5) Coroners Act 1958

Co-sleeping

29. Felix died sometime after his mother had moved him onto the same mattress where she lay down with the child to breast feed him. The autopsy was unable to determine a cause of death. There was evidence from the very experienced social worker, Ms Ann Elliott, who was engaged as part of the independent child death review team. She referred to the fact that although opinions varied in different cultures about risks inherent with co-sleeping between adults and young babies, there was certainly clear evidence that co–sleeping with a young baby where the parent had been using alcohol or drugs, was risky to the infant.

30. There was sufficient evidence from Ms Stiller's past history and from the autopsy itself, that baby Felix was potentially at risk of ingesting illicit drugs from his mother's breast milk. There was the previous incident when it had been documented during his hospital visit for a viral infection, that amphetamines were detected in his urine. Ms Stiller sought to explain this saying she had inadvertently consumed some juice that had been spiked and was at a friend's place. Given the information on medical records about drug use and the suspicions expressed by Paul Smith, this explanation does not appear to be likely.

31. At autopsy, amphetamine was detected. There is no evidence to explain this and the inference that can be drawn in the context of all other information is that the presence of the drug is most likely to be explained due to breast milk from his mother. The autopsy did not conclude that amphetamines were present at such a level as to be causative of death but amphetamine was noted as a contributing factor in Felix's death.

32. I also note that Felix and his mother came home from hospital only one day after his birth. There is no evidence about whether or not Ms Stiller or the father was provided with information from the hospital about risks of co-sleeping in particular circumstances (drug or alcohol use).

33. I simply emphasize the potentially critical importance of that advice about the risks of co-sleeping being provided by hospitals to new mothers after the birth of their baby.

Involvement of Department of Families with Felix, his brother Indigo and their parents.

34. The independent child death review clearly identifies that necessary action was not taken promptly enough to intervene and support this family when it had been identified as necessary to protect two young children. The family had first been identified prior to Felix's birth when the mother, Ms Stiller contacted the department in September 2003 indicating she was having difficulties coping and was worried about the imminent birth. She also indicated a possible diagnosis of bipolar disorder.

35. The family then came to attention when fifteen month old Indigo accidentally ingested his father's Rohypnol sleeping medication and was admitted to hospital. The parents discharged him earlier than advised from hospital and did not take him for review by a doctor as directed. They did so once the Department indicated they would intervene with a court application if this was not attended to.

36. Then, on 15 January, 2003 the infant Felix became seriously ill with septicaemia. His mother appropriately took him to hospital. It was discovered that he had amphetamines present in his urine and the Department was informed and the SCAN team activated. The child was in hospital for a period of thirteen days and the Department decided that action needed to be taken to properly assess what intervention and support this family needed to ensure the child's safety upon discharge. The child was discharged from hospital on 27 January, 2003. No such action occurred prior to or after discharge. The family services officer had practical difficulties trying to arrange attendance on the mother and baby and the first meeting planned for 31 January, 2003 did not happen nor did the second visit, planned for 4 February, 2003 eventuate. Felix died on 6 February, 2003.

37. I note that the undetermined cause of Felix's death precludes any assertion that had the department visited at an earlier time or taken any

particular action that Felix's death might have been averted. Never-the-less, it must be said that there was enough information known to the Department to alert them to take urgent action upon Felix's discharge from hospital to further assess and intervene or offer support as necessary.

38. With hindsight, we know that the pathologist considered it noteworthy that amphetamines were again present at the time Felix died. He considered that the effect of (maternal) methylamphetamine ingestion which was passed on to the baby was a significant condition contributing to Felix's death.

39. Again with hindsight, we can look back and acknowledge the pressures of work on departmental officers, particularly at that time of year. One might also query why information about the presence of amphetamines in the baby's urine was withheld from the other parent. In cases where a possible innocent explanation is proffered, surely the overwhelming vulnerability of a baby must outweigh consideration of confidentiality.

40. Where the risk was prima facie that the mother had passed the drug to the child via breast milk, it would seem appropriately protective of the child's best interests of safety that this information be given to other adults in a position to monitor the child's safety, be they the other parent or a grandparent. This was even more imperative where the department knew of the discharge of the child from hospital and had not yet undertaken the home visit.

41. An insufficient level of case worker supervision and discussion of decision making might also have hindered support for this family. The case worker referred to fortnightly reviews, if possible, whereas the supervisor referred to weekly review.

Information sharing

42. These comments are made of course in the context of practices within the Department of Families and Health Department as applicable at the time of Felix's death. I note the legislative changes that have since been enacted following the review of child protection.

43. In the course of the inquest I noted in particular the observation of the independent reviewer, Ms Elliott that SCAN teams can be invaluable when they operate optimally. These comments are not a criticism of how the SCAN process occurred in this instance, rather an opportunity taken to affirm the potential when these teams operate effectively. I refer to the opportunity for individual experts from various fields to review the information available and identify what other information needs to be gathered and what critical issues need to be addressed. Underpinning the proper function of the SCAN team will be a sufficient level of information informing the process.

44. The hospital social worker, Mr Clements also raised a valid point that from time to time the actual case worker might be the best person to attend and inform the SCAN meeting. His perceptiveness and willingness to document information non-judgmentally but also to alert the department where he thought it appropriate to do so in the interest of child safety is to be commended.

45. Resource limitations might restrict the opportunity for case workers to directly participate in SCAN meetings but I note as valuable his opinion that there may be times when direct information from the case worker should be provided to SCAN.

46. The other issue highlighted by Ms Elliott was the potential ability of a multi disciplinary SCAN group. When working optimally, these multi disciplinary groups can identify and initiate appropriate information gathering so as to better inform decision making.

47. It was suggested that perhaps there are still interagency impediments to the provision of information to SCAN. If this is so, then the primary interests of child safety should be elevated above other concerns.

I extend formal condolences to the parents and family of Felix Stiller-Smith. Thank you to counsel assisting and all counsel and family members for their contribution to this inquest, which is now closed.

Christine Clements
10 August 2007