QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INVESTIGATION

CITATION:	**Non-inquest findings into the death of an eight month old twin whose family was known to Child Safety**
TITLE OF COURT:	Coroners Court
JURISDICTION:	BRISBANE
DATE:	25 June 2025
FILE NO(s):	2019/2767
FINDINGS OF:	Ainslie Kirkegaard, Coroner
CATCHWORDS:	CORONERS: infant death; high risk infant; neglect; parental substance use; methylamphetamine; Child Safety involvement; delay commencing and lapse during Investigation & Assessment; Intervention with Parental Agreement; lack of medical input to Child Safety assessment and decision making; emerging pattern of parental avoidance or disengagement; access to interstate child protection history

Table of Contents

Background

1. Twin 1 was an 8 month old baby boy of Maltese and Aboriginal heritage who died at his mother's home on 21 June 2019 after being left in a cot with his twin brother (Twin 2) for several days while their mother (M) and her new partner (B) neglected them and their six year old half-sister (G) during a three day drug binge.

2. His death was reported to the coroner under section 8(3)(e) of the *Coroners Act 2003* because the cause of his sudden unexpected death was unknown.

3. While coronial autopsy did not identify a definitive cause of death, external examination noted features consistent with malnutrition and dehydration. His growth parameters were all well below the expected range for age. There was extensive nappy rash covering the groin, buttocks and inner thighs. There was no evidence of significant natural disease or injury. Microscopic examination revealed evidence of upper respiratory tract inflammation, but this was not sufficient to account for death.

4. Toxicological analysis detected no alcohol or drug in the blood or urine. However, hair sample analysis detected a number of illicit drugs including MDMA, methylamphetamine, cocaine and the active metabolite of cannabis. The pathologist was not able to comment on the exact route, time or dose of administration or exposure to these drugs.

5. Twin 2 survived. He was diagnosed with severe dehydration consistent with no or minimal fluid intake for over 24 hours. He also had severe nappy rash and dermatitis. This resolved with regular nappy changes and barrier cream to the affected area.

6. Subsequent forensic paediatric review assessed the twins suffered severe neglect of their most basic needs, food and fluid, leading to severe acute dehydration and acute malnutrition causing Twin 1's death. This opinion noted that the hour preceding Twin 1's death would have been extremely distressing physically and emotionally.

7. The harrowing circumstances in which Twin 1 died show just how the vulnerable infants and very young children are to risk of significant harm from parental substance use.

8. Twin 1 and his family were known to Child Safety when he died. These findings examine the adequacy of the Child Safety response to known concerns about his mother's ability to care for her children.

Criminal proceedings

9. On 23 December 2020, M was arrested and charged with murder, failure to provide the necessaries of life for Twin 1 and his siblings and interfering with Twin 1's deceased body. B was subsequently charged with the same offences. The murder charge was later downgraded to manslaughter for both co-accused. It was alleged the couple had forgotten about the babies during a three-day drug binge, leaving them with no food or water for at least 21 hours prior to Twin 1being found deceased.

10. M subsequently pleaded guilty to manslaughter, failure to supply the necessaries of life to Twin 2 and unlawfully omitting to take reasonable precautions to avoid danger to Twin 2's life when it was her duty to do so with this failure causing him bodily harm. She was convicted on all these charges by the Supreme Court of Queensland at Brisbane in late 2024 and sentenced to imprisonment for nine years with parole eligibility on 23 June 2025.

11. The agreed facts leading up to Twin 1's death were as follows:

- On Tuesday 11 June 2019, the boys' paternal aunt took Twin 1 to stay with his paternal grandmother for five days. When collected that day, Twin 1 was observed to have nappy rash described by his aunt to be worst she had ever seen. It was red, raw and bleeding. His aunt observed M's unit was trashed with animal faeces in the bathroom. She saw M feeding S and making bottles for the boys.

- Twin 1's nappy rash was treated while he was with his paternal family.

- He was returned to M and B in apparently good health with some fat stores on his limbs and face.

- Child Safety officers tried to meet with M around 17 June 2019 and when the meeting eventually occurred, M insisted this take place at another house rather than the unit.

- It is not known what happened between Sunday when Twin 1 was returned to M and Friday 20 June 2019, but it was highly likely Twin 1 received little to eat and drink over several days prior to his death and this was a major contribution to his death.

- There is evidence of drug use by M and B over this period and the likelihood M spent the days preceding Twin 1's death in bed not attending to the children's needs.

- Neither M nor B left the unit on 19 or 20 June 2019.

- M told police she had placed the boys together in a cot in their room at around 8:30pm on Friday 20 June 2019 with a bottle of milk between them. The heater was on and the door was closed.

- M says Twin 1 did not have a temperature when he went to bed.

- The boys were not checked again until later the following afternoon, Saturday 21 June 2019, around 5:00pm, about 21 hours after they were put to bed.

- During this time M and B used dangerous drugs and were in and out of bed.

- When M woke up in the afternoon on Saturday 21 June 2019, she went into the boys' room and found Twin 1 unresponsive.

- She did not call 000 immediately.

- The boys were bathed and had fresh nappies put on them.

- M left the unit with G around 4:20pm, went to a neighbour's house and asked to borrow a car.

- M returned about 30 minutes later and took G and Twin 2 to the neighbour's unit.

- B was seen taking a rubbish bag full of dirty baby clothing and dirty nappies and putting them in a neighbour's bin. He told the neighbour not to tell police about this.

- B then brought another bag over the same unit. That bag contained dirty syringes, sharps bins, scales and empty clip seal bags. B told the neighbour to put the bag in a cupboard and not tell police.

- M then phoned 000 at around 5:30pm.

- M told police she thought the boys had been catching up on sleep, but she phoned 000 after about 15 minutes because she freaked out and did not know what to do. When interviewed by police she denied consuming any alcohol or drugs in the prior 24 hours and told police she went to get the boys out of their cot as they had been pretty quiet that day but immediately before that she had seen the neighbour to get car keys to take G to the park.

- M told police she was not concerned by not hearing the boys in the morning as she thought they were catching up on some sleep. It was approaching dinner when she went to get them out the cot. She said she had been in and out of bed that day 'not feeling the best' and B had been unwell with the flu.

- M claimed the boys had been fed solids and a bottle before going to bed but she could not recall what they were fed.

- Child Safety officers and hospital staff asked M whether Twin 1 was dead because she didn't feed him, to which she replied 'maybe'.

- G told police that Twin 1 was crying the night before he died, and he had no food. She said she and the boys had not had any food because N and B were asleep.

12. In sentencing M, Justice Muir observed M's extremely serious offending, describing the agreed fact as tragic and utterly heartbreaking. She describes M's failure to provide the boys with the necessities of life as prolonged, with their physical condition and the state of the household evidencing widespread neglect, both in terms of time and nature. In imposing the sentence, Justice Muir observed it "*acts as a reminder to parents of their responsibilities when taking care of infants and the dangers of drug use which can render a person completely unfit to perform those duties*."

13. On 17 March 2025, B pleaded guilty to manslaughter. The Office of the Director of Public Prosecutions discontinued the other two charges. He is yet to be sentenced.

The twins' family

14. G and the twins were living with M and more recently her new partner B. M's older son had been living with a paternal aunt since his father's death in March 2016 and visited M once a fortnight and on school holidays. The twins' father was in prison at the time of Twin 1's death. The boys had only had contact with him on one or two occasions due to his incarceration. He died in 2022. The boys had limited contact with extended family members.

Child Safety involvement with the family

15. Child Safety first became aware of the twins in late August 2018 during M's pregnancy. It made two Family and Child Connect referrals, one in August 2018 and another after the twins were born. The family was then referred for Intensive Family Support (IFS) in October 2018. A Child Concern Report, approved on 2 November 2018, noted that while there were worries about M's capacity to meet all three children's basic care needs, it appeared the family was engaged with IFS.

16. During February 2019 Child Safety received two separate notifications expressing concerns about M's ability to meet the children's medical needs, G's schooling and hygiene. The information was recorded as a Notification on 13 February 2019 with the three children assessed as being at risk of neglect due to inadequate basic care and emotional harm. A five day Response Priority Timeframe (RPT) was recorded.

17. Child Safety received further information about the children on 20 March 2019 expressing concern about the boys, M's drug taking, mental health, history of domestic and family violence and financial poverty. This was recorded as an Additional Notified Concern Child Concern Report noting there was currently little contextual information to suggest risk of harm or significant risk to the children in M's care or that she was not a willing or able parent.

18. Child Safety commenced an Investigation & Assessment (I&A) in early April 2019. The I&A was allocated to an experienced Child Safety officer who had a good understanding of the risk factors impacting the family and was aware of the need to build rapport and trust with M.

19. The I&A was approved on 31 May 2019 with an outcome of Substantiated – Child in Need of Protection for all three children.

20. M consented to Intervention with Parental Agreement (IPA) and entered an IPA Plan. This process was informed by Parental and Child Strengths and Needs Assessments in early June 2019. The family's case transferred to the IPA team in a different Child Safety Service Centre on 3 June 2019. Both Centres are collocated in the same building.

21. Child Safety officers from the I&A team and the IPA team met with M at a neighbour's unit on 17 June 2019 for a warm handover. They had been trying to meet with M since 7 June 2019.

22. Child Safety's service delivery to the family was examined by the child death review process under the *Child Protection Act 1999*. Issues identified by this process are discussed below in relation at each relevant stage of child safety involvement.

M's social history

23. M's life story is one of significant trauma. She grew up in in an emotionally and physically abusive household. Her family was known to child safety services. She left school after grade 9 and did a hairdressing apprenticeship. She married at age 18 and had her eldest son from that relationship. Her husband was her 'rock and container'.

24. While intermittently using drugs including cannabis, benzodiazepines and methylamphetamine since at least 2012, M's drug use intensified following her husband's sudden unexpected death in 2016. She had subsequent relationships with men who did not treat her well, experiencing domestic violence in several of these relationships.

25. She had a limited support network as her family lived in Melbourne. She had moved to Brisbane from interstate during 2015.

M's previous child protection history as a parent

26. M had an interstate child protection history as a parent dating back to 2008 in relation to her eldest son and G due to her methylamphetamine use, mental health issues and domestically violent relationships with concerns that she was not feeding G regularly, staying in bed until the afternoon and ignoring her cries when she was hungry. There were also concerns about potential developmental delay. G was placed with a foster carer briefly after M attempted suicide in 2015.

M commenced an Intervention with Parental Agreement in relation to G in December 2015 which continued until she withdrew her consent in December 2016. A family support service had been working with her over this period but ceased their involvement due to M being 'avoidant and disengaged'. No concerns were observed during announced and announced home visits over this period.

M falls pregnant with the twins

27. M had been with the twins' biological father for only a few weeks before he was imprisoned for five years in January 2019 for armed robbery, assault, and drug related offending. He had been 'on the run' when he met M and did not live with her.

28. M's pregnancy with the twins was unplanned. It was confirmed in April 2018 when she was at 12 weeks gestation. She had attended two obstetric ultrasound scans at the Ipswich Hospital on 26 June and 27 August 2018, but did not attend the scheduled ultrasound scan in September 2018.

Child Safety becomes involved with the family

29. Child Safety received a notification on 27 August 2018 regarding M's unborn twins because she was not engaging in regular antenatal care. The notification resulted in a referral to Family and Child Connect (FaCC) on 28 August 2018, noting there was no information to indicate current substance use or mental health issues.

30. FaCC closed the referral on 18 September 2018 after four unsuccessful attempts to establish contact with M, including by letter, telephone calls and an unannounced home visit.

The twins are born

31. The twins were born in late September 2018 by emergency caesarean section at 35 weeks + 2 days gestation after M presented in premature labour. Twin 1 weighed 2350g and Twin 2weighed 2020g. The boys were cared for in the special care nursery for 15 days with issues relating to their prematurity, breathing issues, possible sepsis and mild jaundice.

32. Child Safety was informed of the twins' birth and concerns about the arrangements M had made for S's care while she was in hospital. She had left G with two men who she indicated were not suitable individually but 'might be safe enough' if they were both present while caring for G. She was not concerned the men would harm G; rather they had not cared for children before. M told hospital staff G would be able to tell them how to look after her. She repeatedly declined alternative care options suggested by hospital staff. A hospital social worker contacted M's neighbour who agreed to check in on the two men looking after G until M was discharged home.

33. Child Safety made another referral to FaCC, noting the hospital was intending to arrange midwife follow up for M and the twins. The family was subsequently referred to Intensive Family Support (IFS) on 5 October 2018. It was considered this was more appropriate than FaCC referral because the ".. *two newborns in the house will increase stress in the household, combined with M's reported history of drug use, mental health worries and overdose attempt at times of stress, history of domestic violence and current limited support network; and that this family is at risk of re-entering the child protection system should intensive family support not be provided at crucial period of time*." It was recognised that the boys' father was incarcerated and there was no information available about G's father.

34. M needed prompting to visit the boys in the special care nursery and appeared 'flat', staying only for short periods. There were multiple documented concerns about M not visiting or keeping contact with hospital staff about the boys before and after she was discharged.

35. M could not be contacted when the boys were ready to be discharged on 11 October 2018. She had not seen them for two days. Police conducted a welfare check and found M asleep at home. G was present. Child Safety was kept informed of the discharge planning. On 12 October, a pre-notification check with IFS noted they had not yet allocated a case worker but would attempt to contact M.

36. M subsequently completed 'rooming in' with the boys over 13-15 October 2018 but this was disrupted by concerns about who was looking after G. Hospital social workers were heavily involved as M had no clothes for the boys, no car seats, no formula, and no cot. Mission Australia was engaged to provide home support.

37. Child Safety was informed of the discharge. IFS advised that a support worker would be allocated to the family. A Child Concern Report, approved on 2 November 2018, noted that while there were 'worries" about M's capacity to meet all three children's basic care needs, it appeared the family was engaged with IFS. As at 2 November, there had not been any Child Safety engagement/case work with the family. The report noted "*It is known that for the family to make changes that are long term and sustainable there needs to be a period of meaningful engagement in intervention process.*"

38. On 28 October 2018, FaCC informed Child Safety that despite multiple attempts to contact M, contact with the family did not occur.

M's engagement with health, daycare and family support services

39. M did not attend outpatient clinical appointments on 28 November 2018 and 23 January 2019 and cancelled an appointment on 9 January 2019.

40. The boys attended their first GP appointment approximately five weeks post-delivery. They were noted to both be formula fed and taking bottles well. Apart from some eye discharge, there were no documented concerns with either child. After this, the boys were seen at the Health Clinic.

41. Mission Australia helped M to obtain daycare for the children. The three children started there one day a week in December 2018, increasing to two days a week once G started school in late January 2019. M occasionally sought an extra day for the boys. The children were collected from home by the centre's bus and M would generally collect them in the afternoon at around 5:00pm.

42. Childcare staff observed all three children to 'get into food', with the boys guzzling down a bottle of milk very quickly when they first arrived for the day. There were times when the boys arrived 'quite dirty' and appeared to have been in their nappies for quite some time, and their bottles were not washed. There was an occasion with Twin 2 returned wearing the same clothes he had worn to day care two days earlier, smelling like vomit. The boys both started to roll and appeared developmentally normal during the time they attended daycare. On one occasion Twin 2 arrived at daycare rigid and shaking and when given a bottle of milk, he appeared as though he was 'starving' and finished the bottle in one go. Childcare staff were concerned about the boys' care, believing M may be using drugs given their observations of a deterioration in her behaviours and presentation (rapid and erratic speech, twitching, no eye contact, picking at her skin, sores on her body and face) since December 2018.

43. During February 2019 Child Safety received two separate notifications expressing concerns about M's ability to meet the children's medical needs, G's schooling and hygiene. While it was noted that while M appeared to have their best interests at heart, she was struggling to meet their needs due to her drug use. The three children were assessed as being at risk of emotional and physical harm given their young ages.

44. On 28 February 2019, M brought the boys into the Health Clinic for their immunisations. They were both overdue for their scheduled six-week immunisations. N said this was due to personal reasons and transport issues. The doctor noted the boys had a history of nappy rash for which they had been given hydrocortisone dream at the hospital with good results. On examination, Twin 1 was noted to have 'nappy rash +', described as maculopapular rash. M was given advice about using barrier creams and frequent nappy changes. Otherwise, Twin 1 was noted to be well.

45. Child Safety sought information from Queensland Health, Department of Education and Training and police regarding the family in early March 2019. G was only attending school 68% of the time, presented untidy and was not meeting her academic milestones. M was difficult to contact and on one occasion the school principal had to take G home as M was not answering her phone.

46. As at 18 March 2019, it became apparent the family was no longer engaged with IFS. IFS expressed concern that no external service was sighting the children or engaged with the family as they were no longer attending daycare. Child Safety was yet to commence an Investigation & Assessment at this stage.

47. Child Safety received information on 20 March 2019 expressing concern that the boys were significantly different to each other in body size, with concerns relating to M's drug use, mental health, history of domestic and family violence and financial poverty. M was not engaging with the Alcohol and Other Drugs Service. The information was recorded as an Additional Notified Concern Child Concern Report noting there was currently little contextual information to suggest risk of harm or significant to the children in M's care or that she was not a willing or able parent.

48. The boys were next seen at the Health Clinic on 3 April 2019 when they received their scheduled 6-month immunisations. The boys were noted to be bottle fed, had started on solids and were 'growing well'. The doctor noted recurrent nappy rash, described as napkin dermatitis. The doctor recommended using hydrocortisone creams and cloth nappies. M was given advice about patting the area dry and allowing it to air dry and give the boys nappy free time. She said was to continue using hydrocortisone cream. There were no other concerns documented.

49. M brought them back to the Health Clinic on 10 April 2019 with runny noses and a wet cough since their immunisations. Twin B was diagnosed with bronchiolitis and prescribed a short course of prednisolone, with advice given to M to take him to hospital if his fever or shortness of breath worsened. This is the last time the boys were seen at the Health Clinic.

Family observations of M's increasing inability to care for the children from April 2019 onwards

50. The twins' 17 year old aunt E lived locally. She had known M since December 2018, when she first met the boys. She stayed with the family for two weeks. E was aware M used methylamphetamine and eventually M stopped hiding it from her. During her stay with family, the home was clean, and everything was in place. M had two dogs that stayed in the backyard. The children had everything they needed, G was going to school and always had a school lunch. E was aware the boys had nappy rash and observed M using paw paw ointment, sudocream and talcum powder for the rash.

51. E continued to visit the family in early 2019, noting things appeared to be going well.

52. However, around April 2019, E noticed things were 'going downhill' as it seemed M's drug use was increasing, and the children were starting to go without things they needed like nappies and food. She noticed G was having a lot of days off school. She observed the boys' nappy rash started becoming red raw and bled a little when wiped. E used whatever cream M had to try and fix it.

53. Around the start of May 2019, E started spending more time at the unit to make sure the children were taken care of as M was becoming more scatterbrained. E started buying food for the children. M was asking her to look after the boys while she went into her room, possibly to take drugs. E would get up during the night to attend to the boys. M stopped taking her calls around mid-May, so E would just turn up as she had a spare key.

54. E told police she would make a week's worth of sandwiches for G's school lunches and make up bottles for the boys and leave them in the fridge. She noticed the unit was getting dirtier, with stuff everywhere. M was starting to look 'really bad', having lost a lot of weight and as though she hadn't slept. E noticed more random people were coming over to the house and hanging out. E had originally set up the boys' bedroom with two cots, but M let the boys sleep together in the same cot because she found it easier. It became too much for E, so she dropped in once or twice a week. She told her mother how bad things were getting.

Child Safety commences an Investigation & Assessment (I&A)

55. In the meantime, Child Safety officers had attempted to commence the I&A with an unannounced home visit on 3 April 2019. There was no answer, so they left a card for M. She contacted them later that day.

56. Child Safety officers returned for a home visit the following day, 4 April 2019, during which the boys were sighted, and G was interviewed. There were no concerns recorded regarding the twins who appeared clean and appropriately dressed. The Child Safety officers documented no concerns about M and her interactions with the three children. M told the Child Safety officers that the twins had nappy rash because they were allergic to their own urine and faeces, and she had been getting medical treatment for this from the Health Clinic. She denied they had rashes under their necks though this may have occurred when they were transported to daycare by bus if they had vomited. M wondered whether one had autism as she had seen him rigid and shaking and noticed his eyes rolling back. M spoke about how IFS was supporting her, having helped her purchase a cot and a pram and assisted with her Centrelink payments. She said IFS had not raised any concern about the children when they visited her.

57. M felt she was managing emotionally but struggled on the anniversary of her husband's death in March. She was not concerned about her mental health. She reported having reduced her drug use, having last used methylamphetamine and cannabis over a month ago and been referred to the Alcohol and Other Drug Service. She had social support from her neighbours and one of her ex-partners. She explained the twins were no longer attending daycare because she could not afford it. She had initially received free childcare for a 13 week period but to access this again she had to demonstrate to Centrelink she was experiencing financial hardship. She said S had frequent absences from school due to nose bleeds.

58. M agreed to a referral to the Family Participation Program (FPP) for an Independent Person.

59. The safety assessment completed that day assessed the children as 'safe'.

Why did it take around six weeks to commence the Investigation & Assessment?

60. There was a delay of around six weeks between the notification being approved on 13 February 2019 and commencing the I&A on 4 April 2019.

61. The Child Death Review Panel observed that by February 2019 there were multiple services raising concerns and there was a need for an escalated response with the recording of a Notification and investigation. The twins were highly vulnerable due to their age and lack of visibility in the community, so an urgent departmental response was required.

62. The child death review process identified that Child Safety officers were not aware of M's interstate child protection history at intake. They told the internal departmental review team that had they been aware of this information, it would have indicated a pattern of similar concerns for an infant in M's care and immediate concerns for the twins which would have resulted in a 24 hour Response Priority Timeframe in February 2019. They explained that due to the high volume of work at intake, while intake officers do look broadly at a family's entire child protection history, the focus was mainly on the previous two years as they did not have the capacity to look at every intake event in detail.

63. While the internal departmental review team recognised M's interstate child protection identified concerns of parental neglect, it did not consider this information would have altered the outcome of the I&A process. However, it would have prompted conversations with M about her history and helped identify any pattern of concerns for the children currently. This was identified as a systems issue, noting the importance of interstate child protection histories and the need for them to be easily and immediately identifiable on electronic records.

64. A national database, Connect for Safety, was launched in October 2020 to enable interstate child protection history checks. It became available to all Queensland statutory child protection officers in July 2022. I am advised the interstate information request forms will be integrated in the Department's replacement client information management system Unify, and there will be links to Connect for Safety and Unify will give staff better visibility of previously obtained information.

65. The child death review process also identified the I&A was initially sent to another I&A team and once the family's previous child protection history was noted, it was then transferred to the correct I&A team (which managed complex I&As) on 24 February 2019. Requests for information from other government agencies were made on 8 March 2019. The I&A was not allocated to the Child Safety officer until 1 April 2019 due to competing demands on the team. It was also believed that IFS was still working with the family, so there was a monitoring mechanism in place. While having a specialised team for complex I&As had been effective in the short term (by allowing analysis of history and assessment of cumulative harm), the number of cases being carried by this team had become equivalent to those being carried by other I&A teams.

66. I agree with the Child Death Review Panel there was a missed opportunity for earlier engagement following the twins' discharge home with M, especially given her minimal engagement with support services. While acknowledging that some delays may be understandable given resource limitations, the Panel observed there were two high risk infants present in a family where there was a prior pattern of parental neglect of M's older children, multiple indicators of escalating risk and knowing that the wellbeing of young children can rapidly alter, a timely response within the five day Response Priority Timeframe was warranted.

M disengages from IFS

67. On 15 April 2019, IFS informed Child Safety it had formally closed its engagement with the family. It reported having conducted 20 face-to-face visits and expressed ongoing concerns about the children's health, safety, wellbeing, and development. There was concern for the family's safety with the imminent release of M's ex-partner from prison, given her belief he was likely to come to the house. M disengaged from IFS before supports to protect her from this could be put in place. IFS reported concerns about M's ability to budget her Centrelink payments to provide essential day to day items for the children; instead purchasing drugs for herself. The report concluded that M appeared to be open to IFS (having made disclosures about her drug use, anxiety and lack of support networks) but her lack of participation and disengagement sabotaged any change towards addressing these concerns.

68. There was lapse in departmental action during the I&A between 17 April and 20 May 2019. The child death review process identified this was because the allocated Child Safety officer had taken emergent leave, but the case was not reallocated given that officer had already commenced the process, sighted the children, and assessed there were no immediate harm indicators. At that time, the team of four Child Safety officers was down two Child Safety officers on leave and the Senior Team Leader was carrying cases herself, including a highly complex case requiring court work. The internal departmental review team identified this as a systemic issue highlighting the importance of a flexible work group to allow movement of departmental officers between teams to ensure continuity of service delivery.

69. No other services were engaged with the family during this time.

Referral to the Family Participation Program (FPP)

70. The Child Safety officer spoke with the FPP Cultural Practice Advisor who agreed with referral to the service. FPP received the referral on 10 May 2019. However, there was a two-month waiting period and no capacity to allocate the case at that time. It had still not been allocated at the time of Twin 1's death.

71. The internal departmental review team noted FPP was a three-person team carrying a six-person case load during February – September 2019. Due to lengthy waiting periods and short timeframes for IPAs, it was sometimes necessary to proceed with case planning without the involvement of an Independent Person from FPP. The review team considered the Child Safety officers had attempted to work in partnership with Aboriginal representatives during the intake, I&A and ongoing Intervention phases but this was not always successful due to resourcing or process issues of the other agencies.

M consents to Intervention with Parental Agreement (IPA)

72. Child Safety officers next saw the family at home on 20 May 2019. Twin 2 was sighted and observed to be seeking out M and responding to her with smiles when she spoke to him.

73. Child Safety officers visited M at home on 27 May 2019 and discussed opening an Intervention with Parental Agreement (IPA) with her. A Family Risk Evaluation completed that day recorded a high risk of future harm. The boys' room was sighted, the children were noted to have clean clothing and there were no concerns about the state of the home.

74. On 31 May 2019, M provided her consent to IPA. The IPA Plan included the following actions:
    (a) regular and unannounced home visits by departmental officers – M had asked that the Plan include that unannounced home visits only occur if departmental officers could not contact her or if there were immediate concerns raised about the children.

(b) re-enrolling the twins in daycare – in this regard, M did not want the boys to return the same day care centre as she suspected them of having made the child safety notifications. She was given a generic support letter to provide to her childcare centre of choice.
(c) having the twins seen by the Health Clinic.
(d) M working with a Family Intervention Service.
(e) building M's formal and informal support network.
(f) non-negotiable requirements for M not to use drugs and to seek support should her mental health deteriorate.

75. The IPA plan documented more intrusive intervention would be considered should departmental officers not be able to contact M or see the children, the plan being changed with informing Child Safety and M not being willing to work with departmental officers. At M's request, the IPA Plan set out these interventions including increased monitoring with additional home visits each week, developing a Safety Plan, applying for a Protective Supervision Order if M was no longer consenting to work with Child Safety or applying for a custodial order if there were concerns about the children's safety in M's care.

76. The internal departmental review team considered the decision to leave the children in M's care and to commence an IPA was appropriate. The review team noted 'strong engagement' with M who was supported to participate in planning for the children.

Missed opportunities to strengthen the I&A process

77. The child death review process identified opportunities for additional information gathering that could have strengthened the I&A with input from the family's doctor and requiring M to undergo urine drug screening. There were missed opportunities for the Child Safety officers to record observations of the boys' physical appearance in relation to their size, speak with M about their eating routine and sight formula and the medications M said she was using for their nappy rash.

78. The Child Safety officers observed both boys had nappy rash at the start of the I&A which appeared to have improved during the I&A. One Child Safety officer recalled asking M to see the nappy rash creams, but M avoided doing so.

79. The Child Safety officers told the internal departmental review team that Twin 1 was physically bigger than Twin 2 and appeared to be meeting his developmental milestones. Twin 2 was smaller and more irritable than Twin 1. M had expressed concerns about his delayed development compared to Twin 1 and was open to having a paediatric assessment. It was not obvious to them that the children were not being fed adequately but they acknowledged only a health clinician could properly make this assessment.

80. The Child Safety officers recognised the missed opportunity to have further explored M's routine for caring for the children and the challenges of caring for twins. They identified the need to have documented their observations and conversations with M more thoroughly.

81. Efforts by Child Safety to obtain information from the Health Clinic about their contact with the family as reported by M were unsuccessful. These efforts involved follow up emails and a phone call. They were told to try two other email addresses but still received no response, so the I&A was finalised without this information. This was flagged to the IPA team, so they were aware to expect a response.

82. The internal departmental review team noted it was common for departmental officers not to receive a response from the Health Clinic during I&As. The health service response was often received following I&A closure though this did not happen in this case. Nurses from the Health

Clinic told the review team the health service received a request for information on 8 May 2019 and a response to that request was located on file but there was no confirmation fax attached, suggesting the prepared response had not been provided to Child Safety. The receptionist was usually responsible for fax confirmations and on review, the process did not appear to have been completed correctly. There had been some problems with the fax machine at around that time, so staff stopped using it. The review team noted the Health Clinic had since reviewed its process for providing responses to Child Safety to require the Health Services Manager or Senior Nurse scanning and sending records via email and confirming the email has been sent by documenting this on the patient file.

83. The Child Safety officers advised that while urine drug screening was intended and discussed within the I&A team, the Child Safety officer then took emergent leave, and the case was not reallocated in her absence. The Child Safety officers told the internal departmental review team that no one had observed any indication M was using substances during the I&A process, though it was acknowledged the presence of obvious external indicia could depend on the person's tolerance and timing of use. Following Twin 1's death, the team received further specialised training on substance use and testing.

84. Notwithstanding these missed opportunities, the internal departmental review team agreed with the Safety Assessment, Family Risk Evaluation and the recorded outcome of Substantiated - Child in Need of Protection. The combination of risk factors (the twins' very young age, limited support network with M being the sole parent of three children under five years of age, her previous child protection history, M's drug use and history of untreated mental illness and previous domestically violent relationships) indicated the children's high vulnerability and concerns about M's ability to provide for their daily physical and emotional needs on an ongoing basis. This was a case where the concerns were about cumulative rather than immediate harm.

85. The internal departmental review team felt the decision to commence an IPA was appropriate given the absence of any immediate harm indicators and M being assessed as willing and able to work with Child Safety and a family support service. That said, there was some concern about M's ability to engage on a medium to long term basis given her history of avoiding or disengaging with services. Even though she had disengaged with IFS most recently, it was noted this service had worked with her for five months with 20 face-to-face visits, indicating engagement by M over this time.

The events of June 2019

86. Child Safety completed Parental Strengths and Needs Assessments of both parents on 3 June 2019. M's assessment identified drug use, domestic violence, and mental health as priority areas of concern at that time. Her substance use and longstanding mental health concerns in particular "*raises worries for her ability to meet the children's care and protection needs*."

87. Child Strengths and Needs Assessments were also completed that day noting both boys had an allergy to their urine and faeces resulting in blisters/rash in the groin area. The assessments were finalised without corroboration from the Health Clinic about the family's engagement with the health service. It was noted M had shown departmental officers the blisters/rash which appeared to be contained to the groin area and not in common areas where a nappy would sit. The sores appeared as groups of small blisters that M said can pop causing skin peeling and pain. This was identified as an area of need to be followed up during the IPA period.

88. The Assessments noted Twin 1 was cooing and responding when spoken to with noises and smiles. In the most recent home visit, he was seen to roll himself over, prop himself up into a crawling position and rock himself backwards and forwards. M told departmental officers Twin 1 was not yet crawling, but she anticipated it would happen in the coming months. The

Assessments noted the boys had stopped attending daycare due to M's large outstanding bill with the day care centre. The Assessments noted the daycare centre's concerns about the boys' presentation (unclean, unhygienic and with severe nappy rash that appeared untreated for significant period) and identified the requirement for the boys to return to daycare as positive monitoring.

89. The IPA Plan was to be in place until the Case Plan could be developed. The Case Plan would have considered matters including exploring M's extended family. M was very reluctant to provide details for her family as she did not want them to be aware of the Child Safety involvement with her family. A Family Group Meeting would usually occur on the second home visit with the family with the involvement of the IPA Team leader.

90. There was a transfer discussion between the I&A and the IPA Team Leaders on 3 June 2019, but the transfer process required a 'warm' handover meaning the IPA Child Safety officer would accompany the I&A Child Safety officer on a home visit to meet the family before the IPA Child Safety officer assumed case responsibility.

Adequacy of the IPA Plan

91. While the internal departmental review team considered the IPA Plan to be comprehensive, addressed the child protection concerns and clearly articulated the triggers for considering more intrusive action, the Child Death Review Panel considered the non-negotiables needed to include M's compliance with Child Safety contact visits and opportunities for Child Safety officers to sight the children.

M starts a relationship with B

92. M's relationship with the twins' biological father had reportedly ended by May 2019.

93. M commenced a relationship with B (age 32) about a month prior to Twin 1's death. He was living with her and the three children at the time.

94. Around the start of June 2019, M asked E to look after the children. M introduced her to B who she said was staying there because he couldn't go home because someone had ripped them off in a drug deal. They were going out to find this person. They returned after about three hours, acting 'crazy', standing outside with bats waiting for people to show up. They then all went out to stay at someone's house in Rosewood. M's Centrelink payment arrived the following day. She wanted to buy drugs. E tried to reason with M and B not to spend money on drugs, but they wouldn't listen, so she left.

95. E returned several days later. M had to borrow money from a neighbour to buy formula and nappies because she had spent all her money. Things were getting worse, so E organised to take one of the boys out west to meet their paternal grandmother. The plan was to take out one and then the other and then try to take them both together the following week.

M's emerging pattern of disengagement with Child Safety

96. Two Child Safety officers visited the family home on 7 June 2019 to meet with M for the warm handover from the I&A to the IPA team. An unknown male answered the door stating M was in bed, unwell. The children were not sighted.

97. On 11 June 2019, E arrived to collect Twin 1 to take him out west. M was "scatterbrained out of her head", trying to pack up things children would not need. She only had stage 4 pull ups that didn't fit, Twin 1's clothes were too small, and E had to borrow a pram. E noticed Twin 1's nappy

rash was the worst she had ever seen, red raw and bleeding. The house was 'trashed', S's room was filthy with puppies everywhere and there were dog faeces in the bathroom. E bought milk and food for G and packed her lunch and school bag, before leaving with Twin 1. B was still there. He was the only one feeding G and making the boys' bottles. E left with Twin 1 and caught a bus to her mother's. She noticed Twin 1 was coughing a bit, but it wasn't too bad.

98. During his stay, E and her mother took Twin 1 to the chemist and bought Vicks for his chest and ordered vitamins to add to his milk bottles because M had been feeding him cow's milk. E's mother had borrowed money to buy a cot and pram. They started using powder and corn flour to treat his nappy rash. E tried calling M all week, but she didn't answer or respond to the calls.

99. On 13 June 2019, Child Safety tried to contact M to organise a home visit, but she did not answer or respond to the call. The two Child Safety officers attempted another unannounced home visit on 14 June 2019. They heard noises coming from inside, but no one answered the door. The children were not sighted.

100. The two Child Safety officers visited the home again on 14 June 2019. They heard sounds coming from inside, but no one came to the door. The children were not sighted.

101. The internal departmental review team noted the minimum contact requirements for in-home cases with a high Family Risk Evaluation were four face-to-face visits per month with the parent and child. The Child Safety officer told the review team she had also dropped by the family's home on other occasions in the first two weeks of the IPA, but M was not home.

102. Had the Child Safety officers not been able to organise a home visit for the third week of the IPA, this would have prompted the I&A and IPA Team Leaders to discuss the viability of working with the family through an IPA. The review team considered the Child Safety officers should have contacted one of the Team Leaders for advice when they attended on 14 June 2019 and heard noises from inside the unit. The Team Leaders told the review team that had this occurred, they would have advised the Child Safety officers to either stay and call M to come out or to leave and then return 1-2 hours later that day.

103. The Child Death Review Panel considered a delay of six days between the attempted unannounced home visit on 7 June 2019 and contact with M on 13 June 2019 to try to organise a home visit was inadequate.

104. Twin 1 returned home on Sunday 16 June 2019. E described him as being in good health. His nappy rash was improving. She packed the cream they had bought so M could keep using it. M noticed he was sneezing a bit. B had reportedly been unwell with symptoms of a head cold, sleeping a lot. This meant he was not helping around the house much. None of the household had sought medical attention.

105. M was not overly concerned by Twin 1's symptoms and had not sought medical attention or given him any medication.

106. The Child Safety officers returned on Monday 17 June 2019 for an announced home visit. It transpires that M had tried to cancel the visit that morning but when the Child Safety officer insisted the visit needed to go ahead, M said she was at her neighbour's unit and asked that the visit take place there. She said her neighbour was supporting her with the twins. In truth, there were dog faeces in M's unit which she did not want the Chid Safety officers to see.

107. During this visit M consented to initial and ongoing drug screening. She told them Twin 1 had spent the weekend with his paternal aunt. Twin 1 was noted to be bigger than Twin 2. M showed them the boys' nappy rash. Twin 1 was documented as having 'a very red bottom and genital

area from nappy rash'. Twin 2's nappy rash appeared worse than Twin's 1 rash. Twin 1 was out of sorts, with a runny nose and not wanting to be put down. M held him throughout the visit.

108. The Child Safety officers who attended this visit told the internal departmental review team that the children did not appear malnourished to them. One described the nappy rash as very red with pin size blood rising to the surface when M wiped the area. One of the Child Safety officers told M to use a wet face cloth instead of nappy wipes, and barrier cream. Twin 2 was seen crawling on the lounge room floor. One of the Child Safety officers recalled holding the boys who were both able to keep their heads up.

109. When asked whether the Family Group Meeting could occur on 21 June 2019, M said she had plans to attend S's school sports day.

110. During the child death review process, the Child Safety officers reflected that while they are responsive in crisis situations, parental inaction or avoidance can sometimes be missed. It was acknowledged M was a highly anxious person who did not want people to know of Child Safety involvement with the family. She rarely returned phone messages and there was a higher chance of speaking to her by dropping by the house. It was acknowledged her avoidance could also have been because she was using drugs and did not want this to be noticed. The review team observed there was an expectation articulated to the IPA team of the need to reconsider the type of ongoing intervention with the family to be more intrusive if M did not engage.

111. The Systems and Practice Review Committee observed M was 'relatively compliant' during the I&A, but the emerging pattern of disengagement and avoidance appeared to have been overlooked during the transition and handover from I&A to IPA. Committee members discussed the need to maintain vigilance when good partnering is occurring with parents and being attuned to when the partnership starts to become avoidant.

112. The Child Death Review Panel considered M's non-engagement throughout the IPA should have been considered more thoroughly and triggered more intrusive intervention.

113. The child death review process also identified that during 3-17 June 2021, the I&A and IPA Team Leaders each believed the other team held responsibility for the case. This misunderstanding led to a procedural change in transfer process between teams such that the IPA Child Safety officer supports the I&A Child Safety officer for the last half of the I&A to ensure they have met the family prior to the IPA commencing and warm handover. The IPA Child Safety officer also participates in the development of the IPA Plan to ensure all parties are aware of the plan and expectations for engagement.

The other children's condition and state of the home at the time of Twin 1's death

114. When paramedics arrived at 5:37pm on 21 June 2019, M was lying on a mattress in the loungeroom, sobbing. She was cradling Twin 1 who was wrapped in blankets. She was initially reluctant to hand him over to them. As she handed him to one of the paramedics, the blankets fell away. Twin 1 was obviously deceased. He was wearing a nappy, onesie and a jacket with hood. There was lividity on his back and while his limbs were still floppy, rigor mortis had begun to set in as his central body was rigid. There were lesions on both medial thighs, genitals and both buttocks.

115. Attending paramedics described the unit as smelling terrible, like unwashed bodies, sweat, human and animal faeces and rotting food. There were animal faeces all over the floor. The floor was sticky. The boys' room was untidy with dirty nappies and clothes everywhere, cat faeces on the floor, broken toys, food wrappers and other mess on the floor. There were two cots in the room but one of them looked like it was being used for storage. There were multiple

stuffed toys in the cot which appeared to have been where the boys were lying. There was an empty baby bottle inside the cot, as well as chunks of white substances thought to be vomit. M would not tell the paramedics when she put the boys in the cot, only that it was the last time she saw Twin 1 alive.

116. The kitchen was dirty with dirty dishes, food scraps and animal food. There was no food in the fridge. There was a bag of powdered cow's milk on the kitchen bench. There was also a cordial bottle labelled "Puppy milk". M told police this milk had been used to make bottles for the boys.

117. There was a plastic bathtub sitting in the main bath containing bathwater and a cleaning mitt, both of which appeared to have been used recently. There was an extremely soiled nappy on the bathroom vanity. It had red staining on the waist area and the front and back were heavily caked with faeces.

118. M told police she had not bathed Twin 1 since he returned on Sunday 16 June 2019. Instead, she had wiped him down. She explained the boys were both fed Coles powdered milk, store bought solids or mash of whatever N and B were eating.

119. Police subsequently attended the neighbour's unit where they found G and Twin 2. Twin 2 was wearing a vomit-stained onesie, was dirty and appeared thin, frail and had sunken red eyes. His head had to be supported like a newborn baby. His clothing was removed, revealing he was thin with his ribs showing. He did not appear to have head or neck control. Twin 2 was wearing a clean nappy, but it was covered in blood and yellow discharge. There was a mark to his left eyebrow and bruises on his back. He was not crying and lay motionless, appearing lifeless when examined. The nappy was removed revealing severe, black coloured nappy rash covering his genitals and buttocks. The rash had pus and he appeared to be bleeding into the nappy. This was like the rash seen on Twin 2.

120. G was observed to be thin and dirty. She told police she had lice and was itchy and hungry. She had not had any food that day. Both children were taken to the Ipswich Hospital for further examination. Twin 2 was admitted with severe malnutrition (weighing 5.93kg), global developmental delay (with an approximate developmental age of 3 months), severe nappy excoriation and superficial injuries on his forehead.

121. The neighbour told police she was aware both boys had severe nappy rash. She had previously purchased Savlon cream for M to use on the boys. She had bought baby formula, nappies, mild and dog food for M the week before as M had told her she was out of them.

122. Police obtained statements from residents of the unit complex and close by describing M as a known user of methylamphetamine. Various neighbours and associates were helping care for the twins by checking in on M to make sure she had enough food for the children, buying food and nappies, taking G to school and picking her up and looking after the children while M went out. They describe the twins as hungry babies and G going around the neighbours asking for food. They were aware the boys' nappy rash, and that M didn't bathe them frequently. A former neighbour had observed M using only 1-2 scoops instead of the required 3-4 scoops of formula when preparing the boys' bottles.

123. A Child Safety officer was present at the hospital when G asked her mother whether Twin 1 had died "because you didn't feed him", to which M replied "Maybe, we just have to see."

Child Safety decision making about high risk infants

124. The circumstances in which Twin 1 died highlight the importance of specialist medical input to assessment and decision making around child protection concerns relating to health and neglect, particularly regarding infants.

125. The Child Death Review Panel considered observations of Twin 2 being rigid and shaking and his eyes rolling back warranted further exploration and medical assessment and more should have been done to ensure M was seeking urgent treatment for the boys' nappy rash.
126. The Panel queried how comprehensive training was for new staff to understand and recognise when an infant is suffering severe neglect or they are failing to grow and develop within a normal range, noting there were missed opportunities to share or seek information from a range of services, including health agencies which would have enabled the Child Safety officers to gain a better and more comprehensive understanding of the risks for Twin 1 and his siblings and the family's needs.

127. It considered whether given the complexity of the case, a referral to the Suspected Child Abuse and Neglect (SCAN) forum (with representatives from Queensland Health, Queensland Police Services and Department of Education and Child Safety) should have been considered to benefit from the expertise of SCAN members.

128. The Panel observed that for young infants who are vulnerable and have experienced a significant history of neglect, their health status can deteriorate quickly. Consequently, at various stages of departmental intervention there was need to consider removal of the children to ensure their immediate safety while departmental officers assessed ongoing risks.

129. The Child Death Review Board Annual Report 2021–22 reported on the Board's consideration of the need to promote the safety of infants and unborn children. The Board observed the complexity of issues experienced by the families of many infants like the twins, particularly the comorbidity of substance use (particularly methylamphetamines), poor mental health, domestic and family violence and housing instability. It noted agencies were often aware of these issues and held concerns for the infant's safety and wellbeing prior to and following their birth. The Board identified limited early intervention, joined-up assessment between Child Safety and Queensland Health and lack of timely case management as factors resulting in missed opportunities to manage the risk of harm to these infants.

130. Dr Meegan Crawford, Chief Practitioner, provided a statement dated 22 July 2024 explaining how Child Safety has responded to the learnings arising from its management of concerns about Twin 1's family.

131. The Intervention with *High-Risk Infants* practice paper was most recently revised in September 2022 and renamed *Practice Guide: Infants at High Risk*. I am advised the guide reflects contemporary research including the QFCC Taking lives – A Queensland study on parents who kill their children report and The Australian Child Maltreatment Study (ACMS).

132. Child Safety has strengthened training for its practitioners to improve risk assessment of vulnerable infants and young children in recent years. New Child Safety Officers are required to complete a 6.5 hour face to face training module on unborn children and infants at high risk as part of the Readiness for Child Protection Practice one week training program. In March 2025, Child Safety introduced a 90 minute eLearning course on unborn children and infants at high risk for child safety practitioners to complete alongside other mandatory corporate training. This is in addition to other mandatory training which includes content on risk assessment.

133. The Child Safety Practice Manual Investigate and Assess procedure provides that departmental officers should arrange immediate medical examination of any child:

(a) who appears ill, is in a poor physical condition or is dehydrated.
(b) has an altered level of consciousness.
(c) has obvious serious physical injuries.
(d) is manifesting significant abnormalities of behaviour of ideation.
(e) has allegedly been sexually abused.
(f) if an infant who displays a lack of response to stimuli, alterations in breathing or temperature, poor feeding, irritability or lethargy, has bruises or is alleged to have suffered significant trauma or shaking – especially in a child under 2 years of age.

I observe that none of these criteria were apparent to the Child Safety officers during the I&A and IPA processes with the family.

134. The procedure outlines it is preferable for a paediatrician with child protection experience to carry out the medical examination. The *Child Protection Act 1999* enables medical examination or treatment without parental consent where a child is in the custody of the department or were authorised by a Temporary Assessment Order, Court Assessment Order or Temporary Custody Order.

135. The Child Safety Practice Manual *Investigate and Assess* procedure advises departmental officers to consider a referral to a SCAN in circumstances where expert advice from more than one core member representative is required to effectively assess and respond to the protection needs of the child during the notification, ongoing intervention, missing child or child concern report consultation stages.

136. The Unify SCAN Team Product and Portal, introduced in November 2022, provides visibility of SCAN team information and historical SCAN team case information to authorised users.

137. I anticipate this aspect of Child Safety practice will be examined by the recently announced Commission of Inquiry into Queensland's Child Safety system.

Strengthening Child Safety practice in response to parental substance use

138. The circumstances in which Twin 1 died also highlight the importance of equipping Chid Safety officers with guidance to recognise and respond to emerging patterns of parental avoidance or disengagement, particularly where there is a known history of parental substance use and during transition phases of Child Safety involvement.

139. The impact of problematic parental substance use on children has been a focus of attention for the Child Death Review Board in recent years.

140. The Board's Annual Report 2022–2023 reported on the high prevalence of polysubstance use by parents as a factor in many of the child deaths it reviewed during that reporting period. The Board observed the consequences of parental methylamphetamine use can include impaired decision making resulting in children's exposure to harm and their basic needs (nutrition, hydration, hygiene, clothing and medical care) not being met. Parents consistently prioritised funding, obtaining and using substances over the needs of their children. The report notes the Australian Childhood Maltreatment Study found that family substance problems double the risk for multitype maltreatment.

141. The Board's report highlights the heightened vulnerability of infants and very young children to harms of parental substance use.

"*The Board reviewed cases of infants going without food and water, left in dirty nappies, confined for extended periods in cots, not given attention or physical touch, and missing medical appointments. Such neglect, even over relatively short periods of time, can be fatal. Therefore it is vital that care is provided by a safe adult who is consistently responsive to the infant or young child's needs*." [1]

142. The Board observed that while there was often awareness of parental polysubstance use and concerns about their ability to parent safely, this did not always trigger effective responses toward managing the associated risk of harm to their children. Research commissioned by the Board confirmed it can be difficult for practitioners to recognise parental substance use and its impact on children. Further, the trajectory of methylamphetamine use to becoming very problematic is often quite rapid.

143. The Board's findings highlight the importance of equipping frontline staff with guidance and support to recognise parental substance use and understand its impact on children. It recommended the Queensland Government invest in a practice guide to support frontline practitioners in their risk assessments of children whose parents have problematic substance use. The recommendation highlights the need for the practice guide to incorporate a framework of identifiable risk indicators, the safety planning mechanisms and wraparound services that must be implemented to ensure a child's safety and clear definitions of the thresholds for intervention types.

144. The Board reported on the Government's response to this recommendation in the Child Death Review Board: Annual Report 2023–24. The Government's response noted the Child Safety's Assess Harm and Risk of Harm Practice Guide which references drug use as a risk factor to be considered when assessing future likelihood of significant harm to inform decision making about appropriate interventions. Child Safety staff including Child Support officers are required to complete introductory training on alcohol and other drugs and attend a 3-day workshop on assessing risk and safety. They also have access to online training about methylamphetamine and responding to inhalant use.

145. In November 2023, Child Safety engaged Professor Sharon Dawe to present at the Intervention with Parental Agreement Senior Team Leader Forum on undertaking assessment, identifying risk and setting goals for parents with substance use problems. Professor Dawe hosted a statewide webinar in February 2024, which has been uploaded to the department's Practice Hub website and remains available to all departmental staff.

146. As at July 2024, the Office of the Chief Practitioner within Child Safety was recruiting a statewide Alcohol and Other Drugs Practice Leader to support capability development in relation to departmental practice with parents misusing alcohol and other drugs.

147. Dr Crawford advised there is a Drug and Alcohol Practice Kit integrated with the Child Safety Practice Manual and procedures which requires departmental officers to seek information from an Alcohol and Other Drugs Service professional to inform or clarify an assessment of a parent's substance on their ability to parent. As at March 2025 this kit was being redeveloped to ensure it includes the most contemporary information and advice. It is expected to be released this year.

148. The circumstances in which Twin 1 died highlight the challenges in assessing the safety of children whose parents misuse substances. I anticipate this aspect of Child Safety practice will also be a focus of attention for the forthcoming Commission of Inquiry.

[1] p.50

Findings required by s.45

Identity of the deceased – [de-identified for publication]

How he died –

I find that Twin 1 died from severe acute dehydration and acute malnutrition after he and his twin brother received no or minimal fluid or oral intake during his mother's three day drug binge with her new partner.

Child Safety was made aware of concerns about his mother's drug use and its impact on her ability to care for her three children, resulting in a referral to Intensive Family Support with which she engaged until around March-April 2019. From this time onwards, Child Safety was the only agency involved with the family. While the boys' teenage paternal aunt and residents of the unit complex where the family were living observed the consequences of M's increasing drug use on her ability to care for the children, this information was not available to Child Safety. Delay commencing the Investigation & Assessment and a lapse during this phase due to the Child Safety officer's emergent leave without the case being reallocated, meant plans for M to undergo urine drug screening were not implemented. There was no external monitoring of the family during this period. Child Safety officers involved with the family did not observe any indicia of substance use by M during their engagement with her over April – June 2019. They did not identify the emerging pattern of her disengagement with them after 31 May 2019 as indicative of her drug use. Information about M's interstate children protection history as a parent should have alerted Child Safety to consider more assertive engagement with her sooner to monitor for her pattern of substance-use related neglect, particularly with knowledge of the Intensive Family Support concerns as at mid-April 2019.

Twin 1's utterly tragic death illustrates the ongoing challenge for Child Safety and other agencies supporting families where parents have problematic substance use. It is vital that frontline line officers are equipped with adequate training and support to identify the indicia of parental substance use, particularly those using methylamphetamine, and understand the significance of its risk of harm to children, particularly infants and children who are entirely dependent on their parents for their basic needs.

I strongly encourage the Commission of Inquiry in Queensland's Child Safety system to closely examine Child Safety's resourcing to provide early assertive intervention for families like that of this vulnerable infant.

Place of death – [de-identified for publication]

Date of death– 21/06/2019

Cause of death – 1(a) Severe acute dehydration and acute malnutrition

I close the investigation.

Ainslie Kirkegaard
Coroner
CORONERS COURT OF QUEENSLAND
25 June 2025