ORDER:
Restricting the publication of any report of the matter which disclosed the deceased's name and the names of any of his carers and/or anything that may identify the carers.

CITATION: *Inquest into the death of Master F [2012] NTMC 007*

TITLE OF COURT:	Coroner's Court
JURISDICTION:	Darwin
FILE NO(s):	D0165/2011
DELIVERED ON:	28 March 2012
DELIVERED AT:	Darwin
HEARING DATE(s):	26 March 2012
FINDING OF:	Mr Greg Cavanagh SM
CATCHWORDS:	**Unexpected death of child in care, mandatory Inquest, quality of treatment and care prior to death.**

REPRESENTATION:

Counsel:

Assisting:	Jodi Truman

Judgment category classification:	A
Judgement ID number:	[2012] NTMC 007
Number of paragraphs:	66
Number of pages:	18

IN THE CORONER'S COURT
AT DARWIN IN THE NORTHERN
TERRITORY OF AUSTRALIA

No. D0165/2010

In the matter of an Inquest into the death of
MASTER F
ON 12 OCTOBER 2011
AT INTENSIVE CARE UNIT, ROYAL DARWIN HOSPITAL
DARWIN

FINDINGS

Mr Greg Cavanagh SM

Introduction

1. Master F (who's name has been restricted from publication) was an Aboriginal male born on 28 September 1994 at the Royal Darwin Hospital, in Darwin, Northern Territory. His mother is Jodie Foster and his father is Robbie Morton. Master F died at about 6.35pm on 12 October 2011 in the Intensive Care Unit at the Royal Darwin Hospital. He was declared deceased by Intensive Care Unit Specialist, Dr Sidharth Agarwal. Master F was seventeen (17) years of age at the time of his death.

2. For reasons which will appear below, 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 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 in the *Care and Protection of Children Act*. In addition, 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.

3. 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*"

4. 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.

(3) A Coroner shall report to the Commissioner of Police and Director of Public Prosecutions appointed under the Director of Public Prosecutions Act if the Coroner believes that a crime may have been committed in connection with a death or disaster investigated by the Coroner"

5. The Coroner's Court can 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."

6. In these proceedings, I made an order restricting the publication of any report of the matter which disclosed the deceased's name and the names of any of his carers and/or anything that may identify the carers. That order remains in place.

The Conduct of this Inquest

7. A total of three witnesses gave evidence before me. Those persons were:

   7.1 Senior Constable Peter Bound, the Officer in charge of the Coronial Investigation.

   7.2 Ms Merewyn Hurren, Director of Henbury Avenue Out of School Hours Care at the time of Master F’s death.

   7.3 Ms Donna Rowe, Co-ordinator of Person, Place and Planning for Lifestyle Solutions.

8. A formal coronial brief containing various statutory declarations, medical reports, and police documentation (exhibit 1) was tendered into evidence. Senior Constable Bound also obtained the deceased’s entire school records

(exhibit 4), medical records (exhibit 5), Department of Children and Families records (exhibit 6) and the records of Lifestyle Solutions (exhibit 7). Senior Constable Peter Bound of the Coroner's Office undertook a detailed investigation and prepared a very thorough brief and I thank him for his assistance.

Formal Findings

9. 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 Master F, born 28 September 1994 at the Royal Darwin Hospital, in Darwin, Northern Territory.

   ii. The time and place of death was approximately 6.35 pm on 12 October 2011 in the Intensive Care Unit at the Royal Darwin Hospital, Darwin in the Northern Territory of Australia.

   iii. Particulars required to register the death:

      a. The deceased was a male.

      b. The deceased's name was Master F.

      c. The deceased was of Aboriginal descent.

      d. The death was reported to the Coroner.

      e. A post mortem examination was not carried out; however Intensive Care Specialist, Dr Sidharth Agarwal, investigated and assessed the cause of death to be pneumonia and respiratory failure from choreoathetoid cerebral palsy.

      f. The deceased's mother was Jodie Foster and his father was Robbie Morton.

g. The deceased lived at an address in Aunger Crescent, Bakewell in the Northern Territory of Australia.

Background to the Deceased

10. At the time of his death Master F was almost seventeen (17) years of age. I received evidence that Master F had been born at 38 weeks gestation and was born by normal vaginal delivery. Unfortunately it appears that shortly after his birth; Master F suffered unexpected severe birth asphyxia with subsequent cerebral atrophy (or brain damage). Within the first few hours of his life, Master F developed seizures and experienced significant feeding difficulties. He was later diagnosed with severe cerebral palsy. I received evidence that Master F's particular form of cerebral palsy was choreoathetoid cerebral palsy which is associated with abnormal, uncontrollable, writhing movements of the arms and legs.

11. Because of his condition, from birth Master F was in effect totally reliant upon others to ensure his daily living requirements were met including all aspects of his daily living such as feeding, toileting and bathing. Based on the evidence before me, the disabilities that Master F suffered were:

    11.1 Severe cerebral palsy in all four limbs resulting in frequent uncontrollable movements of his arms, legs, torso, neck and face;

    11.2 Intermittent seizures throughout his life;

    11.3 Saliva loss (drooling);

    11.4 Moderate to severe swallowing difficulties characterised by poor lip seal, tongue thrusting and a delayed swallowing reflex;

    11.5 Inability to speak.

12. Because of these disabilities, Master F was vulnerable to the aspiration (i.e. breathing in) of thin fluids, including saliva and this meant he was vulnerable to respiratory tract infections. As a result his food was vitamised

throughout his life and in July 2009 after a significant period of hospitalisation, a percutaneous endoscopic gastrostomy tube ("PEG") was fitted.

13. Although unable to speak, I heard evidence that over time (and particularly in his teenage years) Master F developed a series of communication systems, such as eye gaze, pointing, vocalisation and a communication book which he would utilise with his big left toe to point to pictures with words under them. It is clear from the evidence before me that Master F was considered to be intelligent and a good communicator and was held in very fond regard by those who knew him.

14. After his birth, Master F initially returned with his mother to Ali Curung. It appears from the records that Master F's mother was only 14 years of age and she was unable to cope with a severely disabled baby. Master F's care therefore went to his elderly maternal great grandmother, who at that time it appears was already approximately 65 years of age, having been born around 1929. Thereafter, Master F's biological parents had limited interaction with him.

15. It appears on the evidence that in or about 2001, Master F and his great grandmother moved to 15 Mile Camp and lived with the grandmother of Master F. Thereafter both Master F's grandmother and great grandmother provided his care. At some stage after moving to Darwin, Master F began receiving ongoing medical support from Danila Dilba Health Service ("Danila Dilba").

16. In May 2001 Master F also became enrolled at Nemarluk School, which is a government funded school for preschool and primary school aged children requiring specialised and individualised education programs. It appears that Nemarluk School also provided consistent monitoring of Master F's health and educational needs.

17. Unfortunately however it appears that around this time, the health of Master F's great grandmother deteriorated and his grandmother departed the residence. As a result, in around October 2001 a medical practitioner from Danila Dilba made contact with the Department of Children and Families ("DCF") and raised concern that Master F's great grandmother was no longer able to provide the necessary care to Master F due to her own deteriorating health.

18. Then in November 2001, Master F was admitted into hospital for just over 3 weeks with various ailments associated with inadequate care. DCF were again notified and conducted their inquiries. His great grandmother visited regularly but it was clear her health was deteriorating further. Master F was discharged into the care of his great grandmother but it soon became apparent that his great grandmother required a considerable amount of assistance to care for herself.

19. As a result, on or about 1 March 2002 DCF placed Master F into respite care with Mr and Mrs May. I do not consider it necessary for the purposes of these findings to identify these carers by their full names; however I should say that it appears that Mr and Mrs May were two remarkable and caring individuals who agreed to take Master F into their care. That arrangement in fact evolved to a full time permanent care arrangement on 17 December 2003. Despite all of his significant needs, Master F remained with this family until August 2009 and it is clear that this was a very happy time for Master F and provided for his needs.

20. Alternative family options were not able to be identified by DCF and in May 2002 DCF commenced proceedings seeking orders that Master F be declared in need of care and be placed under the care of the CEO (although I note that this was initially the Minister as per the provisions of the previous legislation). Interim orders were made to this effect on 20 May 2002 and these became final on 14 August 2002, with regular scheduled court reviews of Master F's circumstances.

21. On 20 September 2007 orders were made transferring sole guardianship to the Minister until Master F turned 18 years of age. A final review then occurred on 15 October 2009 whereby orders were made confirming that Master F continued to be in need of protection and long term responsibility was given to the CEO until Master F turned 18 years of age.

22. Master F continued attending Nemarluk School until late January 2007 when he was transferred to Henbury School. This is a purpose built special school for students with disabilities in both middle and senior years of schooling. During school holidays, Master F would attend the Henbury School "Out of School Hours Care". It appears on the evidence before me that Master F was an enthusiastic and popular student who interacted well with teachers and students. Ms Hurren described Master F affectionately in her oral evidence as:

> "… a bit of a celebrity. He was a perky, cheeky, young man".

Ms Rowe stated in her oral evidence that she agreed entirely with this description and added fondly:

> "Master F would light up the whole room. He was larger than life".

23. As briefly mentioned earlier in these reasons, in 2009 Mr and Mrs May ceased being the carers for Master F. This followed an admission by Master F to hospital in April 2009 for a period of 20 months. Master F was suffering from pneumonia. I received evidence that this is not uncommon where a person is vulnerable to respiratory tract infections. Whilst at hospital he suffered a cardiac arrest and then a grand-mal seizure. A subsequent MRI revealed evidence of hypoxic ischaemic encephalopathy, which was believed to have caused further functional deficits. I received evidence that during this admission, Master F's prognosis was considered extremely poor.

24. Consistent with what was clearly his "fighting spirit", Master F entered into a prolonged period of recovery. In July 2009 a percutaneous endoscopic

gastrostomy procedure was undertaken and a tube (known as a "PEG") was fitted to provide for feeding directly into his stomach via the abdominal wall, in order to reduce the risk of further aspiration.

25. As previously set out, in August 2009 Mr and Mrs May advised that they were no longer able to provide care for Master F. On the evidence this appears to have been as a result of Master F losing the capacity for standing transfers and was no longer able to function at the same capacity that he had prior to his hospitalisation. It appears that Master F had simply become too big in size for the family to continue.

26. As a result, DCF commenced the complex procedure of attempting to locate another placement, which was further complicated by the fact that Master F had expressed a wish to remain in Darwin.

27. In September 2009, Master F returned part time to school at Henbury. He would return to the hospital after hours for residential purposes. In February 2010 Master F was back at school full time, however he remained at the hospital as no appropriate accommodation facility could be found.

28. In July 2010, Lifestyle Solutions was awarded a contract by the NTG to provide ongoing housing and support services for the deceased. I received evidence that Lifestyle Solutions is a not for profit registered charity, which offers a broad range of services to people in need. Lifestyle Solutions commenced identifying appropriate accommodation for the deceased, however there were delays. For the purposes of these reasons I note that these delays do not have any relevance to the matters for consideration at this inquest.

29. On 13 December 2010, Master F was placed into shared accommodation with "Life Without Barriers". This is a national not for profit organisation that provides community access support for persons with disabilities. At this time, Master F was on a large number of medications, the majority of which were also administered through his PEG. These medications were

muscle relaxants, antispasmodics, pain relief and others to address his conditions flowing from his cerebral palsy.

30. On 20 March 2011, Master F was transferred to supported accommodation at an address in Aunger Crescent, Bakewell. This was accommodation provided by Lifestyle Solutions. Ms Donna Rowe was the manager of this particular home which provided 24 hour attendant care, consisting of carers who participated in three eight hour shifts. Two carers during the day, and one at night. For the majority of the time, Master F shared the residence with 2 other disabled persons.

31. In addition to the assistance provided at the Henbury School and by Ms Rowe of Lifestyle Solutions, the deceased's DCF case manager was Ms Debra Harrison. It appears from the records that all 3 organisations liaised closely with one another and overall provided a sound level of support to the deceased.

Events leading up to final hospitalisation

32. On Monday 3 October 2011 Master F attended at Henbury Out of School Hours Care. This was as a result of the one week mid-term school holidays having commenced. I received evidence that this program was directed by Ms Merewyn Hurren, who also gave evidence before me. On this day the group, including Master F , undertook a day trip near the Bark Hut Inn, approximately 100 kilometres from Darwin.

33. Ms Hurren gave evidence that at about midday it was discovered that a device known as a "Mic Key" had not been placed with Master F's belongings. I received evidence that this device is used to feed the deceased and administer his medications and was part of his feeding tube. As a result, Ms Hurren contacted Ms Rowe who drove out to the location where the group was and stayed the remainder of the day with Master F.

34. Ms Rowe stated that during her time with Master F on the day trip, he appeared happy and participated in all activities. Ms Rowe stated that she held no concerns for Master F's health that day. Ms Rowe followed Master F back to his residence and stayed for a period of time. Ms Rowe gave evidence that once home, it was discovered that Master F had not been administered his lunch time medications of Baclofen and Gabapentin that day.

35. Ms Rowe stated that back in October 2011, it was the protocol of Lifestyle Solutions to make contact with the Poisons Hotline and seek advice if medications were ever missed, and this protocol was followed on this day. I received evidence that Baclofen was a muscle relaxant medication to manage Master F's muscle spasms and that Gabapentin was a medication to manage Master F's seizures and pain. Ms Rowe stated that the advice received was not to administer the lunch time medications and to simply proceed with the evening medication.

36. Ms Rowe recalled that Master F appeared to be:

> "… so, so happy. You couldn't wipe the smile off his face".

She recalled Master F going to bed at about 8.00pm. When Ms Rowe left the house at 11.30pm, she had no concerns about Master F's health.

37. On Tuesday 4 October 2011, Ms Rowe arrived at the Aunger Crescent residence at about 6.30am. Ms Rowe stated in her evidence she did this to ensure that the "Mic Key" was in Master F's belongings for that day. It was clearly above and beyond her normal duties and reflects the level of care and concern provided to Master F. In accordance with his usual routine, Master F was woken at about this time and was showered, dressed and fed. Consistent with his routine, Master F then watched some television in the lounge room until his disabled taxi arrived to take him to Out of School Hours Care. Ms Rowe stated that on this morning Master F appeared physically fine and was also excited about the day's scheduled activities.

38. I received evidence that Master F arrived for the out of hours care at about 8.00am and appeared to be “his normal self”. Ms Hurren recalled in her statement that Master F had his scheduled PEG feed at 9.00am and at 10.00am the group, including Master F, was loaded up in the bus and went on a “treasure hunt” for the next one and a half hours. Ms Hurren stated that Master F appeared to enjoy himself although he remained in the bus, in the air-conditioning, at the various “treasure” stops due to difficulties in getting him in and out of the bus at each stop. She described him laughing as the group went over speed bumps and excitedly seeking for his music to be played in the bus for the entire group to enjoy.

39. At about noon the group arrived for their scheduled lunch at “Fasta Pasta” at Casuarina. Ms Hurren stated that shortly thereafter a member of her staff advised that Master F had asked for a blanket; however he felt “slightly hot” to the touch. Ms Hurren immediately attended upon Master F and she too noted that he felt “a bit hot” and was concerned that he may have had a temperature. Ms Hurren spoke to Master F who indicated through hand signals that he felt cold.

40. As a result Ms Hurren telephoned Ms Rowe and advised her that Master F appeared to have a temperature and would need separate transport home. Ms Hurren stated that at this time she suggested that there was no rush as she was not overly concerned about Master F’s condition.

41. Unfortunately approximately 10 minutes later Ms Hurren became aware that Master F was now complaining of a headache and that he continued to feel cold. Ms Hurren gave evidence that at this point she felt that Master F was “not well”. As a result Ms Hurren contacted Ms Rowe again and advised that Master F should go home as soon as possible.

42. Ms Rowe arranged for a disabled taxi to collect Master F. Ms Hurren stated that the taxi arrived quickly and transported Master F home. Ms Rowe gave evidence that she also attended at the Aunger residence later that day, by which time Master F was asleep in bed. Ms Rowe returned at approximately

4.00pm and Master F was awake, sitting in his wheel chair, watching television. Ms Rowe stated in evidence that Master F was:

> "… in full spirits and we watched a movie together".

43. Ms Rowe gave evidence that at shift change between 2.30pm and 3.30pm it was discovered that Master F had once again not been administered his lunch time medications of Baclofen and Gabapentin. Again contact was made with the Poisons Hotline who again advised to miss that medication due to the lateness in delivery, but to ensure it was provided the following day, and if not, to make contact with Master F's general practitioner for advice. Again Ms Rowe gave evidence that she did not have any particular concerns for Master F's health when it was discovered that the medications had been missed.

44. Unfortunately at about 6.00pm, Master F indicated that he was feeling "hot". Ms Rowe placed a cold compress on his head and took his temperature. She stated that his temperature was "slightly raised", but he appeared "alright". Ms Rowe could not recall precisely when, but sometime between 6.30pm and 7.00pm, Master F indicated that he had a stomach ache. Ms Rowe gave evidence that at this time she became concerned as to what was happening for Master F and therefore contacted a disabled taxi with the intention of taking him to hospital. Ms Rowe stated she called a taxi because at this time it did not appear there was any emergency surrounding Master F's condition.

45. However, whilst waiting for the taxi, Master F indicated that his chest was starting to feel sore. Ms Rowe gave evidence that when this was communicated by Master F she immediately called an ambulance and Master F was taken to the RDH. I note that the records appear to indicate that the ambulance was called "on case" at about 6.53pm and arrived at the scene at 7.16pm.

Events at the hospital

46. After being attended to at home by the ambulance officers, Master F arrived by ambulance at RDH at about 8.02pm. He was admitted under the care of General Surgery Consultant, Dr Ruth Hardstaff, with his main complaints noted as "abdominal pain, pyrexia (i.e. fever) and swelling in the left side of his neck". He was treated and monitored.

47. Ms Rowe gave evidence that she went with Master F to the hospital and she stayed with him that night to ensure that he was able to properly communicate with staff. Ms Rowe stated that she alerted medical staff about Master F's missed medications and they were aware of this circumstance.

48. As part of the brief of evidence tendered before me, I received a statutory declaration from Dr Hardstaff dated 4 November 2011. Dr Hardstaff reviewed Master F the following morning on 5 October 2011. At that time his abdominal pain had settled and he was without a fever. An ultrasound was ordered for the swelling to his neck and because there were no ongoing abdominal problems, his PEG feed was restarted.

49. Master F's fever returned later that day and tests were undertaken to determine the cause. He was again reviewed by the surgical team who were "happy" with his abdomen. Because of the fever Master F was started on antibiotics.

50. The following morning on 6 October 2011, Master F continued to have a fever, but now with tachycardia, (i.e. a rapid heartbeat) and a rash. It was decided that the rash was more likely than not due to the antibiotic which was ceased. Later that evening Master F complained of head, throat and ear pain, and was continued to be monitored with further tests undertaken.

51. On review on the morning of 7 October 2011, Dr Hardstaff described Master F as appearing to be "slightly better". His rash was less, he no longer had a

fever, and his heart rate was normal. This improvement continued into the morning of 8 October 2011, with Dr Hardstaff describing Master F as "clinically much better". He still had a slight temperature but his abdomen was soft and he communicated that he had no pain.

52. That afternoon however his oxygen saturations dropped and his respiratory rate was high at 28 breaths per minute. He was commenced on further medications and a chest x-ray was undertaken which revealed that Master F had a right lower lobe pneumonia. He was kept under close observations but his oxygen saturations fell even further and a code blue was called. Thereafter a decision was made to take him to the High Dependency Unit for further management.

53. Dr Hardstaff's statement reveals that during this time, communications occurred with Master F as to his continued care. Master F communicated with the assistance of his carers that he did not want intubation or ventilation as he was worried he would not come out of Intensive Care or would not wake up. These wishes were acknowledged and a decision made to have Master F continue high dependency management with high flow oxygen, antibiotics and sedation to keep him comfortable, with invasive ventilation only to occur if absolutely necessary.

54. Unfortunately Master F's respiratory rate continued to increase and he was intubated at 2.30am on 9 October 2011. A CT scan was undertaken of Master F's pulmonary arteries and this confirmed that he was suffering from severe pneumonia. A family meeting took place with doctors and DCF on 10 October 2011 and a decision made to support Master F's respiratory and circulatory systems, but not to go onto renal replacement therapy should renal failure occur.

55. On 11 October 2011 Master F's oxygen requirements had reduced and x-rays revealed his chest to be stable. As a result, and in accordance with Master F's earlier expressed wishes, a decision was made to extubate him. Dr Hardstaff noted that Master F was "tachypnoeic post extubation" (i.e. his

breathing was rapid) and it was felt that he was “having to work hard and may not cope”. Despite these concerns, Master F again communicated with the assistance of his carers that he did not want to be re-intubated and as a result a decision was made to palliate his symptoms and try and keep him as comfortable as possible.

56. Ms Hurren gave evidence that on this day (i.e. the Tuesday), she and another member of staff went to the hospital to visit Master F. She described showing him photographs of their trip on Monday 3 October 2011 and that Master F was happy to see them. Again, I find this a further example of the level of care and concern provided to Master F.

57. Unfortunately however at 6.53pm on 12 October 2011 Master F passed away in the critical care unit.

Cause of Death

58. In this case, there was never any confusion about Master F’s cause of death. It was immediately noted in the “Occurrence of Death” form prepared at the RDH that Master F’s death occurred as a result of pneumonia and subsequent respiratory failure associated with his choreoathetoid cerebral palsy. I received evidence contained in the medical records that had Master F not been a child in care, and therefore an inquest not mandatory, doctors would have issued a medical certificate setting this out as the cause of death.

59. As a result of this information, I gave approval that an autopsy not be performed on the body of Master F.

Decision

60. As previously noted, this inquest occurred as a result of the deceased being a person held in care immediately prior to his death. An inquest was therefore mandatory pursuant to s.15(1) of the *Act*. Due to the evidence before me, it was not a question in this inquest as to the deceased’s cause of

death. I consider that the evidence was clear throughout that Master F's death occurred as a result of pneumonia and subsequent respiratory failure associated with Master F's choreoathetoid cerebral palsy.

61. A question did arise however as to whether there were any deficiencies in Master F's care that may have contributed to his death. As was outlined earlier in these reasons, Master F missed his lunch time medications on 3 and 4 October 2011.

62. Because of this issue, a report was obtained from Master F's paediatrician, Dr Keith Edwards. This formed part of exhibit 2. Dr Edwards details in his report what the medications were (that were missed) as follows:

> "Baclofen medication is to reduce the tone in muscles affected by spasticity and therefore allow more controlled movements. Omitting the midday dose is not likely to have caused a significant change in Master F's ability to move his muscles or affect his ability to swallow and cough as he allegedly received his morning and evening doses both days.
>
> Gabapentin medication is to prevent seizures which could cause loss of ability to swallow and cough and aspiration of saliva or regurgitate food leading to pneumonia. However I am not aware of any evidence that Master F had any seizures during the days prior to his admission to Royal Darwin Hospital. Also, Master F did not suffer from frequent seizures and had only 2 or 3 in his lifetime. An electro-encephalogram (EEG) performed in January 2009, 4 weeks after a (sic) alleged one minute duration seizure at school was normal. I therefore feel that it is unlikely that omission of this medication contributed to Master F's death".

63. I pause to also note here that there was no evidence in the medical files tendered before me to suggest that Master F had any seizures in the days leading up to his final admission to hospital.

64. Given this evidence received from Dr Edwards, I find that although medications were missed on 3 and 4 October 2011, some 8 and 9 days prior to Master F's passing, they were missed in exceptional circumstances and

based on all of the evidence they do not appear to have had anything to do with the cause of Master F's death.

65. As a result of the evidence I have received, I find that Master F was well cared for whist declared in need of care and placed under the long term responsibility of the CEO of DCF. I also find that those organisations that provided assistance to Master F, particularly Lifestyle Solutions and Henbury Out of School Hours Care, also provided a high level of care and support to Master F. I have no doubt, as a result of hearing the evidence of Ms Rowe and Ms Hurren, that Master F was very popular and well supported. Both Ms Rowe and Ms Hurren continue to appear upset at his loss. As Ms Rowe described it in her statement, which she reiterated in court:

> "I was very upset at the death of Master F. He was a wonderful individual and an absolute pleasure to care for".

66. I consider that Master F received excellent care and treatment and therefore have no recommendations to make in relation to this death.

Dated this 28th day of March 2012.

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GREG CAVANAGH
TERRITORY CORONER