IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2018 2773

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
*Section 67 of the **Coroners Act 2008***

Inquest into the Death of BABY J

Delivered On:	16 JULY 2019
Delivered At:	THE CORONERS COURT OF VICTORIA 65 KAVANAGH STREET, SOUTHBANK
Hearing Date:	8 JULY 2019
Findings of:	CORONER PHILLIP BYRNE
Counsel Assisting the Coroner	MR DARREN MCGEE

I, PHILLIP BYRNE, Coroner, having investigated the death of baby J
AND having held an inquest in relation to this death on 8 July 2019
at The Coroners Court of Victoria
find that the identity of the deceased was Baby J
born on 22 November 2016
and the death occurred 10 June 2018
at Royal Children's Hospital, Parkville

from:

1(a) HYPOXIC ISCHAEMIC ENCEPHALOPATHY POST CARDIAC ARREST

1(b) NICOTINE TOXICITY

in the following circumstances:

1. Section 8 of the *Coroners Act 2008*, particularly section 8 (e) and the public interest in protecting the personal information of Baby J's parents, I have redacted their and Baby J's identities for distributing this Finding.

2. Baby J, 18 months old at the time of his death, resided with his parents.

3. In the early evening of 30 May 2018, Baby J's mother was in the dining room with Baby J. Baby J's mother was syringing high concentration liquid nicotine into bottles of vape juice for utilisation in electric cigarettes, which she and Baby J's father were using in an endeavour to quit smoking. The liquid nicotine which Baby J's mother was using, illegal in Australia, had been purchased online from the USA some time earlier.

4. Baby J's mother left the open bottle of liquid nicotine on the bench and turned to put the vape juice bottles she had prepared on the bookshelf. She looked back to see Baby J had reached up, taken the opened bottle and put it into his mouth. He had consumed an unknown amount of the highly toxic liquid.

5. Baby J's mother rushed Baby J to the bathroom and washed his mouth out. Initially Baby J was conscious and there did not appear to be any significant reaction. However, as Baby J's mother rang the 000-emergency number, Baby J went limp in her arms with bubbles coming from his mouth. Shortly after, in a timely manner, Metropolitan Fire Brigade members and Ambulance Victoria paramedics, including a MICA paramedic, attended. Baby J was observed by attending paramedics to be in cardiac arrest. Paramedics carried out the protocols for paediatric cardiac arrest and succeeded after about 15 minutes in achieving a return of spontaneous circulation. Baby J was urgently transported to the Royal Children's Hospital where he was admitted to the Emergency Department.

6. After initial assessment, Baby J was admitted to the Paediatric Intensive Care Unit, where he was intubated and ventilated. The medical management of Baby J is described in detail by Senior Intensive Care Physician Dr James Tibballs, a vastly experienced paediatric physician, who had what he described as the "minute-to-minute" medical management of Baby J, which involved all aspects of treatment of a child with a severe brain injury.

7. In this finding, I do not propose to address all aspects of medical management, save to note that after an apparent improvement in Baby J's neurological condition he was extubated. However, due to stridor, obtundation and hypoxaemia, Baby J was re-intubated and re-ventilated.

8. A CT scan performed on 2 June demonstrated generalised diffuse cerebral oedema. Subsequently, on 4 June, an MRI study showed changes consistent with profound irreversible global hypoxic ischaemia brain injury. After extensive discussion with the family on 10 June 2018, Dr Tibballs, having concluded further intervention was futile, took the decision to withdraw life support. Within 2 hours, Baby J passed away peacefully in the arms of his parents.

ROLE OF THE CORONER

9. In considering Baby J's mother's role in the death of Baby J, it is imperative to understand an important aspect of our function. There is, in my view, some misunderstanding of the role of the coroner in the broader community. The judgement of Callaway JA in *Keown v Khan* (1999) (VR 69) was a landmark judgement. Adopting a statement in the Brodrick Committee (UK) Report His Honour said:

> *"In future the function of an inquest should be simply to seek out and record as many of the facts concerning the death as public interest required, without deducing from those facts any determination or blame".* (My emphasis)

and added:

> *In many cases, perhaps the majority, the facts themselves will demonstrate quite clearly whether anyone bears any responsibility for the death; there is a difference between a form of proceeding which affords to others the opportunity to judge an issue and one which appears to judge the issue itself."*

In *R v South London Coroner; ex-parte Thompson* [1982] 126 SJ 625 Lord Lane commented:

> *"It should not be forgotten that an inquest is a fact finding exercise and not a method of apportioning blame".* (My emphasis)

Several New Zealand cases assist in adequately explaining the apparent contradiction between concluding an entity has caused or contributed to a death, but not laying, or apportioning blame. See *Louw v McLean* (1998 High Court of New Zealand unreported 12 January 1988) and *Coroners Court v Susan Newton and Fairfax New Zealand* [2006] NZAR 312. The notion is that in finding causation, or contribution to a death, the implicit attribution of blame is unavoidable.

10. The circumstances surrounding Baby J's death in relation to him accessing the opened bottle of concentrated liquid nicotine and consuming some quantity leads to the inescapable conclusion that supervision was sub-optimal. I adopt the New Zealand approach and merely say that in the circumstances the implicit attribution of responsibility is unavoidable.

REPORT TO THE CORONER

11. Baby J's death was reported to the coroner. Having considered the circumstances and having conferred with a forensic pathologist, I directed an autopsy and ancillary tests.

12. Subsequently, I received a comprehensive 15 page Autopsy Report from Forensic Pathologist Dr Melissa Baker of Victorian Institute of Forensic Medicine (VIFM). Dr Baker, having examined the VIFM Toxicology Report advised that Baby J's death was due to:

    1(a) HYPOXIC ISCHAEMIC ENCEPHALOPATHY POST CARDIAC ARREST

    1(b) NICOTINE TOXICITY

    Consequently, I am satisfied Baby J's death was directly related to the ingestion of the concentrated nicotine liquid.

FURTHER INVESTIGATION

13. The circumstances of Baby J's death was such that his death was also reported to Victoria Police and Department of Health and Human Services (DHHS). Detective Senior Constable Mei Jin Ong of Brimbank SOCIT attended the Royal Children's Hospital after Baby J's death and recorded a conversation he had with Baby J's mother. In that conversation, Ms Baby J's mother was forthright to the circumstances of the fatal ingestion of the toxic liquid.

14. As an important part of the initial investigation Dr Joanne Tully, Deputy Director, Victorian Paediatric Medical Service, prepared a comprehensive report for Victoria Police and DHHS, Subsequently, a copy of that report was provided to the Court. I have relied on Dr Tully's report which canvasses virtually all aspects of the matter. I include in this finding an important excerpt from Dr Tully's report; she wrote:

    "----then [Baby J's mother] *undoubtedly placed* [Baby J] *at risk by leaving the open bottle of nicotine on the table for a short time while she turned to clear away. However, it is my opinion that this does not constitute supervisory neglect but rather a momentary lapse in vigilance resulting in* [Baby J] *accidentally ingesting nicotine with tragic consequences."*

I concur with Dr Tully's opinion that whilst Baby J was placed at risk by leaving the open bottle on the table and not being adequately supervised whilst the opened bottle was within his reach, this can reasonably be categorised as a "momentary lapse in vigilance" rather than "supervisory neglect".

15. I think it important to formally convey that conclusion, because as I commented at the hearing the death of Baby J visited unimaginable grief upon his mother and had a profound impact on her mental and psychological wellbeing.

PURPOSES AND OBJECTIVES OF CORONIAL SYSTEM – PUBLIC HEALTH AND SAFETY - PREVENTION

16. Having referred in the previous paragraph to aspects of my function I turn to other important aspects of the role, which were formalised in the Coroners Act 2008. The following statement appears in the Preamble to the Act:

> *"The coronial system of Victoria plays an important role in Victorian society. That role involves the independent investigation of deaths and fires for the purpose of finding the cause of those deaths and fires and contribute to the reduction of the number of preventable deaths and fires and the promotion of public health and safety and the administration of justice.*
>
> *This role will be enhanced by creating a Coroners Court and setting out the role of the Coroners Court and the coronial system and the procedures for coronial investigations."*

Furthermore, section 8 provides:

> *"When exercising a function under this Act, a person should have regard, as far as possible in the circumstances, to the following—"*
>
> *"(f) the desirability of promoting public health and safety----"*

These expectations are what I term the "public health and safety perspective".

17. Prior to listing the matter for inquest I had my coroner's solicitor Mr Darren McGee enquire of several obvious entities as to whether they supported my proposal to list the matter for an open court hearing and if they did, would they like to make submissions on the broad issue of liquid nicotine. Safer Care Victoria, Victorian Forensic Paediatric Medical Service and the Commission for Children and Young People supported the proposed hearing and indicated they would like to lodge written submissions.

18. My principal rationale for an inquest hearing was to bring the issue into to the public domain with the prospect I would consider making a formal recommendation that the Department of Health and Human Services consider conducting a public awareness campaign on the issue in the interest of the public health and safety.

19. Prior to the proposed hearing, at the 11th hour, unsolicited material was lodged by the Australian Tobacco Harm Reduction Association (ATHRA) under the hand of Associate Professor Colin Mendelsohn, material I had not had the opportunity to exchange with the other entities from whom submissions had been received. Consequently, at the hearing I indicated I would leave in abeyance further consideration of proposed recommendations.

20. Following the inquest hearing, presumably becoming aware of the controversial issue, additional unsolicited material was provided by other entities including Quit Victoria. This material was accompanied by several articles and editorials published in the Medical Journal of Australia. Furthermore, the following morning an article appeared in the Melbourne Herald Sun newspaper, an excerpt of which I include here:

> *"The state government is also continuing its push for more control of so-called e-liquid used for vaping. Acting Health Minister Gabrielle Williams said the state would urge the federal government to protect children from the dangerous liquids."*

Reading that statement it was unclear to me precisely what the State Government's position was as presently use and possession of liquid nicotine in Australia is illegal.

21. After receiving the letter, which I treated as a submission, lodged by ATHRA I had my coroner's solicitor Mr McGee go back to Safer Care Victoria, provide a copy of Associate Professor Mendelsohn's letter and invited a response. Safer Care Victoria through Professor Euan Wallace responded advising the organisation maintained its opposition to legislative changes; in effect legalisation. It was further claimed by both Safer Care Victoria and material provided by Quit Victoria that Associate Professor Mendelsohn's organisation may not be entirely objective due to claimed connections with the e-cigarette industry.

22. When he initially responded to the ATHRA material, Professor Wallace indicated he was prepared to provide a more detailed response. I indicated I would accept a further response. On 12 July 2019 I received the more detailed response. In his response, Professor Wallace referred to deliberations of the Standing Committee on Health, Aged Care and Sports (Cwlth) and their report of March 2018 titled Report on the Inquiry into the Use and Marketing of Electronic Cigarettes and Personal Vaporisers in Australia which apparently did not come down in favour to legalise liquid nicotine. I include an excerpt from Professor Wallace's most recent response, he wrote:

"First and foremost in the context of the death of baby [J], *increasing the availability of liquid nicotine products in Australia will only increase the likelihood of accidental ingestion by children, irrespective of packaging regulations. The most effective approach to minimise accidental exposure is to limit exposure per se by maintaining a broad ban on general liquid nicotine availability. The enforcement of tamper-proof packaging for all liquid nicotine products will afford protection against accidental ingestion of those products made available under special access measures."*

23. I see a conundrum; if the product is banned in Australia, how can we in this country enforce safeguards like tamper-proof packing of a product manufactured overseas and accessed online illegally.

24. In his recent response, Professor Wallace advised the Victoria Minister for Health and Human Services, the Honourable Jenny Mikakos, raised the broad issue of e-cigarette safety at the COAG Health Council in March this year. Apparently consideration is being given to the broad issues generally, but I have no knowledge of the outcome of those deliberations.

25. Whatever other recommendations I may, or may not, have considered at the outset I proposed to recommend that the Department of Health and Human Services conduct a public awareness campaign in relation to liquid nicotine per se, not the broad issues surrounding e-cigarettes, and nicotine free liquids utilised in vaping.

26. However, in regard to a public awareness campaign, information contained in Professor Wallace's most recent submission indicates work is presently being undertaken in this State jointly by Safer Care Victoria and the Department of Health and Human Services. I include an excerpt from that submission:

"At a local level, Safer Care Victoria has been working with the Department of Health and Human Services to disseminate messages that inform the wider Victorian community of the risks associated with the use of e-cigarettes around children and remind health professionals to contact the Victorian Poisons Information Centre if they are concerned that anyone has ingested liquid from e-cigarettes."

While that information may render a proposed recommendation along those lines somewhat superfluous, nevertheless I propose to recommend a public awareness campaign.

27. At first blush, the legalisation in Australia of liquid nicotine for use in vaping liquid has a logical attraction if it enables regulation of content and safeguard packaging. However, with claim and counterclaim the issues are far more complex, indeed controversial, than I initially thought. To buy into the debate would be akin to sailing into a maelstrom. Consequently, I am

not prepared to make any recommendation that would alter the status quo. Ultimately, legislative change is a matter for Government.

FINDING

28. Baby J died at the Royal Children's Hospital, Parkville on 10 June 2018 as a result of him ingesting an unknown quantity of concentrated liquid nicotine; his untimely death was due to a tragic accident.

29. Pursuant to section 73 (1) of the *Coroners Act 2008*, I order that this Finding be published on the Coroners Court of Victoria website.

RECOMMENDATION

30. Pursuant to section 72 (2) of the *Coroners Act 2008* I make the following recommendation in relation to this matter.

31. I recommend that the Department of Health and Human Services conduct a public awareness campaign in relation to liquid nicotine per se, not the broad issues surrounding e-cigarettes, and nicotine free liquids utilised in vaping.

32. I will leave it to the Department of Health and Human Services to identify the most appropriate campaign model.

COMMENT

33. Pursuant to section 67 (3) of the Coroners Act 2008 I make the following comment in relation to this matter.

34. It should be noted that a limited suppression order in the following terms is in place:

    1. Publication of the name or image of the Deceased or his parents, and any information that would identify or tend to identify the Deceased or his parents, is prohibited pursuant to section 17 of the ***Open Courts Act***.

    2. The prohibition on publication in paragraph 1 applies throughout Australia pursuant to section 21 of the *Open Courts Act 2013*.

    3. This Order is made pursuant to 18(2) of the ***Open Courts Act***, as I am satisfied based upon sufficient credible information that publication would be contrary to the public interest.

    4. This Order remains in operation unless otherwise ordered or upon the expiry of five years, being 14 June 2024, whichever is the earlier.

35. I thank those entities who lodged submissions including additional materials:

- Dr Joanne Tully (Victorian Forensic Paediatric Medical Service)
- Professor Euan Wallace (Safer Care Victoria)
- Dr Sarah White (Quit Victoria)
- Associate Professor Colin Mendelsohn (ATHRA)

36. The Commission for Children and Young Persons did not lodge a formal submission but by letter under the hand of Principal Commissioner Ms Liana Buchanan, advised they have conducted a child death enquiry which will be finalised "once police investigations are complete". As I understand the position the publication of this finding will complete Victoria Police involvement. I do not believe charges were in prospect.

DISTRIBUTION OF THE FINDING

37. I direct that a copy of this finding be provided to the following:

- Baby J's mother, Senior Next of Kin;
- Dr Joanna Tully, Deputy Director, Victorian Forensic Paediatric Medical Service;
- Professor Euan Wallace, Chief Executive Officer, Safer Care Victoria;
- Ms Liana Buchanan, Principal Commissioner, Commission for Children and Young People;
- Associate Professor Colin Mendelsohn, Chairman, Australian Tobacco Harm Reduction Association;
- Dr Sarah White, Director, Quit Victoria;
- Ms Melissa Boag, Manager, Tobacco Control, Prevention and Population Health, Department of Health and Human Services;
- Ms Emma Carnovale, General Counsel, Royal Children's Hospital; and
- Detective Senior Constable Nicola Verbeek, Coroner's Investigator, Victoria Police

Signature:

PHILLIP BYRNE
CORONER
Date: 16 July 2019

Coroners Court of Victoria