CITATION: *Inquest into the death of Skye Bree Burnett* [2003] NTMC 064

TITLE OF COURT:	Coroner's Court
JURISDICTION:	Darwin
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FINDING OF:	Mr Greg Cavanagh S.M.

CATCHWORDS:

REPRESENTATION:

Counsel:

Assisting:	Mr Michael Grant

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IN THE CORONERS COURT
AT DARWIN IN THE NORTHERN
TERRITORY OF AUSTRALIA

No. D0085/2003

In the matter of an Inquest into the death of

SKYE BREE BURNETT
ON 25 MAY 2002
AT 8 ROBERTSON STREET,
LARRAKEYAH

FINDINGS

(Delivered 15 December 2003)

Mr GREG CAVANAGH:

The nature and scope of the inquest

1. Skye Bree Burnett ("the deceased") died at some time between 0100 hours and 0500 hours on 25 May 2002. The deceased was born at the Darwin Private Hospital on 15 March 2002. She was 27 weeks gestation at the time of her birth and her due date had been 12 June 2002. For reasons that follow, the death was entirely unexpected and, as such, was a "reportable death" within the meaning of s12(1) of the *Coroners Act* ("the Act").

2. Section 34(1) of the Act details the matters that an investigating coroner is required to find during the course of an inquest into a death. The section provides:

> "(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) the particulars needed to register the death under the *Births, Deaths and Marriages Registration Act*; and

(v) any relevant circumstances concerning the death; or …

3. Section 34(2) of the Act operates to extend my function as follows:

> "(2) A coroner may comment on a matter, including public health or safety or the administration of justice, connected with the death or disaster being investigated."

4. The duties and discretions set out in subsections 34(1) and (2) are enlarged by s35 of the Act, which provides 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."

5. The public Inquest in this matter was heard at the Darwin Magistrates Court between 13 and 16 October 2003 (inclusive). Counsel assisting me was Mr Michael Grant. Ms Merran Short attended the hearing for a period representing Dr Michael Williams, one of the Consultant Paediatricians involved in the postnatal care of the deceased. Ms Short did not seek leave to appear and adopted an observer's role.

Formal findings

6. The mandatory findings pursuant to s34(1) of the Act are as follow.

(1) The identity of the deceased was Skye Bree Burnett.

(2) The time and place of death was at some time between 0100 and 0500 hours on 25 May 2002 at 8 Robertson Street, Larrakeyah in the Northern Territory of Australia.

(3) The cause of the death was "sudden death in an infant with broncho-pulmonary dysplasia".

(4) The particulars required to register the death are:

(i) the deceased was female;

(ii) the deceased was Caucasian;

(iii) the death was reported to the Coroner;

(iv) the cause of death was confirmed by post-mortem examinations;

(v) the cause of the death is as described in paragraph (3) above;

(vi) the pathologist viewed the body after death;

(vii) the pathologist was Professor Michael Green of the Royal Darwin Hospital;

(viii) the father of the deceased was Robert Burnett and the mother was Leanda Mary Allen;

(ix) the usual address of the deceased was 8 Robertson Street, Larrakeyah in the Northern Territory of Australia; and

(x) the deceased was an infant.

Relevant circumstances concerning the death

7. The deceased was the much-loved and much-wanted baby of Sergeant Robert Burnett, who was stationed in Darwin at the time with the military, and Leanda Allen. It is plain from the evidence that the death was not a preventable death, either on the part of the health-care professionals involved in the deceased's postnatal care or on the part of the parents.

8. The deceased was born grossly premature at 27 weeks. Following her birth she was placed on supported ventilation for a time and experienced the

usual difficulties associated with a premature birth. She was initially under the paediatric care of Dr Charles Kilburn, a Consultant Paediatrician. The deceased was also attended to from time to time in the after hours and weekend setting by Dr Kilburn's colleagues in the medical practice of "Northern Consultant Paediatricians", Dr Ross Diplock, Dr Annie Whybourne and Dr Michael Williams.

9. The deceased was transferred from the Royal Darwin Hospital to the Darwin Private Hospital on 29 April 2002. She developed functionally such that she was breathing unsupported, taking full feeds and gaining weight. She was, by all accounts, an active, strong and interactive child.

10. On or about 15 May 2002, Dr Kilburn travelled overseas and the deceased's primary paediatric care was assumed by Dr Diplock. The deceased was discharged from hospital on 22 May 2002. At that time she was 37 weeks and two days gestation and weighed just under two kilograms. She thrived at home and gained significant weight over three days.

11. On the evening of Friday 24 May 2002 the deceased appeared to her parents to be slightly grizzly and unsettled. Ms Allen is a competent and experienced mother with two older children. She also has nursing training. Ms Allen nursed the deceased until about 0100 hours on that night, at which time the deceased was put down in her cot. Ms Allen awoke at 0455 hours that morning and immediately checked the deceased. The deceased was cold to the touch. Records tendered during the course of the Inquest showed that an ambulance was called at 0456 hours. It arrived on the premises at 0511 hours. Observations made at that time indicated that the deceased had expired, was cyanosed and immobile. No attempt was made at resuscitation.

12. Later that day the parents spoke to Dr Diplock and Dr Whybourne in relation to the death. The parents were clearly and understandably in a state of some shock. During the course of the meeting Dr Diplock and Dr Whybourne expressed the view that the death was attributable to sudden infant death syndrome (SIDS), evidently in the absence of any known physiological cause and having regard to the deceased's sound progress prior to death.

13. On Monday 27 May 2002, a post-mortem examination was conducted by Emeritus Professor Michael Green, who was then a locum pathologist at the Royal Darwin Hospital. On examination Professor Green observed that the lungs did not completely fill the pleural cavities and had a slightly granular texture with areas of peripheral congestion consistent with broncho-pulmonary dysplasia. He considered that broncho-pulmonary dysplasia was the primary cause of death. The parents discussed the results of the autopsy examination with Professor Green that afternoon. His findings were a matter of some concern to the parents in circumstances where they had previously understood the deceased to be perfectly healthy, and where the treating paediatricians had initially attributed the death to SIDS.

14. The death was subsequently the subject of investigation by the Coroner's Constable Anne Lade. I find that her investigation was thorough, competent and professional. During the course of that investigation a number of clinical issues arising from the death were submitted for expert opinion of the highest calibre. The issue of the care provided to the deceased at the Royal Darwin Hospital and the Darwin Private Hospital was addressed by Dr Andrew McPhee, who is the Director of the Neonatal Intensive Care Unit at the Women's and Children's Hospital in Adelaide and Deputy Head of Neonatal Medicine at that same institution. The cause of death was addressed by Professor Roger Byard, a Specialist Forensic

and Paediatric Pathologist employed by the Forensic Science Centre in Adelaide. Professor Byard holds a number of clinical professorships and consultancies, and is a world-renowned expert in the field of paediatric pathology with a specific interest in sudden infant and childhood death. Those experts were called to give evidence during the course of the Inquest. The issues addressed are detailed below.

Whether the care at the Royal Darwin Hospital and the Darwin Private Hospital was appropriate

15. It was Dr McPhee's conclusion that the level of clinical care provided at the Royal Darwin Hospital, and later at the Darwin Private Hospital, was of a good standard and consistent with professional and competent contemporary care modalities in Australia. He also expressed the view that the case notes were of a high quality. Both matters I find to be so.

16. The only qualification to that opinion was in relation to the deceased's nutritional management. Dr McPhee observed that contemporary nutritional management of very low birth weight babies involved the administration of total parenteral nutrition from day 1 or 2. In the deceased's case, total parenteral nutrition was not introduced until day 5 and not fully initiated until on or about day 12. The Inquest heard some evidence from Dr Williams and Dr Kilburn to the effect that the deceased's dextrose intolerance was such that prepackaged total parenteral nutrition was not appropriate until the condition was stabilized, but Dr McPhee was of the view that the intolerance could have been addressed by the introduction of protein alone.

17. In any event, Dr McPhee was of the opinion that this matter had no impact on the outcome and indicated there was no scientific evidence to support the contention that an aggressive approach to nutrition in very low birth

weight babies reduces the risk of sudden unexpected death. This is primarily a clinical issue and I make no comment on the matter save to observe that contemporary nutritional management of very low birth weight babies would in the normal course appear to favour the administration of total parenteral nutrition from day 1 or 2.

Whether it was appropriate to discharge the deceased on 22 May 2002

18. Dr McPhee made the observation that in contemporary clinical practice, the decision to discharge was determined predominantly by function and acceptable cardiopulmonary stability. The deceased was discharged at 68 days of age which, following delivery at 27 weeks and four days equated to discharge at 37 weeks and two days gestation. Dr McPhee was of the view that the deceased's age at discharge was consistent with contemporary Australasian practice. He also noted that the deceased had achieved an acceptable level of function by the time of discharge, had comfortably acceptable oximetry levels (ie the level of oxygen in the blood), had no reason significant apnoea, and was on full sucking feeds and gaining weight. His conclusion was that the decision to discharge was appropriate and consistent with contemporary practice and I find that to be so.

19. There was a suggestion prior to commencement of the Inquest that had the parents of the deceased had access to a monitoring device on discharge, the death may have been avoided. Dr Williams gave evidence in relation to matter of the following terms:

> "Is there ever a case for releasing a premature child with a monitoring device?---This has been addressed since Skye died, by the American Academy of Paediatrics who've released a position statement on apnoea and sudden infant death syndrome, home monitoring, their conclusions there - I'll give you copy of this – is that home cardio respiratory monitoring should not be prescribed to prevent SIDS. The monitors have been used now for many years,

there's not been any documentation that they prevent SIDS. And in hospital situations where children have been monitored and had sudden death and had prompt resuscitation, which there's been documented cases, numerously aware, that's been unsuccessful.

20. I accept that the provision of a monitor was not necessary or indicated in this case, and there is nothing to suggest that the provision of a monitor would have been helpful in averting the tragic death.

21. Two matters require some further attention in the context of the discharge.

22. First, Dr Williams, one of the deceased's treating paediatricians, gave evidence to the effect that he adopted weight as one of the primary indicia as to discharge. He indicated further that he tended not to discharge until a premature child had reached to 2200 to 2400 grams in weight. That is not to say the discharge of the deceased in the circumstances was inappropriate having regard to her function and cardiopulmonary stability. Dr Williams acknowledged that his was a more conservative approach which was drawn somewhat arbitrarily by reference to weight.

23. The second observation to be made in this context is that the deceased experienced some bradycardic episodes in the week prior to her discharge. These were noted by the mother of the deceased and also recorded in the hospital notes. The evidence in this respect was uniformly that bradycardic episodes of that kind are transient in nature and not a contraindication to discharge. Dr Whybourne's evidence in relation to the matter was as follows:

"Skye's parents or mother particularly, will give evidence to the effect that in that last seven or so days after caffeine therapy was ceased; when the baby was resting on the chest, it would sometimes go into a - at the very least - a deep sleep if not a apnoea attack and the nurses used to revive her by tickling her on the foot. Is that the sort of episode that you would have expected to be recorded in the

medical notes?---Yes. The nursing staff actually keep an observation chart about apnoeal bradycardia episodes and I did have a lot of that chart today which is with those notes. And there are - it is probably important to understand the difference between apnoea and bradycardia so.

"Thank you. Thanks could you explain that to us?---Yes. An apnoea is medically defined as an episode where a baby stops breathing for a period of 20 seconds or longer. The alarms in the nurseries are often set to alarm at 10 -15 seconds or so to alert a nurse that a baby is having a prolonged respiratory pause. By definition, a baby is not having a pathological apnoea until they have stopped breathing for 20 seconds. The alarm will also alarm when a baby has a bradycardia episode. So their heart rate drops below about 120. Now we know that all babies have bradycardia episodes even healthy term babies have bradycardia episodes but most of the time you wouldn't know that because they are not on monitors because.

"THE CORONER: How do you spell bradycardia?--- B-R-A-D-Y-C-A-R-D-I-A, which means slow heart.

"Yes, go on?---So it may well, be that when Skye was being stimulated is was because she was having bradycardia episodes and one might question whether she needed stimulation because most babies recover from bradycardia episodes by themselves when their heart was slow and they will pick up again and that is a natural coping mechanism with the baby to respond to a bradycardia episode. Now on Skye's observation chart there were several bradycardia episodes noted in about the last two weeks in the nursery. But no apnoea.

"All right. So there is a distinction drawn between the two quite obviously?---Yes, and a nurse may respond to the such a episode, presumably the saturation monitor alarming or the heart rate dropping in the same way."

24. The matter was also addressed by Dr McPhee in his evidence:

"Doctor, you may not recall now, but I think in the nursing observations, there are a couple of records of mild bradycardic incidents in the ten - seven to ten days before Skye was discharged. Would that have been - well, first of all, I'll ask you, do you recall those - - -?---Yes, yes.

"- - - references?---Yes, I do.

> "Was that a contraindication to discharge at the time?---I don't believe so. They were all transient observations. They were transient deceleration - not decelerations, that's the wrong word. Transient bradycardic events, drops in heart rate. In other words, Skye picked them up herself. And in particular, the lungs that were - the last ones documented in the notes were in relationship to the first four hourly feed she had. So presumably related to her first, very big feed. I think these events in relationship to feeding, probably just reflect little episodes of reflux and milk coming up the back of the throat and so on. And I don't place a great deal of concern on those, if they're not associated with bradycardias or events that require stimulation. I think, transient events can largely be ignored."

25. In light of that evidence, I do not consider that there was any contraindication to discharge at the relevant time.

Whether the broncho-pulmonary dysplasia should have been identified prior to the deceased's death

26. The medical evidence in this respect is unanimous. The condition was clinically silent in that it could not have been known to the paediatricians prior to death. It was only discernible, and was only discerned, on post-mortem examination. The only tests which could theoretically have been undertaken during the deceased's life in an attempt to identify the condition were those available in specialised research facilities, of which there are none in Australia. Having said this, the deceased's clinical presentation was not such that special testing was indicated even had such facilities been available.

27. Given that the condition was not apparent clinically, and could not be discerned other than on post-mortem examination, there was simply nothing that could have been done to avert the death. Dr Byard addressed the issue in the following terms:

"Now, professor, given our current level of technology and given that the clinical findings in this case weren't indicative of bronchopulmonary dysplasia, is there anything that can be done to avert those sorts of occurrences?---Unfortunately not. I think it's very, very difficult for parents to come to terms with the fact that they have a child that appears quite normal, then dies unexpectedly and something is found at autopsy. Because they feel that they should have been able to detect it. The doctor should have been able to detect it. But I've had a number of cases now over the years where we've had this sort of situation. And I think I submitted a paper that I did with Doctor Whybourne, which actually showed a video tape of a baby who had tremendous leukaemia and was videoed the day before he died and he looked like a normal healthy, happy little baby."

28. Even had the deceased's mild to moderate broncho-pulmonary dysplasia been known prior to death, that knowledge would have been largely irrelevant to the care of the deceased and the clinical decisions made in the course of that care. The evidence indicates that 50% of 27 week premature babies have the condition to that degree.

29. Questions of identification of the condition and clinical care considerations were addressed by Dr McPhee in his evidence:

"Doctor, the third matter you've addressed in your report, you've already really spoken to today and that is whether or not the condition of Skye's lungs should have, or could have revealed itself to the treating paediatricians, prior to her discharge. If I - at the risk of asking you to repeat yourself, could you just give us - or give His Worship your views in that respect?---Well, as I've already mentioned, I don't think there was any clinical evidence that Skye had any respiratory difficulties. In fact, there was very compelling evidence that she had no clinical problems with her respiratory system. So other than the fact that she was pre-term and had been ventilated, which are risk factors, I guess for BPD, I don't see how the treating clinicians could have appreciated or made that diagnosis.

"And then, doctor, if I could ask you to address a hypothetical point. Assuming that the doctors had have known that Skye had BPD, even though clinically she was presenting as she did, would that have changed anything in terms of care directions, the time of discharge and those sorts of issues?---Well, I don't believe it would have.

> Because the only reason that it would have, was if we knew that there was an increased risk associated with those observations. And I'm unaware of that knowledge. So, I'm not sure how it would influence that practice.
>
> "I think you say in your report, doctor, BPD of this level of severity, or a diagnosis, or information indicating pre-mortem that there was this level of BPD, wouldn't have been reasonably relevant to any decision regarding clinical care?---Exactly. Yes."

30. There is one further matter that requires some consideration in this context. Some concern was expressed by the mother of the deceased during the course of the Inquest that taking the deceased in and out of air-conditioned environments during the three days following her discharge may have put some burden on of the deceased's lungs and contributed to her death. That matter was put squarely to Dr McPhee during the course of his evidence. Dr McPhee's response was that this was "extraordinarily unlikely". I trust that response brings some comfort to Ms Allen.

The cause of death and communications between the parents of the deceased and the various medical practitioners

31. The cause of the deceased's death was the most vexed issue considered during the course of the Inquest. The source of that vexation was not that there is in this case any relevance in terms of treatment or preventability in the distinction between the diagnosis of SIDS and that of sudden death in an infant with broncho-pulmonary dysplasia. The source of that vexation was the parents' understandable confusion when told that their child had died from lung disease when the previous, albeit preliminary, indication was that the death was inexplicable. Their consequent vexation was based on the mistaken premise that the condition could have been identified prior to death, and that the course of treatment and care might have somehow been different. For the reasons already discussed, that is not the case and I

understand that the parents have come to that understanding during the course of the coronial process.

32. The circumstances of the communications with the parents in relation to the cause of death are considered further below. Before doing so, it is appropriate to give some consideration to the cause of death and the distinction between SIDS and that of sudden death in an infant with broncho-pulmonary dysplasia.

33. It was Professor Byard's evidence that the accepted definition of SIDS is "the sudden death of an infant under one year of age which remains unexplained after a thorough case investigation, including performance of a complete autopsy, examination of the death scene and review of the clinical history". Thus, the terms SIDS can only be used when no significant organic disease has been found at autopsy and full microbiological and toxicological testing has been performed. Pulmonary pathology testing conducted at the Women's and Children's Hospital in Adelaide found that the changes in the deceased's lungs amounted to "up to moderate broncho-pulmonary dysplasia". Professor Byard considered that the abnormalities found in the deceased's lungs on autopsy precluded a diagnosis of SIDS. Professor Byard's opinion in relation to the definition of SIDS and the consequent preclusion of the diagnosis given the findings on autopsy was largely accepted by the other witnesses during the course of the Inquest.

34. As to the cause of death, in his written report Professor Byard noted that broncho-pulmonary dysplasia could not be excluded as a potential contributor to death. That report did not seek to attribute the death in whole or in part to that condition. In the circumstances, he assigned the death as "sudden death in an infant with broncho-pulmonary dysplasia".

35. There was some discussion during the course of the Inquest as to whether the broncho-pulmonary dysplasia was the cause of death, a contributing factor, or just coincidentally present in the deceased. The various views posited are summarised in the following exchange with Professor Byard:

> "Now, when you say, doctor, that you can't exclude the BPD as a potential contributor to the death, are you able to spin it around the other way and say you can't say that it was a contributor to the death, or does that not follow?---I think I'd be - I think I'm favouring that it is the cause of death, I just can't be absolutely certain.
>
> "THE CORONER: Well, you're back to the position really that we heard from Professor Green yesterday. Which he agreed with you, but he thought on the balance of probabilities the lung problem did cause the death, but he couldn't be certain. That's around - that's about the circle, isn't it, counselor?
>
> "MR GRANT: That was my understanding of Professor Green's evidence, yes.
>
> "That accords with your view as well, professor?---As much as I don't like agreeing with Professor Green, I'm afraid I do on this occasion."

36. The general consensus seemed to be that the broncho-pulmonary dysplasia was more likely than not the cause of the death in the absence of any other condition, pathology or information. The matter is not entirely clear. The histopathologist who conducted an examination of the deceased's tissue at the Women's and Children's Hospital in Adelaide in conjunction with Professor Byard identified a "central cause" in a written report tendered during the cause of the Inquest. That matter was raised with Professor Byard in the following terms:

> "Doctor Lipsod also says that she felt that a central cause was more likely. What do you understand her to mean by that?---I'm not certain what she means by that. It's - excuse me, Your Honour, if I could just close this door.

"THE CORONER: Well, before the professor finishes his answer, I think I interrupted yesterday and said words to the effect that I took that to mean a central nervous system problem, ie, the electricity in the body from the brain switched off. Was I being a little bit too pedestrian and working class, to put it that way, professor? ---Well, that's exactly my understanding, Your Worship.

Thanks.

"MR GRANT: That's your understanding of what it is that Doctor Lipsod is saying there?---Yes, she's referring to some problem with the brain and the chemicals of the brain, or the electric circuitry of the brain. It's not working properly and that's why the baby was having problems with breathing and problems with the heart rate. Now, I would tie that in with bronchopulmonary dysplasia. We know that these babies have significant respiratory problems. They're short of oxygen. They may get central nervous system damage. So it may be that the scarring of the lungs is just a marker of some central problem. So I don't think the two are mutually exclusive, they may be very well tied in together."

37. It is not necessary for me to go so far for the purpose of attributing a cause to the death and, as is apparent from the formal findings, I adopt Professor Byard's formulation of "sudden death in an infant with broncho-pulmonary dysplasia".

38. As stated, one of the significant concerns expressed by the parents during the course of the Inquest revolved around the nature and tenor of their communications with various medical practitioners. There were three particular transactions the subject of some attention and I will deal with each in turn.

39. The first involved the transfer of the deceased from the Royal Darwin Hospital to the Darwin Private Hospital on 29 April 2002. Ms Allen was of the view that there was a lower level of care available at the Darwin Private Hospital, a matter of which she was not fully apprised prior to the transfer. This was conceded during the course of the medical evidence, but in this limited respect. The Royal Darwin Hospital contains Darwin's only

Level 3 nursery. Level 3 nurseries provide a more intensive level of care and are generally staffed by health care professionals with a higher level of training in acute paediatric care. The Royal Darwin Hospital also has a Level 2 nursery. Once a child's condition has adequately stabilised, they transfer or "step down" to Level 2 care. The nursery at the Darwin Private Hospital is also a Level 2 nursery. Dr Kilburn gave evidence in the following terms:

> "Now, it was Skye's mother's observation, as she's related it to me and she'll give her evidence, that the level of care that she experienced in the private hospital wasn't of the equal level experienced in the public hospital, in terms of either the equipment that was there or the level of training of the nursing staff. Do you accept how it is or why it is that she might have that perception?---Yes, I can see how she may have that perception. I think her experience in Royal Darwin Hospital had been essentially in the level 3 nursery, in the more intensive part of that nursery and had she - I think she would have - she may have had a different experience had Skye actually been stepped down into the level 3 - into the level 2 section of the Royal Darwin Hospital nursery.
>
> "All right, now, there are special trained neonatal nurses at the Royal Darwin Hospital nursery?---Yes.
>
> "There are no such nurses over at the Darwin Private Hospital nursery?---There are nurses in the Darwin hospital nursery who have had neonatal training and in fact a number of those nurses started off their careers in the public hospital nursery. They no longer do if you like, the highly intensive neonatal nursing, but there are a number of nurses. There are a couple of nurses there who are very experienced neonatal nurses but not everybody on the roster has equal experience.
>
> "Whereas in the Royal Darwin Hospital in the nursery there all of the nurses would have at least experience, if not, specialised training in neonatal care? ---Unfortunately, it would be nice if they all had training in neonatal care, we struggle to get 60 to 70% of them to have their neonatal certificate, but most of them have had experience in looking after babies, yes. Having said that I believe that most of the nurses in the private hospital nursery will have had some experience in looking after babies, although certainly that mightn't be as extensive."

40. It is plain that by 29 April 2002, the deceased's condition had stabilised such that transfer to a Level 2 nursery was appropriate. In these circumstances, the transfer was from the Level 3 nursery at the Royal Darwin Hospital to the Level 2 nursery at the Darwin Private Hospital. Ms Allen attributed the change in the level of care accorded to the deceased to the change in institutions rather than to the change in the level of care. The expert evidence indicates that the nature and level of care accorded to the deceased was at all times appropriate given her progress. There is no basis on which to find that there was any material difference between Level 2 care at the Royal Darwin Hospital and Level 2 care at the Darwin Private Hospital. Had the deceased been moved to "step down" or Level 2 care at the Royal Darwin Hospital, Ms Allen's observations in relation to the change in the level of care may well have been the same.

41. The matter does not call for any comment save to make the observation that some parents may be unprepared for the change from acute care to a "step down" facility and may require preparation and advice in relation to the change.

42. The second transaction in which some communication difficulty or confusion arose was in relation to the discharge of the deceased on 22 May 2002. The expert evidence indicated that premature babies have a significantly increased risk of SIDS, and that 27 week premature babies have something in the order of a 50% chance of developing broncho-pulmonary dysplasia. Ms Allen indicated during the course of the Inquest that had she been advised of those matters she may have been better prepared for this tragic death. She indicated that she would not have been so devastated that her apparently healthy baby would die three days after discharge.

43. Dr McPhee was questioned in relation to the need or desirability to apprise the parents of premature babies of these matters prior to discharge. He questioned both the need and the desirability of doing so. All mothers, not just those of premature babies, are counselled in relation to strategies to ameliorate the risk of SIDS, so far as medical science has been able to develop such strategies. It is also the case that even in the face of the risk of a latent broncho-pulmonary dysplasia, the directions for the deceased's care after discharge would have been no different to those for a baby without any risk of the condition given the level of cardiopulmonary stability that she had achieved prior to the time of discharge. Against that background and for those reasons, Dr McPhee questioned the need to overload parents with "negative information" that he perceived to be irrelevant to the care of the child.

44. It does not seem to me possible to set any rule or standard in relation to the matters that should be discussed with the parents of premature babies prior to discharge. As with all questions dealing with the level of information and warning that should be given by medical practitioners to patients, the requisite level must be assessed on a case-by-case basis having regard to factors such as the child's condition, the parents' apparent desire for information, the level of the risk, and the personal characteristics of the parents involved. However, in my view medical practitioners ought provide more rather than less information if there is any doubt about the matter, or no reason not to do so.

45. The third context in which some communication difficulty or confusion arose was following the death of the deceased. As stated above, the parents conferred with Dr Diplock and Dr Whybourne on the date of the death. Dr Diplock gave the following evidence in relation to the matter:

"Now, can I take you back to that discussion you had with Skye's parents on the Saturday afternoon in company with Doctor Whybourne. This is a matter that arises out of an interview that Ms Allen had with Senior Constable Lade. There is a suggestion that Ms Allen presented, as is often the case in those sorts of circumstances blaming herself for the death of the child. Is that correct?---That is correct.

"That is your recollection. Now did that concern on the part of Ms Allen that obviously misplaced concern that no doubt occurs quite frequently, did that at all inform your advice to her that it was a SIDS death?---Well, I am sure that we tried to reassure her that Skye's death was not due to any errors of omission of commission on her part.

"And is one way of doing that to describe it as a SIDS death, an unexplainable death? ---Probably. In thinking back it's - - -

"THE CORONER: Doctor, I can as a father and that's talking as a lawyer, I can understand in those circumstances why a doctor, a treating doctor would in terms of placating and reassuring a concerned mother, want to point to some reason for the death other than any actions by the mother. So, if you say to me that you think that did play a part, I would have though that was perfectly understandable. So do you say that to me?---I am sure it did play a part."

46. During the course of the Inquest, Dr Whybourne also gave evidence in relation to the dealings with the parents on the day of the death, and the distinction between the two competing diagnoses of cause of death:

"MR GRANT: Doctor on reading the interview that Ms Allen had with Senior Constable Lade after the death. It is apparent that when Ms Allen and Mr Burnett came to see you on the Saturday afternoon she was harboring some concerns that she might have done something wrong that might have contributed to the death?---Is that your recollection of the - - -?---Yes.

"And is that a matter that informed how you dealt with Ms Allen and Mr Burnett during the course of the discussion?---We were both very much of the opinion that that was not at all a possibility - that the parents had contributed in any way to the death.

"And is there - let me put it to you this way - is the description SIDS a totally unexplained death without any trauma is that one way of saying to grieving parents it had nothing to do with them? Or is that not something that crossed your mind when you were attributing that particular label to the death?---I think we wanted to find an explanation but with all the evidence in front of us that was to us the most logical conclusion to draw. But certainly we needed - we were desperate for something reassure Leander and Rob of the - there had not been contribution on their part to the death of this child. If anything they had taken very good care of her.

"All right. But it is your professional opinion to this day that there was no way as at that Saturday afternoon that you or Doctor Diplock could have known that Skye had BPD - - -

"THE CORONER: The lung problems?---No.

"MR GRANT: And you have had access to Professor Byard's report. What is your interpretation of that report of what he assesses as the contribution of the BPD to the death?---He had made some comment about the fact that sudden death has been noted to occur with children with BPD that there is - certainly children who are premortem - like before their death as recognised to have clinical BPD. There is certainly an increased risk of death. He also quotes cases of sudden death with BPD but to me he is drawing a conclusion that this child died of a sudden death and in findings within the child supported that she had an element of bronchopulmonary dysplasia, but I don't conclude that he has drawn that conclusion that her death was due to bronchopulmonary dysplasia.

"All right. And is it you opinion that the only factor the precludes this death being described as a true SIDS death is the fact that upon autopsy the BPD was identified?---Yes."

47. Those dealings took place in a context where the treating paediatricians were attempting to provide answers to the grieving parents shortly after the death of the deceased, and in circumstances where Ms Allen was wondering whether she had contributed to the death in any way. The discussions were conducted prior to the conduct of the autopsy and the suggestion made by the paediatricians in relation to SIDS being the cause of death was necessarily speculative. In the circumstances, however, it is

quite understandable why the suggestion was made. The existence of the broncho-pulmonary dysplasia was, at that time, entirely unknown.

48. The parents had dealings with Professor Green after he had performed the autopsy on the following Monday. That meeting took place in circumstances where the preliminary results of the autopsy were in and the parents wanted and needed answers to medical questions which the Coroner's Constable was unable to give. Thereafter the parents had some further dealings with certain of the paediatricians involved in the deceased's postnatal care. Those dealings took place in an environment where the parents were confused and angry at what they perceived as inconsistent information in relation to the cause of the deceased's death. It was also the case that at that stage the paediatricians did not accept Professor Green's opinion in that respect, and considered his direct dealing with the parents without consulting the deceased's treating clinicians to be inappropriate.

49. There can be no doubt that society now demands a higher level of communication, transparency and openness from medical, legal and other professionals. Against that background, Professor Green had every warrant to discuss his findings with the parents. I am unable to find fault with the Coroner's Constable and the SIDS counsellor arranging for the parents to speak to Professor Green where there was some confusion in their minds as to the medical cause of death. Indeed, I find that it was entirely appropriate. Similarly, I am unable to find fault with Dr Diplock and Dr Whybourne speaking to the parents following the death and expressing the opinions they did. Such interaction is obviously to be encouraged.

50. With the benefit of hindsight, however, the situation is a primary exemplar of the need to ensure that opinions are delivered with the necessary qualifications. In hindsight, it is unfortunate that the preliminary opinion

as to cause of death posited by the paediatricians was not subject to the qualification that the autopsy was still to be conducted, and that further matters might come to light at that time. Again in hindsight, it is unfortunate that the information was given by the forensic pathologist to the parents in isolation from any assessment of the deceased's clinical history. These observations are not intended to be critical in nature, as hindsight is often a most unforgiving perspective from which to view any transaction or dealing.

51. There remains the paediatricians' concern that the deceased's clinical profile and the autopsy findings were not discussed with them by the forensic pathologist before he consulted with the parents. That is a complaint which must be regarded with some caution. The forensic pathologist was conducting an autopsy at the behest of the Coroner. There may be circumstances where it is inappropriate to discuss findings with the treating medical practitioners. That was not the case here, of course, but I am unable to accede to the proposition that such consultation is appropriate in all circumstances. The issues of professional courtesy that attend the dealings in this particular case otherwise fall to be addressed by the medical profession rather than by way of finding, comment or recommendation in this forum.

Paediatric pathology services

52. One final matter arises from certain observations made during the course of evidence in the Inquest. As is apparent from the foregoing, there is no resident paediatric pathologist in the Territory. During the course of the Coroner's investigation, the matter was referred to Professor Byard for specialist comment in that field. During the course of his evidence, Dr Williams lamented the lack of a paediatric pathologist in the Territory and opined that such a facility was necessary for research purposes and in order

to enhance the level of care available to infants. The general consensus is that the level of work in that field would not warrant a full-time specialist in the Territory. It was variously suggested that a visiting specialist could be engaged from time to time, or that remains could be routinely flown interstate for examination.

53. Accepting that the level of demand for that service in the Territory could not justify a full-time specialist, I consider that there are very real difficulties that attend the notion that the bodies of deceased infants could be taken interstate for examination. Logistical issues probably render that notion impractical. The Territory also has a large Aboriginal and migrant population. The practice would doubtless give rise to significant cultural difficulties. There is no call for any comment or recommendation in that respect. I simply note that the matter has been raised and it is there to be considered by those responsible for the administration of public health in the Territory if appropriate.

Dated this the 15th day of December 2003

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GREG CAVANAGH

Territory Coroner