QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Daniel Thomas Wright**
TITLE OF COURT:	Coroners Court
JURISDICTION:	CAIRNS
FILE NO(s):	2019/1418
DELIVERED ON:	15 July 2025
DELIVERED AT:	BRISBANE
HEARING DATE(s):	5 to 9 February 2024 and 19 to 21 March 2024.
FINDINGS OF:	Stephanie Gallagher, Deputy State Coroner
CATCHWORDS:	Coroners: inquest, child death, Department of Children, Youth Justice and Multicultural Affairs, Child Safety, adequacy of health care by hospital and health services (THHS and MHHS), appropriateness of discharge decisions, consideration of capacity of parents to care for the child, adequacy of care of the child in community, adequacy of communication between child services and health services

REPRESENTATION:

Counsel Assisting:	Ms C Grant and Ms S Lane
Ms Zara Williams:	Ms D Musumeci instructed by Mr M Murray, Townsville Community Law
Townsville Hospital and Health Service and Mackay Hospital and Health Service:	Ms K McMillan KC instructed by Ms K Pyra, Corrs Chambers Westgarth
Department of Child Safety, Seniors and Disability Services	Ms K Carmody instructed by Ms A Hamilton, Department of Children, Youth Justice and Multicultural Affairs
Registered nurses Tracey Petersen, Francine Baretta, Kellie Haratsis and Penelope Richards	Mr G Rebetzke instructed by Ms E Smyth, QNMU Law
Officer Belinda Young	Mr C Pratt instructed by Ms S O'Connor, Gilshenan & Luton

Contents

Introduction

1. Daniel Thomas Wright was a premature infant who was eight months old[1] when he died at his home in Bowen, Queensland, on 30 March 2019. The cause of Daniel's death was determined to be prematurity-associated lung and bowel disease.

2. Daniel was a high-needs infant who had been born four months premature. He had spent most of his short life in hospital in Townsville and Mackay. Daniel's parents, Ben Wright and Zara Williams, both live with intellectual disabilities. Concerns by hospital staff as to Mr Wright and Ms William's ability to properly care for Daniel once he was discharged from hospital led to a number of reports to the Child Protection branch of what is now known as the Department of Families, Seniors, Disability Services and Child Safety (**Child Safety**).

3. The coronial investigation and inquest examined Daniel's medical treatment over the course of his short life, the appropriateness of decisions to transfer and/or discharge him from hospital and the involvement of Child Safety both during and after his stay in hospital.

4. Because the cause of Daniel's death was not immediately apparent, Daniel's death was reported to the Coroners Court of Queensland by the Queensland Police Service (**QPS**) pursuant to s8(3) of the *Coroners Act 2003* (**the Act**).

Coronial Jurisdiction

5. Section 45(2) of the Act provides:

   A coroner who is investigating a death or suspected death must, if possible, find –

   (a) who the deceased person is; and
   (b) how the person died; and
   (c) when the person died; and
   (d) where the person died, and in particular whether the person died in Queensland; and
   (e) what caused the person to die.

6. After considering all of the evidence presented at the inquest, findings must be given in relation to each of these matters to the extent that they are able to be proved. An inquest is not a trial between opposing parties but an inquiry into the death (or suspected death). Lord Lane CJ in *R v South London Coroner; Ex parte Thompson* (1982) 126 S.J. 625 described a coronial inquest in this way:

   "…an inquest is a fact finding exercise and not a method of apportioning guilt. The procedure and rules of evidence which are suitable for one are unsuitable for the other. In an inquest it should never be forgotten that there are no parties, there is no indictment, there is no prosecution, there is no defence, there is no trial, simply an attempt to establish facts. It is an inquisitorial process, a process of investigation quite unlike a criminal trial where the prosecutor accuses and the accused defends,"… (and) … "the function of an inquest is to seek out and record as many of the facts concerning the death as [the] public interest requires."

[1] This was Daniel's chronological age at the date of his death. His gestational age (adjusted for his prematurity) was four months old.

7. The focus is on discovering what happened, not on ascribing guilt, attributing blame or apportioning liability. The purpose is to inform the family and the public of how the death occurred with a view to reducing the likelihood of similar deaths. As a result, the Act authorises a coroner to make preventative recommendations (s46) but prohibits findings being framed in a way that appears to determine questions of civil liability or suggests a person is guilty of any criminal offence (s45(5)).

8. Section 37 of the Act provides that "the Coroner Court is not bound by the rules of evidence but may inform itself in any way it considers appropriate". This flexibility has been explained as a consequence of being a fact-finding exercise rather than a means of apportioning guilt: an inquiry rather than a trial. However, the rules of evidence and the cornerstone of relevance should not be disregarded and in all cases the evidence relied upon must be logically or rationally probative of the fact to be determined.[2]

9. A coroner should apply the civil standard of proof, namely the balance of probabilities, but the approach referred to as the Briginshaw scale is applicable.[3] This means that the more significant the issue to be determined, the more serious an allegation or the more inherently unlikely an occurrence, the clearer and more persuasive the evidence needed for the trier of fact to be sufficiently satisfied that it has been proven to the civil standard.[4] It is also clear that a coroner is obliged to comply with the rules of natural justice and to act judicially.[5] This means no findings adverse to the interest of any party may be made without that party first being given a right to be heard in opposition to that finding. As the High Court made clear in *Annetts v McCann* (1990) 65 ALJR 167 at 168 this includes being given an opportunity to make submissions against findings that might be damaging to the reputation of any individual or organisation.

10. Further, by s46(1) of the Act a coroner may, whenever appropriate, comment on anything connected with a death investigated at an inquest that relates to:

    a. public health or safety;

    b. the administration of justice; or

    c. ways to prevent similar deaths from happening in similar circumstances in the future.

Investigation

Autopsy

11. On 1 April 2019 forensic pathologist, Professor Paull Botterill, conducted an autopsy consisting of an external and full internal examination of Daniel's body

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[2] See Evatt, J in *R v War Pensions Entitlement Appeal Tribunal; Ex parte Bott* (1933) 50 CLR 228 at 256; Lockhart J in *Pearce v Button* (1986) 65 ALR 83, at 97; *Lillywhite v Chief Executive Liquor Licensing Division* [2008] QCA 88 at [34]; Priest v West [2012] VSCA 327 at [14] (Coroners Court matter) and *Epeabaka v MIMA* (1997) 150 ALR 397 at 400.
[3] *Anderson v Blashki* [1993] 2 VR 89 at 96 per Gobbo J
[4] *Briginshaw v Briginshaw* (1938) 60 CLR 336 at 361 per Sir Owen Dixon J
[5] *Harmsworth v State Coroner* [1989] VR 989 at 994; Freckelton I., "Inquest Law" in The Inquest Handbook, Selby H., Federation Press, 1998 at p 13

12. The post-mortem examination showed a small for age child with scarring of the lungs, expansion of the cavities within the brain, prominent distortion of the belly associated with a hernia of bowel through the right side of the belly wall, expansion and widespread discolouration of the bowel, but no apparent blockage of the bowel. There was a rash involving the nappy region, as well as drying of the skin around the mouth, but some of the skin discolouration appeared to be due to bacterial overgrowth.

13. A review of post-mortem radiology showed a large right sided abdominal wall defect with protruding dilated bowel, chronic lung changes, enlargement of the cavity spaces of the brain and no bony injuries.

14. The cause of death was most probably complications of prematurity-associated chronic lung disease, and of the bowel problems present, possibly associated with alterations in body biochemistry, but the possible contribution of overwhelming infection or drug toxicity were difficult to completely exclude at the time of autopsy examination.

15. Although overt injury and drug toxicity were excluded, the exact cause of death remained difficult to establish. Complications of prematurity-associated chronic lung and bowel disease remained the most likely explanation.

16. The toxicology results showed there were no drugs or alcohol present.

17. Professor Botterill determined that the cause of death was prematurity-associated lung and bowel disease.

Other investigations

18. In the course of the Coronial Investigation statements were obtained from medical practitioners, allied health professionals, social workers, members of the Townsville and Bowen Hospital Child Protection Units who had interactions with Daniel and his family and/or were involved in Daniel's case. Medical records were obtained from the Townsville Hospital and Health Service (**THHS**) and Mackay Hospital and Health Service (**MHHS**), as well as other information including the report of the Root Cause Analysis (**RCA**) conducted by the MHHS.

19. Statements were also obtained from the Child Safety workers who were involved in Daniel's case, and Child Safety provided records and other information which included the report a Child Safety Systems and Practice Review (**SPR**) and a Child Death Case review Panel Report.

20. Independent expert evidence was obtained in the Coronial Investigation from Dr Julie McEniery, Chair of the Queensland Paediatric Quality Council and Dr Maree Crawford, Specialist Paediatrician at the Queensland Children's Hospital, Brisbane.

Further discussion regarding Daniel's cause of death

21. Having reviewed the autopsy report, Dr McEniery made the following comments in respect of the cause of Daniel's death:

> *The pathologist considered that the cause of death was complications of prematurity associated chronic lung disease and bowel disease. And yet Daniel's respiratory*

condition had been stable and satisfactory on multiple reviews up to the day before he died. Did something change?

The presence of longstanding pathologic changes in the lungs, when not associated with acute lung pathology such as infection, makes death due to respiratory cause unlikely.

…

If for some reason his oxygen treatment was not administered that final night, this could have contributed to or caused his death. Daniel's father Ben was quoted many times as saying he believed Daniel did not need oxygen. Against this, Daniel's mother Zara was compliant with his medical cares. The ambulance report did not mention the presence of the oxygen tubing. Had it been removed by the parents during the attempts at resuscitation? Before?[6]

22. After raising a series of other 'unknown' factors in Daniel's death, including the position in which he was found, whether he was checked overnight and whether he was fed at all the night before, Dr McEniery advised that she did not agree with Dr Botterill's cause of death, instead preferring 'undetermined', and possibly including a number of existing co-morbidities (global developmental delay, failure to thrive, critical weight loss) as well as social factors such as inadequate physical care, unhygienic home environment and unsafe sleeping practices.

23. Dr Botterill was provided with Dr McEniery's report and asked to comment. He responded to a number of specific queries by Dr McEniery about the autopsy and test findings. Regarding the cause of death, he said:

I agree that it is debatable what the actual cause of death was - indeed in the summary section of my report I included the comment that although overt injury and drug toxicity were excluded, the exact cause of death remained difficult to establish, and agreed that alterations in body biochemistry (related to bowel dysfunction from whatever cause) and contribution from infection could not be completely excluded. My opinion remains that the problems with bowel dysfunction, on a background of general long-standing impairment following his prematurity remains the most likely explanation for the death, but I acknowledge other considerations remain. I would be very reluctant to consider attributing a death such as this, with such pre-existing conditions, as being a SIDS, and I would not be willing to label this as fatal child abuse (through starvation &/or neglect) based on the autopsy findings alone. Nevertheless, even though my opinion as to the cause of death was to a level of "balance of probabilities" rather than any higher degree of certainty, I acknowledge that my proposed cause of death can be reasonably questioned, and considering the other listed co-morbidities, "undetermined" may be as reasonable an alternative.[7]

Inquest

24. Because of Daniel's vulnerability, questions about whether Child Safety was notified about his situation in a timely manner, whether Child Safety's response to any notification was appropriate and whether the decision by treating practitioners to release him to his parents was appropriate, I determined, pursuant to s28(1) of the *Coroners Act 2003,* that it was in the public interest to hold an inquest in this case.

25. An inquest is intended to provide the public and, most importantly, the family of the deceased with transparency regarding the circumstances of the death, and to answer any questions which may have been raised following the death.

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[6] H1 - Report of Dr Julie McEniery, p 14.
[7] H1.1 – Email from Dr Botterill.

26. Counsel Assisting tendered the brief of evidence at the Pre-Inquest Conference which was held in Brisbane on 9 January 2024.

27. It was agreed at the pre-inquest conference that, in addition to the findings required by s45 of the Act, the following issues were to be explored and determined at the inquest:

    a. Issue 1 – The clinical condition of and the care required by Daniel as at 6 February 2019.

    b. Issue 2 - Whether the transfer of Daniel from the Townsville University Hospital to the Mackay Base Hospital on 6 February 2019 was appropriate given his clinical condition and the care he required.

    c. Issue 3 - The clinical condition of and the care required by Daniel as at 28 February 2019;

    d. Issue 4 - Whether the discharge of Daniel from Mackay Base Hospital to the care of his parents on 28 February 2019 was appropriate, given his clinical condition and the care he required;

    e. Issue 5 - The clinical condition of and care required by Daniel as at 19 March 2019;

    f. Issue 6 - Whether the discharge of Daniel from Mackay Base Hospital to the care of his parents on 19 March 2019 was appropriate, given his clinical condition and the care he required;

    g. Issue 7 - The appropriateness of the care afforded to Daniel, and the support afforded to his parents, by Mackay Base Hospital during his admissions to and following discharge from the Mackay Hospital on 28 February 2019 and 19 March 2019;

    h. Issue 8 - The appropriateness of the actions of the Department of Child Safety, Youth Justice and Multicultural Affairs[8] in relation to Daniel;

    i. Issue 9 - The level of effective information sharing between Mackay Hospital and Health Service and the Department of Child Safety, Youth Justice and Multicultural Affairs[9] in respect of Daniel;

28. The Inquest hearing was held in two stages. The Court sat in Bowen from 5 to 9 February 2024, and in Brisbane from 19 to 21 March 2024. Evidence was heard from 18 witnesses over those 8 sitting days.

Consideration of issues

Preliminary issues

Daniel's growth charts

[8] Now the Department of Child Safety, Seniors and Disability Services.
[9] Ibid.

29. Before the inquest, complete medical records were requested from THHS and MHHS. The material provided by each HHS was considered by the expert medical witnesses who both noted that there did not appear to be any growth charts relevant to the admissions to the Mackay Base Hospital (**MBH**) in this material.

30. On the first day of inquest, Kings Counsel for MHHS advised that the growth charts produced during Daniel's admission to the MBH had been located, and these were provided to the Court.

31. As the evidence unfolded, it became clear that the growth chart used at the MBH, and relied on by the paediatric clinicians was not the correct chart for Daniel's circumstances. The chart used was the World Health Organisation weight for age chart from zero to two years for boys. A pre-term corrected age chart should have been chosen and used.

32. Evidence was given by the Staff Specialist Paediatricians that the different charts are available in Queensland Health's electronic records system (**ieMR**), and that when a patient is admitted (or born), a paediatrician or a nurse chooses the correct chart in ieMR, enters the baby's age (corrected if appropriate), and thereafter, all weights recorded in ieMR are automatically plotted on the chart. All of the Staff Specialist Paediatricians who gave evidence confirmed that they had looked at Daniel's chart each time they reviewed him.

33. One of the medical experts and each of the Staff Specialist Paediatricians plotted Daniel's weights on a chart using his corrected age. By comparison of the chart used at the time of Daniel's admissions, and the corrected charts, it is clear that the *trend* of Daniel's weight is the same on both charts. The difference in the two charts is in the deviation of the trend from the last centile – which is actually larger on the non-corrected chart which was used during Daniel's admission. As one of the Staff Specialist Paediatricians put it in court, the deviation on the un-corrected chart is "more alarming compared to the other one – the corrected age one".[10]

34. Given this evidence, I determined that the issue raised by the experts as to whether the corrected chart was used, or any chart used at all, need not be considered further. A chart *was* used to track Daniel's growth and weight trends. The uncorrected chart actually showed Daniel as more underweight (in comparison to the centiles) than he would have been had the corrected chart been used. While it is best practice to use the correct chart, in Daniel's case the use of the wrong chart did not contribute to any underestimation by clinicians of Daniel's true condition.

35. I note, however, Dr McEniery's addendum report, which she provided after considering the chart which was used and the clinicians' evidence that they did view the chart when reviewing Daniel. She advised that this evidence did not change her view that:

> *…based on my reading of the clinical notes, these charts were rarely referenced to in the clinical notes, and inaccurately interpreted at times. I consider that this may have contributed to a lack of shared understanding about his failure to thrive*.[11]

[10] Transcript, Day 3, T26L11.
[11] H1.3 – Addendum report of Dr McEniery, p 2.

Evidence of Joanne Ward

36. Joanne Ward was the Senior Team Leader (**STL**) at the Bowen Child Safety Service Centre (**CSSC**). She supervised the Child Safety Officers (**CSO**s) and Child Safety Support Officers (**CSSO**s) who were assigned to Daniel's case. At the time of inquest Ms Ward was no longer employed by Child Safety, having resigned in April 2022. When contacted by the court to give a statement, Ms Ward advised that she was unwell and could not remember Daniel's case. She did not provide a medical certificate.

37. Ms Ward gave evidence at inquest. Evidence had already been given by Jessica Hillery, a CSO assigned to Daniel's case. Ms Hillary said that all her decisions in respect of Daniel's case were discussed with and approved by Ms Ward. The Child Safety records reflect this, with Ms Ward noted as having initiated the Investigation and Assessment (**I&A**) and approved both Safety Assessments and the Intervention with Parental Assessment (**IPA**).

38. In her evidence, Ms Ward denied that she made or approved these decisions, saying that her supervisor, Norma Day, made the final decisions. Child Safety subsequently provided a statement by Ms Day in which she reproduced the relevant delegation which showed Ms Ward had the authority to make the decisions mentioned above, and denied having been involved in these decisions herself in Daniel's case. Ms Day said that, as Manager, she would only exercise that delegation if an STL such as Ms Ward was not available to do so.

39. Given Ms Day's evidence, and Ms Ward's admitted difficulties with recall of Daniel's case, I find that Ms Ward's evidence must be given little weight where it is inconsistent with the Child Safety records and the evidence of other Child Safety staff involved in Daniel's case. Accordingly, I have not referred to Ms Ward's evidence further below in my discussion of the issues considered at inquest.

Issues considered at inquest

Issues 1 & 2: Daniel's condition and care as at 6 February 2019 and was Daniel's transfer from Townsville Hospital to Mackay Hospital appropriate?

40. It is convenient to deal with Issues 1 and 2 together.

Townsville University Hospital – 20 July 2018 – 6 February 2019

41. Daniel was the outcome of Ms Williams first pregnancy, which was a high-risk pregnancy due to Ms Williams' health conditions and intellectual disability, an early mild antepartum haemorrhage, and later premature rupture of membranes and oligohydramnios.

42. During Ms Williams' pregnancy she sought regular antenatal care from her General Practitioner and her local hospital in Bowen (part of the MHHS).

43. On 20 July 2018, Daniel was born in the Townsville University Hospital (**TUH**) (part of THHS) at 24 weeks gestation. Ms Williams had been admitted to the TUH with concerns about low amniotic fluid (oligohydramnios) and imminent labour.

44. Dr McEniery gave the following very detailed summary of Daniel's condition and care over his admission at TUH:

Daniel received tertiary level neonatal intensive care for the first 6.6 months of his life in The Townsville Hospital. His birth occurred precipitously as a spontaneous breech vaginal delivery after his mother had been admitted to The Townsville Hospital for oligohydramnios and concerns about imminent delivery. There was not an opportunity to administer to Zara the optimal dose of antenatal steroids which would had benefitted Daniel's immature lungs. Daniel incurred many complications, including neonatal respiratory failure from lung immaturity, lung haemorrhage, prolonged ventilation until the age of 15 weeks, treated with recurrent courses of steroids and antibiotics, evolving into chronic neonatal lung disease, pulmonary hypertension (a complication of the blood vessels supplying the lungs) and oxygen dependency. Other complications included intraventricular haemorrhage (a fairly common serious complication in very premature infants when the brain is still forming, of bleeding into immature parts of the brain), with ventricular dilatation (widening of the fluid spaces in the brain) perhaps reflecting reduction in cerebral cortical mass (a smaller brain), and later diagnosis of neurological sequelae fitting the pattern of cerebral palsy.

He developed necrotising enterocolitis (a fairly common serious complication in very premature infants when the bowel is still forming, causing inflammation and damage to the bowel) at 17 days of age, initially managed conservatively, with emergency surgery needed on day 24 for several perforations in the terminal ileum (small bowel) causing faeculent peritonitis (infection due to bowel contents spilling into the normally sterile abdominal cavity). He was critically unwell at this stage with septic shock requiring drugs to support his blood pressure, and a derangement of his coagulation. The surgery at this stage was resection of the terminal ileum and ileo-caecal valve and limited hemicolectomy (removal of the damaged sections of the small and large bowel) and formation of an ileostomy (a temporary opening of the small bowel out through the abdominal wall to allow time for the residual bowel to rest and heal. After recovery and growth, it is usual for further surgery to join the bowel ends back together internally). After this he was stable for several months, gaining weight but falling away from the growth centile he had previously been tracking.

(It is standard clinical practice to regularly chart the changing weight of infants over time onto a growth chart which has guidelines showing the range of weight expected for healthy growth. A range of weight gain can be expected and the guidelines (=centiles) on the chart show how the infant compares with the "normal'" range for the population. For example, the 1st centile shows the lowest "normal weight" for the population and means that only 1% of infants weigh less than this. The weight is charted on the Y axis according to the age of the infant on the x axis. The age of the infant is "corrected for gestation" if the infant is born prematurely. For Daniel, he was born nearly 16 weeks prematurely. For example, this means that when he was 16 weeks of age chronologically, his gestational age was zero.)

Daniel's faecal output from his stoma was considered to be high and he had low levels of sodium and magnesium suggestion these were being lost from his stoma. (This is a fairly common complication of an ileostomy, occurring because of the interruption of the normal process of reabsorption of the small bowel liquid and nutrients contents when these pass through the large bowel. As the stoma opens onto the skin before reaching the large bowel, this reabsorption does not occur and so the faeces / stool is more liquid and some nutrients are lost.) A nutritional assessment at approximately 11 weeks of age noted his malnutrition, and weight falling away from the 40% centile at birth, and further falling away from the 1st-2nd centile he had been tracking, to below the first centile for weight according to gestation. He had been receiving 146Cal/kg/day and a calculation of his estimated requirements including catchup growth and increased energy expenditure (as his lung disease caused him to have faster breathing than normal and he was still needing humidified high flow oxygen therapy to support his breathing) suggested he needed 224-280Cal/kg/day. His protein and calorie intake were increased and his formula was changed to an elemental formula (more easily

digested by his bowel) to enhance absorption. A surgical review was sought regarding the role if any of the stoma losses or intestinal surgery in the weight concerns, with discussion about timing of reanastomosis (surgery to join the bowel back together).

At the age of 115 days (gestational age of 41 weeks), his stoma prolapsed (a fairly common complication of a small bowel stoma where in the area where the bowel opening joins the skin, a length of bowel extrudes out through the opening onto the skin) and he required surgery to repair this. After this, his stomal stool losses increased significantly, with concerns about malabsorption and necessitating intravenous rehydration. His feeding volume was reduced. A surgical wound infection was treated with antibiotics. At age 126 days (gestational age 42+4 weeks), he had a radiology investigation of the bowel which lead to an exploratory laparotomy and adhesiolysis (removal of scar tissue around the bowel affecting its function) and his stoma was closed (the two ends of the bowel were joined back together and returned to inside his abdomen, so that stool now came out of his anus or bottom). This surgery was complicated by life threatening pneumonia and infection and it was several weeks before he became stable in late December. (This complication, while not expected, is certainly described as a complication of surgery in a very fragile ex preterm infant with multiple comorbidities).

Daniel had a major set-back with weight loss, was slow to re-establish feeding, had ongoing poor weight gain, and from that time he never returned to the previous growth trajectory. He also needed surgery for an incarcerated inguinal hernia. From that time his weight fell to between the -3.5 SD to -4.5 SD (centile guidelines well below even the extremes for the normal healthy age range) below expected weight corrected for gestation and never improved. The reason for this was not elucidated. There were occasional mentions of "short gut syndrome" in his daily list of problems (this describes the condition where disease and surgery have so reduced the length of the bowel that there is insufficient length for absorption of nutrients to occur as the feed passes along so that excess bowel contents containing un-absorbed nutrients reach his anus and are lost.) It was not clear that he had a formal diagnosis of short gut syndrome. He had episodes of vomiting and watery stool which, whilst not unusual, were significant given the setting of poor weight gain, in my opinion. Despite diligent care in the nursery, his watery stool caused perianal excoriation that was difficult to resolve. Rickets (bone disease due to inadequate intake of vitamins and minerals) was diagnosed on blood tests and xrays in early December, and appropriate vitamins and minerals were added to his treatment.

Regular case conferences were held with the paediatric multidisciplinary team in Mackay Base Hospital, which was the major regional centre closer to his home. In January, when his condition was stable, discharge planning escalated. Health care professionals in Townsville were concerned about the capacity of his parents to provide care for him. There were also concerns about Daniel's father's pattern of aggressive verbal behaviour, lack of health literacy of both parents, social isolation and lack of a support network for his parents, financial difficulties, and limited emotional engagement with Daniel.

There were many nursing shift notes from many nurses documenting the challenging conversations with Daniel's parents particularly his father. Many notes indicated concern that the parents could not remember simple care instructions, and did not have the capacity to understand Daniel's current complex situation let alone the support and care he would need when eventually discharged. Social worker notes indicate concerns re parental capacity to budget or manage money, their personal presentation of poor personal hygiene, ill-fitting clothes and poor dental hygiene raising concerns about household hygiene and suitability for raising an infant. Father prioritised feeding household cats over visiting Daniel and when parents did visit, they stayed for a short time only and did not frequently request to touch or hold Daniel.

There were discussions about referring Daniel to the Department of Child Safety, and a plan was documented by the social worker on 4th October to submit a "suspicion

report" to Department Child Safety "when baby is closer to discharge". After many discussions with his parents, Townsville health professionals determined that a further period of in-patient care closer to home would be the best course, noting that without having his parents boarding in and providing all cares for Daniel, it will be hard to assess his parents level of understanding of Daniel's medical needs and their ability to provide adequate care and protection.

At a multidisciplinary team discharge planning meeting on 10th January involving Townsville and Mackay staff, it was noted that there had not yet been a notification to Child Safety as the family capacity was assessed as "borderline". Daniel was referred to the Nurse Navigator service in Mackay in preparation for his discharge from Townsville to the Mackay Base Hospital for further in-patient care on the 6th of February 2019. He was 202 days of age (chronological age 6.6 months), gestational age 53+2 weeks, corrected age 13 weeks (3 months).[12]

Consideration of notification to Child Safety

45. During his stay at the TUH, Daniel's parents were provided social support by Susan Thompson, a hospital Social Worker (**SW**) in the Neonatal Intensive Care Unit. Ms Thompson was responsible for providing emotional and practical support to Ms Williams and Mr Wright from the time of Daniel's birth until his transfer to the Mackay Base Hospital.

46. In her statement, Ms Thompson advised that she had the following concerns about Mr Wright and Ms Williams:

- *…their ability to care for themselves due to their obvious intellectual impairments;*
- *…Ben and Zara's health literacy was so poor that they didn't understand what was being said irrespective of different ways things were being said;*
- *…Ben made it clear during my interactions with him that he had his own ideas on how a baby should be raised, and his ideas appeared to be very rigid. I also did not believe Zara had the intellectual capacity to question or challenge Ben's rigid ideas and would most likely go along with them, in my opinion, even to the detriment of Daniel;*
- *I found Ben to be very aggressive and hard to deal with on many occasions;*
- *Notwithstanding my conversations with Ben and Zara, I still believed they did not have the capacity to care for Daniel.*[13]

47. Ms Thompson also gave evidence at inquest. She said that on 12 September 2018, when Daniel had been in the Neonatal Unit for 55 days, she had decided that a report to Child Safety was necessary as she had formed the opinion that Daniel's parents did not have "the intellectual capacity to care for or protect Daniel if they were to take him home".[14]

48. Ms Thompson confirmed in court that, in the event, she did not make any report to Child Safety, or discuss Daniel's case with the Child Protection Unit (**CPU**) at TUH. During her evidence Ms Thompson explained that she believed that Daniel was a high-risk child, and that "a suspicion report needed to be submitted to the Department of Child Safety prior to Daniel being ready for discharge".[15] She said that she had not submitted such a report, however, because, based on her prior

[12] H1 - Report of Dr Julie McEniery, pp 3 - 5.
[13] C3.12 – Statement of Susan Thompson.
[14] Transcript, Day 1, T8L1.
[15] Ibid, T31L15.

experience of contacting Child Safety on behalf of the Hospital to say they had concerns about a baby, she believed Child Safety's response would be "please get back to us when the baby is ready for discharge, because then we can assess the parents and their ability to care [for] and protect the baby".[16] Ms Thompson told the court that if Daniel had been discharged home from TUH, she certainly would have made a notification to Child Safety, but because Daniel was being transferred to another hospital, in her view the responsibility to make a notification to Child Safety before discharge shifted to staff at that hospital.

49. Ms Thompson gave evidence she transferred out of the Neonatal Unit to the Emergency Department about 3 weeks before Daniel's discharge. However, she confirmed that, on 7 February 2018, the day after Daniel's transfer, she gave an oral handover to Ariana Williams, the social worker at MBH who would be working with Daniel's family.

50. On 19 September 2018, a SW in Bowen, Natasha Leaver, contacted the Whitsunday Child Protection Unit (**CPU**). Kellie Haratsis, Child Protection Liaison Officer (**CPLO**) and Clinical Nurse recorded the contact in a form titled 'Child Protection Record of an Enquiry' (**ROAI**), noting that:

Issues - remained in hospital since birth.
 # Prematurity # NEC with stoma formation (ileostomy) # Hyponatraemia # AOP D36 post-laparotomy with excision terminal ileum and formation stoma

SW Bowen - Enquiry if there is a DOCS report in by TTH. MW is telling her to make a report - SW has no involvement and no concerns.
…
Advised SW that iemr shows 12/09/2018 - no report due to inpatient and not released in care of parents. SW & NICU team monitoring closely an will reassess if child survives the admission.

Advised SW that MW can make report if has concerns[17]

51. Ms Haratsis gave evidence at inquest that an ROAI was informal document which she would use to record conversations or queries that came into the CPU. She kept these records on a secure server in a folder accessible to her and to the Mackay CPU. Ms Haratsis said that she did not "store them in the clinical notes".[18] Ms Haratsis also told the court that, if she needed to, she could make entries in the Bowen Hospital records which, at the time, were paper based. She said that she could access ieMR used at MBH (and TUH) but that she did not have the authority to make entries in ieMR.

52. Ms Haratsis also told the court that the ROAIs were her way of:

…keeping notes of conversations to keep track on what I needed to follow up on or advice that people were seeking that I needed to get back to them on. Just the same as other CPUs will use a notebook.[19]

53. She said that she had assumed that the clinicians who spoke to her, and whose concerns she documented in her ROAIs, would have been documenting their concerns in the medical records.

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[16] Transcript, Day 1, T31L25.
[17] B3.5.2 – Williams Wright Bo Enquiry.
[18] Transcript, Day 4, T74L5.
[19] Ibid, T90L8.

Opinion of medical experts as to Daniel's condition and care as at 6 February 2019

54. Dr McEniery advised in her report that:

> *In my opinion, Daniel's very long hospital admission, clinical course and complications were typical of those encountered when birth occurs so prematurely. His treatment was appropriate and the sequelae evident at the time of his discharge were to be expected. His lung disease was improving and could be expected to continue to improve as infants show remarkable lung growth and recovery in the first year of life. It was not life threatening. The outlook from his growth and development was less certain. The conditions that he had were well within the scope of the specialist paediatric service in Mackay Base Hospital.*
>
> *In the discharge documentation, the Townsville Hospital health professionals described Daniel as a fragile and vulnerable infant who had high needs in terms of current care and who will have future and ongoing high needs with anticipated delays in his neurodevelopment, and that his parents would need a high level of support if they were to be able to provide adequate care for him at home. I agree with this assessment at the time.*[20]

55. Dr McEniery also noted, in respect of the "discussion about a notification to Child Safety which did not eventuate"[21], that this failure to notify "occurred at the expense of a lost opportunity for advocacy for Daniel".[22] She also raised concerns as to whether his weight had been charted with proper reference to his centiles, and queried whether sufficient attention had been given to his "failure to thrive".[23]

56. Expert opinion as to Daniel's feeding plan and whether it was adequately managed was sought by the court from Dr Maree Crawford, Specialist Paediatrician at the Queensland Children's Hospital, Brisbane. Dr Crawford produced a report dated 30 June 2023, in which she agreed with Daniel's medical history as outlined by Dr McEniery.

57. In respect of the care at TUH, Dr Crawford advised in her report, and confirmed at inquest, that:

> *Reading Daniel's neonatal notes, my overall impression is that he received very appropriate care for his prematurity and the complications of this early gestation.*
>
> *By time of discharge on 3rd March 2019 his Chronic Neonatal Lung Disease was stable and he was mainly requiring ongoing growth and oxygen support until lung growth occurred. He was feeding orally, having ceased nasogastric feed support by 30 December 2018, and his weight gain was adequate however he had not achieved catch-up weight gain following the losses resulting from his surgeries particularly the last hernia surgery in December.*
>
> *The hospital notes did not portray significant concern about this reduced weight trajectory and percentiles were not references during notes or on discharge. It was noted on discharge that his weight had been problematic but improving.*
>
> *Length and head circumference percentiles were also not recorded in the Townsville Hospital notes except sporadically in dietician notes. The measurements recorded*

[20] H1 - Report of Dr Julie McEniery, pp 5 - 6.
[21] Ibid, p 6.
[22] Ibid
[23] Ibid.

indicate that, in addition to the lower weight percentiles, Daniel had had a drop in his length percentile and while weight for length was decreased, it was not as concerning as the weight percentiles alone would suggest.

In my opinion the lack of emphasis on undernutrition and need for catch up growth may have contributed to a less aggressive approach to nutrition support during his early period in MacKay Hospital.[24]

Conclusions

58. I find that, as at 6 February 2019, Daniel was a very vulnerable premature infant with high needs, who required ongoing high levels of care and support.

59. According to the experts, Daniel received appropriate care at TUH overall. At the time of his transfer to MBH, Daniel's condition was stable. The intention of the transfer was that he would be in a hospital care closer to his parent's home in Bowen, and that they would be given the necessary support to learn to care for him before he was discharged home. In these circumstances, I find that Daniel's discharge to MBH was appropriate given his clinical condition and the care he required at that stage.

60. I note the medical experts' reservations as to whether sufficient attention was given to Daniel's failure to thrive and need for catch up growth. While this may be the case, it does not make the decision to discharge Daniel to another hospital inappropriate, given that the paediatric subspecialty expertise available at MBH included neonatology.

Issues 3 & 4: Daniel's condition and care as at 28 February 2019 and was Daniel's discharge from Mackay Hospital to the care of his parents appropriate?

61. It is convenient to deal with issues 3 and 4 together.

Mackay Base Hospital Child Protection Unit

62. At the time of Daniel's admission to the MBH, the MBH CPU consisted of the following staff:

    a. Dr Clara Menezes – Staff Specialist Paediatrician and Child Protection Advisor (**CPA**);
    b. Susan Ralph – Child Protection Social Worker (**CPSW**);
    c. Sally Roberts – Child Protection Liaison Officer and Clinical Nurse Consultant (**CPLO/CNC**); and
    d. An administration officer.

63. The MBH CPU acts as a point of contact between hospital staff and Child Safety, and the CPU provides support and education to hospital staff about child safety concerns and facilitates communication and information sharing between the hospital and health service and Child Safety.

64. At the time, Lucia Atta was the Child Safety Officer – Health Liaison (**CSO–HL**) at the CPU. Ms Atta was employed by Child Safety but sat at MBH in the CPU office part-time.

[24] H2 – Report of Dr Crawford, p 8 and Transcript, Day 8, T10.

65. Once Daniel's case was reported to Child Safety, it was managed by the Bowen Child Safety Team because his parents lived in Bowen. As a result, Daniel's case fell under the responsibility of the Whitsunday CPU. Ms Haratsis was therefore responsible for Daniel's case in her role as CPLO at the Whitsunday CPU.

66. Ms Roberts described the CPLO role in these terms:

> *A key part of the work I undertake in my role as CPLO is to provide support and education to staff about child safety concerns where they are unsure of policy and legislative requirements, and to facilitate communication and information sharing between MHHS and Child Safety.*[25]

Mackay Base Hospital – 6 February – 28 February 2018

67. Daniel was admitted to the MBH on the evening of 6 February 2019 under the care of Staff Specialist Paediatrician and Consultant Neonatologist Dr Gopakumar Hariharan (referred to as 'Dr Gopan'). Dr Gopan explained at inquest that he was Daniel's long-term consultant as he was the consultant on-call when Daniel was admitted.

68. Staff Specialist Paediatricians were on week-long shifts, starting on a Friday and finishing the following Thursday. Patients would be discussed with the consultant on call for that week at a multidisciplinary team (**MDT**) meeting held each Tuesday.

69. Before Daniel's admission, Dr Gopan had had some preliminary conversations with Registered Nurse (**RN**) Penny Richards, the Connected Care Program (**CCP**) Nurse, about Daniel's case. The CCP nurse is involved in co-ordinating the healthcare team and providing education to families, and their role is to "support, guide and empower families to manage their child's healthcare needs".[26]

70. Daniel's initial medical review and assessment following his transfer was conducted by Dr Andrew Dawson-Smith, Paediatric Registrar. Dr Dawson-Smith recorded that Daniel was medically stable at the time of the review. Various supports were put in place, including ongoing feeding supports, ongoing allied health input, home oxygen arrangements and retinopathy of prematurity check-up.

71. On 7 February 2019, RN Richards met with Ms Williams to explain her role to her. RN Richards put together a resource folder for Daniel's parents to use while they were at the MBH and after discharge, and read through all the resources with them as they were put into the folder.

72. On Friday 8 February 2019, Dr Clara Menezes reviewed Daniel on the morning ward round. Dr Menezes was aware of Daniel's management plan from the handover that morning and she observed that Daniel was alert and feeding well. She requested that Daniel be weighed twice-weekly and that his case be discussed at the paediatrics MDT meeting the following Tuesday, 12 February 2019. Dr Menezes reviewed Daniel daily until 14 February 2019, when she went off-roster as the inpatient ward paediatrician.

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[25] B3.14 – Statement of Sally Roberts, para 7.
[26] B3.15 – Statement of Penny Richards, para 6.

73. Dietician, Katrina Brittain, also saw Daniel on 8 February. She gave evidence that she reviewed the feeding plan which had been forwarded by TUH and determined that it was appropriate that that plan should continue. Ms Brittain said that she noted that Mr Wright and Ms Williams seemed to have some issues understanding the amounts and frequency set out in the feeding plan.

74. On 11 February 2019, Daniel was reviewed by the Paediatric Feeding Team (**PFT**), which consisted of Ms Brittain and Speech Pathologist Nicole Kibby and, on occasion, an occupational therapist. Ms Kibby gave evidence that the PFT usually only dealt with outpatients, but given Daniel's extreme prematurity, it was considered that he would benefit from inpatient support by the PFT. During that review Ms Kibby spoke to Daniel's parents and formed the view that they would require ongoing support from the PFT to help them understand the difference between Daniel's actual age and his corrected age, and to implement feeding strategies as he progressed. Ms Brittain gave evidence that she explained to Daniel's parents why he couldn't be given solids yet, and re-iterated the feeding plan with them.

75. On 12 February 2019, the MDT meeting occurred. Dr Menezes, RN Penny Richards, SW Williams and Allied Health (the PFT, occupational therapists, physio) attended the meeting. Bowen Nurse Navigator (**NN**) Troy Wake also attended. Discharge options were discussed and a plan was made for home oxygen to be installed by NN Wake later that week. The PFT raised their concerns with respect to the parents' understanding of Daniel's feeding plan. Dr Menezes advised in her statement that 'the collective view of the MDT was that there was a need for further parental capacity building and training before Daniel could be discharged home".[27] Ms Williams attended part-way through the meeting and the MDT view was explained to her. It was agreed that Daniel's case would be reviewed at the following week's MDT meeting "to review progress and determine readiness for [discharge]".[28]

76. NN Wake was asked to make an Intensive Family Support service (**IFS**) referral in order to support Daniel's parents at home. According to the IFS model and guidelines:

> *The aim of IFS services is to provide intensive and extended, but time limited, in-home support to improve family functioning and safety for children by building the skills and capacity of parents/caregivers to a level that can be sustained by less intensive and more universally available services. While some families may need a longer intervention, it is anticipated that families will generally engage with the IFS for up to nine months.*[29]

77. NN Wake contacted Ms Haratsis with respect to the referral to IFS and Ms Haratsis recorded in a ROAI that:

> *Child is being prepared for discharge.*
> *NN wanting to refer to IFS - to ensure support for family*
>
> *Risk of neglect if family is not well supported.*

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[27] B3.8 - Statement of Dr Menezes, para 51.
[28] B1.3 – MBH records, pp 229 – 231.
[29] https://www.dcssds.qld.gov.au/resources/dcsyw/about-us/funding-grants/specifications/ifs-model-guidelines.pdf, p 11. Note – this is the latest version – 2023 Version 3.0. Version 2.1 would have been relevant at the time.

Advised of IFS/ FACC referral pathway.
Support given. Referral made 12/02/2019.
Phone call from IFS Whitsunday Sylvia - d/w Troy . IFS to attend next case conference, look at Child Health nurse from IFS also engaging for support.[30]

78. In her evidence, Ms Haratsis said, effectively, that she can't recall if she and NN Wake discussed whether a notification should be made to Child Safety, but that:

[b]eing that this child was an inpatient at the time, with significant clinical involvement, I – I would have hoped that any sort of real risk of neglect would have been identified by the treating team in the Mackay CPU who would have been the main contact point for this child and family whilst an inpatient at that hospital.[31]

79. On 14 February 2019 Ms Brittain reviewed Daniel's feeding and congratulated his parents as he had gained weight. She told the court that, on this occasion, "my concerns were relieved. I felt more confident in their understanding on this review".[32]

80. That day, Dr Menezes sent an email to Dr Gopan and RN Richards in which she said:

…I personally think Daniel is ready for discharge and we have to smooth that process. MDT meeting on Tuesday raised a few issues from Allied health staff that mother is not ready and she is asking lots of questions
Ward nurses are leaving the whole care to mum and as far as I am aware she is doing a great job.
Everything is done by her. Not sure what else we are waiting for?...[33]

81. Dr Menezes advised in her statement that she thought Daniel was ready for discharge based upon his clinical presentation in the ward on 14 February 2019 and in the preceding days. She believed he was 'ready for discharge' from a clinical perspective only, not a from a social perspective. In her evidence at inquest, Dr Menezes clarified further, saying that she sent the email on the last day of her ward roster as a handover, and that:

I would be giving a little heads-up to the consultant involved, saying he's getting ready from a medical perspective, so we have to organise the rest of the things, so that is to prepare the discharge process. And in the context of Daniel being new, they – we needed lots of support. It's only when we say we are ready to discharge, we can activate that supports. So that – that was the process, not that – physically sending him home.[34]

82. Dr Gopan explained at inquest that he recalled Dr Menezes' email and her view that Daniel was ready for discharge:

But I was – I was not in agreement with that at that point because I needed more evidence that baby would be – would be safe in the community…

[and]

… That is what I read but I – I wouldn't be able to make that decision…because I have not seen Daniel, I have not had an opportunity to see how safe Daniel would be in the

[30] B3.5.3 – Williams Wright Enquiry.
[31] Transcript, Day 4, T79L8.
[32] Transcript, Day 3, T67L46.
[33] B3.6 – Statement of Dr Hariharan, para 22 and Exhibit B3.6.2.
[34] Transcript, Day 5, T12L4.

community and I – I haven't been part of the plan where I could organise support system for Daniel's care. So I wouldn't be able to make that decision.[35]

83. The hospital records show that the paediatric ward rounds from 15 to 17 February 2019 were done by Paediatric Registrar Joshi and Paediatric Intern Capuano. Various arrangements were being made to get ready for Daniel's discharge, including that home oxygen was installed 15 February 2019. The notes also record that Daniel's parents had conversations about discharge with various staff members in this period and were 'eager' for discharge.

84. On 18 February 2019 Staff Specialist Paediatrician Dr Sheelangi Subodhini Kalathunga Puhambugoda Arachchige (known as '**Dr Subo'**) met Daniel and his parents for the first time. Dr Subo gave evidence that her impression of Daniel on that day was that he was clinically stable but still establishing feeds. She intended to discuss Daniel's progress with other treating teams at the MDT meeting the following day.

85. The same day, the PFT reviewed Daniel. Ms Kibby observed Ms Williams bottle feeding Daniel. She gave evidence that her impression of Daniel was that he could feed safely, in that there were no signs of difficulty swallowing of fluid going into the lungs, but that he and Ms Williams would need further support for him to feed more efficiently. Ms Brittain looked at the record Ms Williams had made of the feeds for the last 4 days, and noted that Daniel was not meeting the goal of having 600mls of formula per day. Ms Brittain gave evidence that, at that point, she did not consider that feeding Daniel with a nasogastric (**NG**) tube was necessary. She said that she thought that with adjustments to the feeding plan such as the timing of feeds, Daniel's feeding could be better supported and more efficient.

86. Ms Brittain also explained in her evidence that she worked very closely with the paediatric consultants, and that if either she or the paediatrician thought there needed to be a change in Daniel's feeding plan they would have had that discussion.

87. That day RN Richards recorded that Mr Wright had called her several times during the day demanding that Daniel be discharged and becoming quite aggressive. She explained to him that discharge was a decision for the medical staff and that Daniel had to be well enough to go home. Later, Ms Williams was speaking to Mr Wright on the phone and requested that one of the doctors speak to him. The doctor recorded a similar conversation with Mr Wright in the notes.

88. On Tuesday 19 February 2019 the second MDT meeting was held at around 3:45pm. Dr Subo gave this recollection of the meeting at inquest:

So that happened in the a – early afternoon, as I can remember, and there – the family was there and then we had the chronic illness nurse, and the dietician and at that – and the social worker who were involved. And then at that time, I think we have the impression that the family wanted to take the – take Daniel home. And – but there were concerns raised from dietician and speech pathologist that Daniel is very slow to feed and he's not completing his feeding quota. And we had concerns about – especially being – related to the fact that geographical isolation in Bowen, we wanted – we haven't been able to have some support services in place yet appropriately. So – and then – which have been conveyed to the family and we – I didn't agree with discharge. I wanted

[35] Transcript, Day 5, T56L37 and T57L18.

to keep Daniel still on the ward because of those reasons.[36]

89. Dr Subo gave evidence that her concerns about Daniel's milk intake were medical concerns related to Daniel's ability to finish feeds and get the calories he needed. Her concerns about support services were in respect of ensuring there was monitoring and support in place for his parents, who had intellectual impairments, to assist them to follow feeding instructions and care for Daniel.

90. Dr Subo explained these concerns to Ms Williams and Mr Wright and advised against discharge. Dr Subo's recollection at inquest was that Daniel's parents were not happy and left the meeting. In their absence, the meeting attendees "discussed the possibility of activating a care and treatment order"[37] if Daniel's parents decided to take him home. Dr Subo explained that this was not necessary in the end as Daniel's parents returned and agreed to keep him in hospital.

91. Tracy Good, an MBH SW, was present at the meeting. She had become involved with the family a week or two into Daniel's admission and had received a handover from SW Arianna Williams. Ms Good gave evidence at inquest that Mr Wright was quite escalated on that day, and that he wanted Daniel discharged that day. Ms Good said that she was aware that Mr Wright and Ms Williams were under financial strain because of the constant travelling back and forth from Bowen to Mackay. Ms Good's evidence was that she and other hospital staff spent a long time that day trying to come up with suitable options and support for the family.

92. Ms Kibby gave evidence that she attended this meeting, but at inquest did not have an independent recollection of what occurred. Ms Brittain gave evidence that it was her view that, at that point, she thought that Daniel "would be safer in hospital to achieve his weight gain than at home...".[38]

93. That night Mr Wright and Ms Williams left Daniel in hospital and went home. They told nursing staff that they would not be back until the following Monday.

94. On Thursday 21 February 2019, Dr Dawson-Smith reviewed Daniel on the ward. Dr Dawson-Smith said, in his statement, that "[b]y this stage, the focus of Daniel's admission was to facilitate weight gain and ensure he was taking his feeds appropriately. A Speech Pathologist, Kirsty Dwyer, attended the review to assess Daniel's feed. Dr Dawson-Smith and Ms Dwyer made a plan for Daniel to have three hourly feeds of 110mL per feed, with a follow up and weight the next day. Dr Dawson-Smith gave evidence at inquest that, for the purpose of the review, he had accessed Daniel's growth chart to look at the centiles to see where Daniel was tracking.

95. Ms Good gave evidence that 21 February was her next work-day following the MDT meeting. She noted in the medical records that she spoke with Mr Wright on the phone and that he "appears fixated on a discharge date".[39] She spoke to CPU SW Ralph about her concerns about Daniel's parents, and whether a report should be made to Child Safety. She told the court that it seemed that Daniel's parents wanted him to go home earlier than anticipated, and the multi-disciplinary

[36] Transcript, Day 3, T6L39.
[37] Ibid, T9L22.
[38] Ibid, T70L42.
[39] B1.3 – MBH records, p 162.

team were "wanting more time to be able to assess and provide enough supports for him to go home".[40]

96. Friday 22 February 2019, was the first day that Dr Gopan reviewed Daniel on the ward as he was on-shift that week. Dr Gopan gave evidence at inquest that it is his standard practice to look at the growth charts when he reviews a patient and believes he would have done so for Daniel. He advised in his statement that:

> *The plan handed over to me from the previous on-call team members caring for Daniel was that if there was satisfactory progress in terms of Daniel's feeding and he was able to feed well, then with adequate communication and community support he might be able to be discharged so long as his safety was addressed.*[41]

97. Ms Brittain saw Daniel that day and noted that he had gained weight and his feeding efficiency had improved. Later that day SW Williams spoke to Mr Wright on the phone and noted in the records that he said "that if [Daniel] is not [discharged] on Monday they are "walking out with him" because "its stressful" and "we're sick of this".[42]

98. On the same day, Child Safety received a call from Ms Williams to request information about what may happen if she and Daniel's father discharged Daniel against medical advice. The Child Safety Regional Intake Service (**RIS**) created an 'Intake Event' to be assessed by the intake team.

99. On Saturday 23 February 2019, Ms Williams called a nurse at the hospital. Mr Wright could be heard in the background with a raised voice. Ms Williams said that they were happy to come and discharge Daniel against medical advice. The nurse advised that she would get a doctor to call them back. Registrar Jacqueline Fradley was on duty and spoke to Dr Gopan before she called Daniel's parents back. Dr Gopan advised Dr Fradley that he did not feel it was safe for Daniel to be discharged at that time.

100. At about 5:15pm Dr Fradley spoke to Ms Williams and then to Mr Wright. Ms Williams said that they wanted to pick Daniel up from hospital and bring him back for a check up on Monday. Dr Fradley explained that the medical team does not feel it is safe to discharge Daniel and explained his medical needs. She explained that if he was taken out of the hospital against medical advice, it would result in a notification to Child Safety. During the phone call Mr Wright was angry and aggressive and Dr Fradley noted he said the following:

- *this is bullshit*;
- *yes you fucking can [discharge Daniel]. You're a doctor. You're lying*;
- *you better let him go home or we will sign him out against medical advice*;
- *we've already spoken to child safety and they don't know why he's still there either*;
- *As I fucking said, youse better discharge him Monday or we are taking him and I'm hanging up now*.[43]

[40] Transcript, Day 2, T8L12.
[41] B3.6 – Statement of Dr Gopan, para 27.
[42] B1.3 – MBH records, pp 155 – 156.
[43] Ibid, p 146.

101. After the phone call, Dr Fradley spoke to X[44], who made a notification to Child Safety that evening. X gave evidence at inquest that:

> *…I was on call that day and staff from the children's ward rang me to say there'd been multiple phone calls [from Ben]. I don't believe Ben had been back to the hospital at that point since the multidisciplinary meeting, is my recollection. He had been abusive, I guess, escalating to hospital staff and they phoned me for support or some advice. It was at that point that I completed the Child Safety report.*
> *…*
> *My recollection is that I was concerned Ben would present to the hospital and request to discharge Daniel against medical advice, and my assessment at the time was that that could happen, so I believe the risks to Daniel were obviously more imminent than previously.*[45]

102. X gave evidence that she was aware that concerns had been raised by staff before she made her report, and she tried to capture those concerns in her report. She said that her assessment was that it was on 23 February 2019, that the concerns "met the threshold for a Child Safety report".[46] X said that, after she made her report, she passed on further information related to her report, including concerns raised by other members of staff, to Ms Ralph in the CPU.

103. During her evidence, X was asked to consider whether she now thought that she should have made a report to Child Safety earlier. She said:

> *It's difficult to answer. I'm not sure there would have been a different response. Daniel was safe – seemed to be safe in hospital, so while the child remains safe in hospital, the risk is not imminent, and it wasn't until it was evident that Daniel was going to be discharged sooner, that it was deemed that that risk was high.*[47]

104. On Monday 25 February 2019, Ms Kibby saw Daniel twice, in the morning and the afternoon. In her evidence Ms Kibby told the court that, by this stage, she was aware that a report had been made to Child Safety about Daniel. When Ms Kibby saw Daniel in the afternoon, she made a note in the record of her concern that Daniel appeared to feed less efficiently when he was fed by Ms Williams rather than by the nurses. She also noted that Mr Wright had said various things about caring for Daniel while she was present, which included words to the effect that "if I had to look after boy for 24 hours, I'd be in the mental health unit" and "we took him out for an hour and he didn't die, so we will be fine".[48] In addition, she emailed her concerns to X to be added to the Child Safety report.

105. Ms Brittain saw Daniel on this day and noted that Daniel had been feeding well and gaining weight.

106. On Tuesday 26 February 2019, the mandatory notification by X was transferred from the Child Safety After Hours Service Centre to the RIS. At that point Ms William's phone call was connected to the mandatory notification, and they were joined into the same 'Intake Event'.

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[44] On 4 February 2024, I made an order prohibiting the publication of "The name, or any information from which the name or identity of any person who notified Child Safety that they suspected that Daniel had been, was being or was likely to be harmed, pursuant to the Child Protection Act 1999 (notifier), or information from which the name or identity of the notifier could be deduced."
[45] Transcript, Day 2, T8L32.
[46] Ibid, T9L10.
[47] Ibid, T11L39.
[48] Transcript, Day 3, T45 - 48.

107. That day another MDT meeting was held. Dr Gopan gave this account of the meeting in his statement:

> *Social workers in the hospital had extensive involvement in Daniel's case. I cannot specifically recall child safety being at the meeting. If there were not there, they would have been made aware about the case. Daniel's care plan was discussed. I was advised that staff were worried about the parent's capacity to care for him. In these situations, we as physicians are reliant on decisions from child safety regarding discharge, and regular communications were made with the child safety team regarding various concerns about parents' capacity to care. I knew of the regular communication with child safety through the MDT meetings at which child safety were present where Daniel was discussed, and also through communication with Social Work and their notes on the ieMR*
>
> *…*
>
> *During the MDT meeting I re-iterated that Daniel could only be discharged if there was a safe plan to care for him in the community.*
>
> *From a clinical perspective, it was not possible to keep a child in hospital indefinitely if they were otherwise clinically stable. There will come a point at which the child needs to be discharged. Our role as clinicians was to ensure a child such as Daniel was medically stable to go home and that there was nothing which actively required hospital treatment.*[49]

108. Dr Gopan explained the last statement further at in his evidence at inquest, saying:

> *That is generally the approach. We paediatricians work on – in a risky environment all the time, so it's a balanced risk that we take on a regular basis. I have several babies who are at risk of dying in the community but we have to take into consideration what protective factors are there for the baby, work very closely with the community and in Daniel's case, there were some protective factors such as extended family members who are invested in care of Daniel, so I had to tel – I have to take those into account and then determine whether baby can be discharged.*[50]

109. Dr Gopan made a note in the records at 1:44pm that he told Ms Williams at the MDT that she would need to demonstrate she could care for Daniel before he could be discharged home. He said that ward staff would have minimal involvement with Daniel over the next two days so she could care from him.

110. Dr Gopan was asked at inquest what he could have done if he was not satisfied that Ms Williams could care for Daniel, and he said:

> *If I had sufficient concerns, there were no protective factors, and I had – I had concerns that the medical needs of Daniel would be affected which could result in adversity, then I have the – I have – I can call for a care and protection order. But again, within that framework, it doesn't actually – the physician still shouldn't be reassured by the fact that there is a care and protection order that they could invoke. Again, that needs to be followed up through Child Safety. So ultimately, the decision – our escalation pathway is to Child Safety, which we have consistently done.*[51]

111. At 2:00pm that day, Ms Atta sent an email to the intake CSO at Child Safety, cc'd to the MBH CPU address and to Ms Ralph, advising that:

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[49] B3.6 – Statement of Dr Gopan, paras 37 and 40 - 41.
[50] Transcript, Day 5, T63L9.
[51] Ibid, T64L38.

I see you have an intake re: Daniel Williams opened. I just wanted you to be aware that baby Daniel Williams (DOB 22/7/18) is due for discharge from Mackay Base Hospital on Thursday 28/2/19. I understand that QH have placed a report based on their concerns of Daniel's parent's inability to care for Daniel following discharge.[52]

112. On Wednesday 27 February 2019, Dr Gopan reviewed Daniel and reported that Daniel was very settled and looked well. It was reported to him by nursing staff that Daniel's care was done entirely by Ms Williams overnight, and he advised Ms Williams that she would have to spend the whole day with him attending to his feed and cares. Dr Gopan considered that Daniel was medically stable and safe for discharge.

113. The same day an MDT discharge planning meeting was held. Present were Dr Gopan, Paediatric Intern Capuano, SW Ralph, NN Wake and a CSO from Child Safety. Staff in paediatrics and the allied health team believed it was safe for Daniel to be discharged home. Dr Gopan gave evidence at inquest that, during the discharge planning, all of the supports which were to be provided for Daniel were checked and relevant providers were contacted, including CPLO Roberts, Child Safety, IFS, the Bowen Child Health Nurse, the SW in the Bowen Hospital, Daniel's GP and NN Wake. Contact was also made with Mr Wright's mother, who said she would be supporting Ms Williams and visiting her often.

114. That day, X telephoned the RIS to advise that Daniel would be discharged the following day, and to check whether Child Safety needed any further information. A CSO contacted X and took further information from her over the phone which was recorded in the Child Safety records.

115. On Thursday 28 February 2019, at 10:26am, Y sent the following email to the RIS. She cc'd others to the email, and attached concerns from 25 February 2019:

To whom it may concern:
I believe numerous staff have provided information in relation to their concerns over the past three days in relation to the inability of the parents to manage the cares of this high needs infant.
Mother has an intellectual disability and father and (sic) ABI with high levels of emotional dysregulation (displays of anger and aggression)
After a 3 week admission in trying to educate the parents in how to manage the cares staff at MBH have spent the past 4 days providing information in regards to their worries of the significant risk to this baby.
Staff that have individually spoken/reported to RIS includes, A, B, C
Please find the concerns as documented by D as listed below.
Baby will be discharged today.

116. At about 4:45 that afternoon, Daniel was discharged from MBH into the care of his parents. The medical records record Dr Subo as having authorised discharge, though according to her statement, which she confirmed in her evidence, this is in error and she had no direct involvement in discharge on this date.

Expert opinion as to Daniel's condition and care as at 28 February 2019

117. In respect of Daniel's care during his three weeks at the MBH Dr McEniery has advised that:

My opinion is that Daniel's failure to exhibit catch up weight was of critical importance,

[52] B3.14.2 – SR-02 to Statement of Sally Roberts.

especially given his terminal weight loss. His weight was following between the -4th and -3rd SD (half a kg below the 0.4th centile, 1kg below the 2nd centile, all corrected for age).

I am concerned that there was a lack of shared understanding of Daniel's poor weight gain, from reviewing the documentation. These include:

- *Almost every entry mis-documented Daniel's corrected gestational age. For example on the day he was admitted, his corrected age was mis-stated as 10 weeks instead of 13 plus weeks.*
- *He was being weighed regularly, and there were references to plotting his weight regularly on an infant growth chart, however his centiles were not quoted and used as a regular reference point and I could not find a copy of the growth chart in the documentation.*[53] *Phrases such as "failure to thrive" which might have triggered more alarm and attention, were not used.*
- *There were errors in documentation about which centile Daniel's weight was following, and his condition was considerable worse than stated.*

There were documented concerns about loose and foul-smelling faeces. Some microbiology tests were ordered. There was no documentation of consideration of malabsorption or other possible causes or investigation for these. With the benefit of hindsight I wonder if there had been more consideration of other causes of failure to thrive, including possible bowel pathology (short gut syndrome, malabsorption) which could have redirected his management and improved his weight gain.[54]

118. In respect of Daniel's discharge, and his condition at the time, Dr McEniery said that:

…it was evident that Mackay Base Hospital staff had major reservations about discharging Daniel to his parents' care. He remained significantly underweight, needed specific care and attentional during feeds which his mother was intermittently able to provide, as well as have high needs regarding oxygen therapy and therapies for his developmental delay. Extraordinary effort was put in to support and prepare his parents to care for him. The combination of his poor feed efficiency, the marginal capacity of his mother to feed him the volume of food he required, and his severe failure to thrive, created a particular nexus, perhaps the term "a perfect storm" could be applied here. Again with the benefit of hindsight, my opinion is that he should not have been discharged home into the care of his parents. This was certainly not because of lack of effort on the part of the hospital staff, instead I believe it was an overly optimistic assessment of the capacity of his parents to keep Daniel safe and thriving. [55]

119. Dr Crawford advised in her report that, although "the overall treatment at [MBH] during first admission 6 – 28th February, was very appropriate…":

However, an area which could have been improved was nutritional support during the period of poor weight gain which occurred between 11 – 18th Feb when Daniel was struggling to take full volume quota, was feeding slowly and inefficiently and resultant weight gain was slow. At this age a weight gain of minimum 150gm/week would be expected….weight gain fell well below that…

From 20 Feb to discharge on 28 Feb the weight gain was 240gms ie appropriate. Daniel could have been assisted by Nasogastric tube feeding to top up to the required quota at least during the period of inefficient feeding. An infant with [chronic neonatal lung

[53] See 'Preliminary Issues' above.
[54] H1 - Report of Dr Julie McEniery, p 7.
[55] Ibid, p 8.

disease] has increased requirements related to work of breathing and adequate calories important to allow successful lung growth.[56]

120. At inquest, Dr Crawford accepted that intervention like NG feeding "is complex and there may be reasons that it wasn't suitable for either the baby or the parents…".[57] Dr Crawford was asked whether, if she had been the treating paediatrician, she would have overridden the parent's concerns and insisted on NG tube feeding, and she explained:

I – no, I don't think I would. At – at this point in time I don't think the concerns of the weight were at such a degree – at this point in time the baby was putting on weight, that you would – you'd want to work with the family and go along with their – I just don't – there was certainly compromise if the family were not willing to, you know, follow that advice. So I wouldn't want to override their - their consent in any way at that time.[58]

Response by treating clinicians

121. Drs Menezes, Subo and Gopan had the opportunity to consider the expert reports before they gave their evidence at inquest and were asked to respond to the opinions of the experts.

122. Dr Menezes confirmed at inquest that she did think about NG feeding when she was on ward rounds looking after Daniel. She said that:

So nasogastric tube insertion is done to help the child to speed up the process of feeding and weight gain. And I acknowledge what Dr Crawford has mentioned, but in reality, when I saw the child, the child was gaining weight and was tolerating the feeds okay. There are two reasons we did not consider nasogastric. Number one was he was almost close to the volume what we wanted, so I didn't want to add lots more extra at that time. Number two was that he would also delay – that is a step backwards. Before I take that step – during my time there between the 11th and the 14th, I would give a few more days, because that's again a step backwards and it's quite traumatic for everyone if it's not needed. Instead, if he had been vomiting and having lots of diarrhoea, other than one diarrhoea I mention in my report, I would have considered nasogastric at that time.[59]

Conclusions

123. I find that, as at 28 February 2019, Daniel was failing to thrive and he continued to require high levels of care and intervention to increase his weight and to address his significant developmental delays. The opinion of the experts is that there could have been further investigation of the possible reasons for Daniel's slow weight gain, and that intervention such as NG feeding could have assisted in increasing Daniel's weight gain.

124. I note the evidence of the clinicians that NG feeding was considered but not determined to have been necessary at that time, and I also note Dr Crawford's concession that she would not have insisted on it if the parents had objected. There is no evidence in the medical records, however, that such an option was discussed with Daniel's parents at this time. The emphasis was on educating Ms Williams and Mr Wright to feed Daniel themselves. There is repeated evidence in the notes as to difficulties experienced by various staff while attempting to

[56] H2 – Report of Dr Crawford, p 8.
[57] Transcript Day 8, T4L17.
[58] Transcript Day 8, T5L3.
[59] Transcript Day 5, T17L47.

provide this education and concerns as to the parents' understanding and ability to feed Daniel properly.

125. I also note the submissions made on behalf of MHHS and THHS that:

> *It was in Daniel's direct interests for staff to support his parents, as maintaining lines of communication and engagement with the parents meant that they were likely to attend their GP or the hospital and seek help, should they have concerns about Daniel's health. It was a fine line being trod by staff, balancing Daniels' interests and welfare, and how best to advance in those circumstances.*

126. Dr McEneiry is critical of the decision to discharge Daniel at this time. There is some tension between Dr McEniery's view of Daniel's condition at discharge, and Dr Gopan's view that he was medically stable. Dr McEniery did not examine Daniel, and she does admit that her opinion that Daniel should not have been discharged on 28 February 2019, is given with the benefit of hindsight. Dr Gopan, who had the benefit of examining Daniel, has also advised that paediatricians must make difficult decisions, and that infants who are medically stable cannot be kept in hospital forever.

127. This tension is resolved if it is understood that Dr McEniery's view is that the decision to discharge Daniel was not necessarily wrong in a medical sense but was based on an "overly optimistic" view of his parents' ability to care for him. While Daniel might have been medically stable at discharge, there can be no argument that, unless he was very attentively and carefully cared for at home, his condition was such that he would deteriorate very quickly. Ms Williams had only cared for him "on her own" for the last 48 hours before discharge. During this time she still had nursing staff on hand at all times to ask questions, and to prompt her to feed Daniel when necessary. Further, Mr Wright was not at the hospital during this time. All indications in the medical records up to this point were that Ms Williams and Mr Wright struggled with an understanding of their responsibilities and needed constant prompting and correction. It was also noted that Mr Wright was often aggressive, abusive, resistant to medical advice and dismissive of Daniel's needs, and that he tended to override Ms Wright when he was present.

128. However, I note the submissions made on behalf of MHHS and THHS that:

> *…Should there be no medical reason to keep Daniel as an inpatient and the parents wished to discharge him, there was no real option open to the health practitioners caring for him to compel a stay in hospital, as it would not have been open to impose a Care and Treatment Order (CTO) if the parents were following advice from Daniel's treating team.*[60]

and

> *Staff at MBH were responsible for Daniel's medical care and medical welfare. Decisions as to whether Daniel should be removed from the care of his parents could only properly be made by Child Safety, which was the ultimate decision-maker in this regard. In circumstances where the parents were complying with instructions from Daniel's health care providers, imposition of a CTO was problematic. A CTO would have risked impacting the therapeutic relationship which would have been to Daniel's detriment, in circumstances where Child Safety were clearly intent on implementing an intervention*

[60] Submissions on behalf of MHHS and THHS, para 25.

with Parental Agreement (IPA) meaning Daniel would remain in the community cared for by his parents.[61]

129. In these circumstances, I find that the decision to discharge Daniel on 28 February 2019 was finely balanced. In hindsight, it is easy to say that it was not appropriate given Daniel's fragility and the demonstrated inability of his parents to meet the high levels of care he required. However, at the time, I find that the relevant clinicians made a decision which was medically sound, but perhaps placed an over-reliance on Daniel's parents' ability to care for him and Child Safety's decision that Daniel would be safe with his parents. I accept that, in the circumstances, a CTO would have been counter-productive and that the clinicians were entitled to rely on the Child Safety's decisions.

Issues 5 & 6 – Daniel's condition and care as at 19 March 2019 and was Daniel's discharge from Mackay Hospital to the care of his parents on 19 March 2019 appropriate?

130. It is convenient to deal with issues 5 and 6 together.

In care of parents with Child Safety involvement – 28 February – 19 March 2019

131. On 2 March 2019, the second day after his discharge from MBH, Daniel was taken to the Bowen Hospital by his parents with a high temperature. He was transferred to the MBH in the early hours of 3 March 2019.

132. Daniel was reviewed by Dr Dawson-Smith at about 1:30pm on the afternoon ward round. Dr Dawson-Smith noted that:

> …Daniel had not had any fevers overnight, was feeding as normal and had no concerning symptoms (such as vomiting, cough, rash or diarrhoea), his observations were all within the normal range and he was generally very well looking. Essentially, his examination was very reassuring. I concluded, based on my examination, that Daniel's fever the previous day was likely due to a viral infection which had since resolved.[62]

133. Dr Dawson-Smith consulted Dr Subo, who was the on-call paediatrician and had authorised the transfer from Bowen Hospital to MBH, to discuss his review and assessment. Dr Subo confirmed in her evidence that she was comfortable with Dr Dawson-Smith's assessment and concluded that Daniel was able to be discharged home. Dr Subo said that she was aware that Daniel was to be admitted to TUH in three days time (6 March 2019) for his hernia repair, and this was part of her consideration as to whether it was safe to discharge Daniel at that point.

134. Dr Dawson-Smith advised Ms Williams that Daniel was being discharged that afternoon, but urged her to present Daniel to the Bowen Hospital if Daniel had any further fevers or if they had any concerns.

135. At inquest, Dr Dawson-Smith said that he was not aware, at the time of this review, that a notification had been made to Child Safety about Daniel. Dr Dawson-Smith was asked whether would have been helpful to him, even as a junior clinician, to know whether a notification had been made to Child Safety about a patient he was reviewing. He said:

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[61] Ibid, para 27.
[62] B3.3 – Statement of Dr Dawson-Smith, para 26.

I think it's important because we're all team members, so we all – even the junior ones do have a responsibility, particularly, you know, as doctors we're mandatory reporters. That doesn't extend necessarily to neglect – concerns around neglect but it's – is – is something that I've certainly reported many times in my career. And – and so we're all very much aware of how to do that. And we're aware of things to be kind of looking out for that would be of concern to the health of our – our patient. So I – yeah, I do – I do think that it's important that the juniors have as much of that context as possible.[63]

136. Dr Dawson-Smith confirmed in his evidence that the question of whether or not Daniel was being fed adequately at home was directly relevant to him in assessing Daniel, and if he had known this concern was raised in the notification, it would have been a factor in his assessment and subsequent conversation with Dr Subo as to whether Daniel should be discharged.

137. On 4 March 2019 at 10:39am, Z sent an email to MBH and Whitsunday CPUs in which she told Ms Haratsis that:

*…the worries about **Daniel Williams** is a notification. The I&A is sitting pending allocation with Mackay CCSC, which may be in error as I thought the family are from Bowen".*[64]

138. Z apparently "chased this up" with Child Safety and Daniel's matter was allocated to the Bowen CCSC.

139. Daniel was reviewed at Bowen Hospital that day by Bowen Child Health Nurse Janet Russell. Daniel was weighed at 4660 grams. RN Russell gave evidence that this was the first time she had met Daniel and his parents, and that she had been asked to weigh and review Daniel every second day following his discharge.

140. After reviewing Daniel and meeting his parents, RN Russell called Ms Haratsis and advised that the parents had presented with Daniel for his weigh-in. Ms Haratsis advised RN Russell that Child Safety were opening an I&A with this family, and that RN Russell should engage with the family and encourage them to attend Bowen Hospital for support.

141. An hour after RN Russell Spoke to Ms Haratsis, NN Shannon Breckon from Bowen Hospital also called her about Daniel's case. Ms Haratsis recorded in an ROAI that:

NN sat in with CHN [RN Russell] with review. Frustrated that no handover presented to Bowen staff by Medical team in Bowen – ED staff Riskman an incident report. No referral in place for NN. Stated dad was using inappropriate language directed at baby (using word shit – referring to the child need to take the dummy). Felt father appeared to be domineering in the relationship ? DV, ? understanding of development delay and expectations of the child. Believes that IFS will be visiting today at home.
…
[A]dvised CHN that ChS are going to be I&A with this family. Encouraged NN to engage the family and encourage them to attend Hospital for support. NN to follow up with NN Mackay if any referral required for her case management.[65]

[63] Transcript, Day 5, T42L6.
[64] B3.14.3 – SR-03 to Statement of Sally Roberts.
[65] B3.5.6 – Wright Williams Enquiry.

142. On 5 March 2019, Child Safety Bowen commenced the I&A of the notification of 23 February 2019. The I&A process was as follows:

> *During the course of the I&A [Child Safety] staff gathered information from various medical staff who had had interactions with the family as well as information from police, Mother and Father. [Child Safety] staff addressed concerns they held with Mother and Father and assessed that an Intervention with Parental Agreement (IPA) case would be appropriate to open with the family to ensure Daniel's ongoing safety and wellbeing needs were met.*[66]

143. CSO Helen Dawe and CSSO Kristy Munro from the Bowen CCSC attended Daniel's home on this day. Following the home visit, CSO Dawe completed a Safety Assessment. The Safety Assessment was approved by STL Joanne Ward at Bowen CCSC. Daniel was considered to be safe, with the rationale for the decision recorded as follows:

> *No immediate harm indicators present at this time. Daniel was sighted by [Child Safety Officer] and [Child Safety Support Officer] at his home residence….with his parents Zara Williams and Benjamin Wright. Daniel presented bright eyed, alert and active, Daniel was able to hold his head up without assistance and look around.*
>
> *Daniel stretched and yawn and appeared comfortable while being nursed by Dad.*
>
> *Zara advised a person from IFS was coming to visit them at 3pm today and Daniel would be having operation to remove his hernias in Townsville and would be driving him up tomorrow.*[67]

144. On 6 March 2019, Daniel attended the TUH for surgery for his inguinal hernia. It had been planned that Daniel would have an outpatient appointment on 6 March 2019, stay with his parents overnight, and then be admitted for surgery on 7 March 2019. However, Mr Wright and Mr Williams had not brought enough oxygen with them, and it was necessary to admit Daniel to the paediatrics ward for the night of 6 March 2019. Mr Wright and Ms Williams were told that one parent would have to stay with Daniel overnight to attend to his cares, and they refused. Mr Wright became angry and aggressive and had to be told not to swear at staff.

145. CSSO Kristy Munro phoned Ms Williams that day. They discussed what was happening with Daniel at the hospital, and CSSO Munro heard Mr Wright in the background telling her what to say.

146. That evening, Daniel's parents chose to leave Daniel at the hospital after dinner, and came back at 11:45pm, 3:40am and around 7:00am to feed him. Mr Wright was impatient for the doctors to arrive on the morning of 7 March 2019, and for Daniel to be taken into surgery, because he wanted to go and have breakfast and then get some sleep. Daniel's surgery was uneventful. He stayed overnight in the Paediatric Intensive Care Unit (**PICU**) and his parents were not required to stay with him. They visited him briefly at about 9:00pm.

147. On 8 March 2019. Daniel was discharged from TUH after hospital staff confirmed that Daniel's parents had enough oxygen for the drive back to Bowen. PICU nursing staff had been in touch the Paediatric SW to discuss their concerns about Daniel's parents' behaviour. In particular it was noted that Mr Wright had said

[66] F1.1 – SPR Report, p 16.
[67] F3.3 - Records – ICMS, p 82.

"shut up you little dickhead" to Daniel, accused him of just wanting attention, threatened not to go to upcoming appointments in Mackay, and refused to move so Ms Williams could sit in a chair while she was holding Daniel. Later that day, W made a mandatory child safety notification was made concerning Mr Wright and Ms Williams' behaviour at the hospital during Daniel's admission for his hernia surgery. Mr Wright was reported to have had aggressive outbursts and controlling behaviour. It was noted Ms Williams was unable to put Daniel's needs above acquiescing to the Mr Wright.

148. On 11 March 2019, Ms Haratsis recorded a number of contacts with Ms Atta, NN Breckon, and Sally Roberts, MBH CPLO and Clinical Nurse Consultant, in an ROAI as follows:

> *3 separate enquiries.*
> *Email to Lucia Atta CSO HLO – re: update on I&A. response: "Per your request, the current IA for Daniel William's is in progress. Baby has been sighted and a number of interviews have occurred. Current CSO for this one is CSO Jessica Genrich; although I do see that CSO Helen Dawe has had some contact with the family too. Do you have any information re: services that Daniel is getting from Bowen hospital that I can pass along to the CSO's". Advised Lucia that 159N response has just been sent to Kristy Munro CSO.*
>
> *Shannon Breckon NN – weighed baby. Concerns that father was using inappropriate language with baby. Father not holding baby appropriately – one hand passing to mother, no neck support. Fa refused to change soiled nappy – believed 'womans job' – NN changed nappy. Advised NN to document concerns and I will forward to child safety as 2nd 159N response today.*
>
> *Sally Roberts CPLO – requesting any updates from Child Safety as per query by Penny Richards CN CCP. Advised the above from HLO email and that I was advised Penny was on a phone call when NN weighed baby just before – Sally will respond to Penny.*[68]

149. On 12 March 2019, Daniel's case was discussed at an MDT meeting which Dr Gopan attended, and it was confirmed that a paediatric phone review had been booked for 19 March 2019, and an in-person paediatric review for 26 March 2019.

150. On 13 March 2019, Ms Haratsis referred Daniel's case to the Mackay Suspected Child Abuse and Neglect Team (**SCAN**) for the SCAN meeting on 26 March 2019. Ms Haratsis gave evidence that SCAN meetings were held weekly, and she would attend them remotely if they involved a Bowen case.

151. Carissa Scott was the Child Safety SCAN Team Co-ordinator for Mackay at the time. She was responsible for convening and facilitating the weekly SCAN meetings, making the administrative arrangements for the meeting, circulating the agenda and material to attendees, taking the minutes and dealing with amendments to the minutes. Ms Scott gave evidence during cross-examination that usually a referral would be discussed at a meeting within 10 business days of the referral, which was the case with Daniel's referral.

152. The same day RN Russell emailed RN Richards and Dr Gopan to ask Dr Gopan how often he would like Daniel's weight taken. Dr Gopan replied and said "[l]et's

[68] B3.5.8 – Wright Williams Enquiry.

continue to do it twice weekly…"[69] until Daniel's weight is back on track. At inquest, Dr Gopan explained that:

…when we do weight on a daily basis, or even second daily, there would be a lot of fluctuation. And so it is very difficult to determine the trend. And – and that is one reason why we might say it – every second – second day or third – third day. Because we do expect some degree of – even if the baby has milk before being weighed, that is a substantial weight gain for the baby of that size or the baby has [indistinct] that itself – so all those factors are taken into consideration at that – when we do daily weights.[70]

153. Daniel was reviewed at the Bowen Hospital on 15 March 2019. RN Russell documented that he weighed 4900g which was an increase of 180g from his last weigh. She observed that Daniel had nappy rash. RN Russell emailed RN Richards and Dr Gopan to update them.

154. On 18 March 2019, RN Russell attended a home visit to weigh Daniel. She was accompanied by V. RN Russell emailed RN Richards and Dr Gopan again:

Good Morning,
I just visited Daniel at home. His weight is 4830 down 70g from Friday. He has pale, loose stools since Friday afternoon according to mother. His nappy rash is much worse and he is clearly uncomfortable when the area is touched. I got Zara to make an appointment with their GP Dr Mallett, for review of rash and stools. I've checked in and they are booked in today.
I went through safe formula feeding, making, cleaning, sterilising, etcetera, and she tells me they aren't sterilising. I thought it might be better if they did and encouraged them to do so, also more attention to hand hygiene.
The house is untidy and not that clean with cats roaming around and cat litter in the kitchen. Daniel looked bright and well today, though, and was comforted when cuddled, which I have encouraged with Zara. According to her, Ben thinks this is spoiling him.
I've made an appointment for them to bring Zara into the hospital on Thursday morning for review. Still has lots of wet nappies according to Zara.
Regards,
Janet[71]

155. RN Richards replied to RN Russell and Dr Gopan, and cc'd NN Wake and Dr Dawson-Smith. She acknowledged RN Russell's efforts and said that it might be a bit difficult to feed Daniel the whole 900mLs, but "I am concerned that if we aimed for a smaller amount then they would become complacent and just go with the smaller volume".[72]

156. At inquest, Dr Gopan was asked what his role was in receiving these emails, and he said:

I think some of the emails are for my awareness that there is a particular issue. From my point of view, if I feel that this baby needs to be in the hospital, that would be my obligation that I would say, "Well, that is not safe. The baby needs to be admitted in the – in the ward."[73]

[69] B3.6.8 – GH – 08 to Statement of Dr Gopan.
[70] Transcript, Day 5, T71L12.
[71] B3.6.8 – GH – 08 to Statement of Dr Gopan.
[72] Ibid.
[73] Transcript, Day 5, T74L16.

157. Dr Gopan explained that, because he knew that Daniel's GP would be seeing Daniel, he "would wait for the GP to – GP to let me know whether there was sufficient concern at that point."[74]

158. V contacted Ms Haratsis after the visit, and Ms Haratsis recorded in an ROAI that:

> *SW called – did a home visit with Child Health Nurse – extremely excoriated nappy rash.*
> *Troy Wake stated spoke with Penny (CCP) who advised child is on ab's which can also exacerbate nappy rash/*
> *…*
> *Advised SW that family will be discussed at SCAN next week. To document any concerns for discussion.*
> *Iemr check 1643hr shows pt is in Bowen hospital – been accepted for transfer to MKY paeds* [75]

159. Dr Gopan asked Dr Dawson-Smith to conduct the outpatient phone review that morning. Dr Dawson-Smith spoke to Ms Williams, who said Daniel was struggling to drink the amount of formula required and had a bad nappy rash. Dr Dawson-Smith spoke to Ms Brittain and RN Richards, and then phoned Ms Williams back and gave her advice. He was aware Ms Williams was going to her GP that day.

160. Ms Williams took Daniel to see Dr Mallett that afternoon. Dr Mallett found Daniel to be "acutely unwell, with fever, poor feeding and irritability."[76] Dr Mallett urgently referred Daniel to the Bowen Hospital.

161. Daniel presented to the Bowen Hospital that afternoon with a high temperature, decline in feeds and irritability, and was transferred to the MBH on that evening. He was reviewed by Dr Subo during the morning ward round on 19 March 2019. Dr Subo gave evidence that, by this stage, Daniel did not have a fever and his observations were fine. She ordered a full blood count to see if he had a bacterial infection, but it came back normal. Dr Subo said that she reviewed Daniel again during the afternoon ward round at around 3:00pm at which time a plan was made for Daniel to be discharged at around 6:00pm if he remained clinically stable.[77] Dr Subo said that, at the afternoon ward round, Mr Wright "would have been happy if I discharged but I was not ready to do an early discharge [without] having that period of observation".[78]

162. On 19 March 2019, while Daniel and his parents were at the hospital, CSO Jessica Hillery (formerly Genrich) and CSSO Munro tried to conduct a home visit. CSSO Munro then spoke to Ms Williams on the phone and discussed Daniel's situation with her.

163. Dr Dawson-Smith reviewed Daniel at 6:20pm on 19 March 2019 and noted that he had no further fevers, had tolerated his feed well, had no further vomits, was alert, and there were no new concerns upon review. In accordance with Dr Subo's pre-determined discharge plan, Dr Dawson-Smith advised Ms Williams and Mr Wright that Daniel was able to be discharged. He advised them to return to the Bowen Hospital or Mackay Base Hospital if Daniel experienced any further

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[74] Ibid, T74L27.
[75] B3.5.9 – Wright Williams Enquiry.
[76] D1.2 – Report of Dr Mallett, p 2.
[77] Transcript, Day 3, T15L15.
[78] Ibid, T16L45.

feeding difficulties, wet nappies or had noticeable difficulty breathing. Daniel was discharged on later that evening.

164. At inquest, Dr Dawson-Smith gave evidence that he was not aware of the concerns held by V and RN Richards following the home visit the day before, but that that information would have been helpful to him during his review that evening.

165. During the admission there were a number of notes made of Mr Wright's behaviour. He was noted as rude, angry and aggressive, questioning the abilities of the staff (particularly RN Richards) and telling them they didn't know what they were doing. At one point he asked 'Siri' on his iPhone for advice about nappy rash.

166. Following discharge, the stool test results revealed Daniel had salmonella growing in his stool. His family was contacted and advised. Dr Subo said at inquest that she considered the Antibiotic Guidelines from the Royal Children's Hospital in Melbourne and determined that, given Daniel's age and prematurity, and the fact that he seemed systemically well in hospital and had had no recurrence of his fever, antibiotics were not indicated to treat the salmonella. Dr Subo explained that antibiotics have to be carefully considered as they can "cause more problems in a pre-term baby".[79]

Expert opinion as to Daniel's condition and care as at 19 March 2019

167. In respect of Daniel's discharge from MBH on 19 March and the stool test results showing salmonella, Dr McEniery advised that:

> *I am concerned that Daniel was discharged so soon after being admitted with weight loss, new gastrointestinal symptoms, and hypoglycaemia at presentation. I acknowledge this may be with hindsight bias, however I consider that with the knowledge of his vulnerable physical state, the escalating concerns about his parents capacity to provide adequate care, and the new weight loss, that a more appropriate course would have been to have kept him in hospital until he had re-established weight gain. During the brief admission, once again there was no shared understanding documented of his failure to thrive and where his weight was plotting on the centiles.*
> *…*
> *I am concerned that antibiotic therapy was not given for the salmonella infection. I acknowledge this may be with hindsight bias. Best practice (for example using the reference UpToDate) suggests that although antibiotics are not indicated for recovering older children and adults, therapy can be considered in infants under 1 year of age, especially given the comorbidities and failure to thrive. I acknowledge that there is no evidence that ongoing salmonellosis placed a part in Daniel's further weight loss and death, conversely there is also no evidence to say that it wasn't an important causative factor.*[80]

168. Dr Crawford raised the following concerns in respect of this admission to MBH:

> *The second admission between 18-19 mar was more problematic [than the previous admission ending 28 February]. Daniel was admitted with fever, vomiting, offensive loose stools, significant nappy rash, and decreased feeding. The admission was brief with discharged on 19 March as the baby reportedly appeared well.*

[79] Transcript, Day 3, T45L25.
[80] H1 - Report of Dr Julie McEniery, pp 10 - 11.

The weight on admission was 4830gms, 70gms less than Bowen hospital weight of 4900gms on 15 Feb and not unexpected that there would be some weight loss from fluids loss with a gastrointestinal illness.
However, given there had been previous significant concerns around the family's ability to feed, I would have expected that the baby's weight gain during period since discharge be considered, and if done this would have flagged again that this child was not thriving – i.e. 4680gms on discharge on 28 Feb to 4900gms on 15 mar i.e. a suboptimal 220gm in 2 weeks.
Unfortunately, this admission was an opportunity to again ensure infant was able to put on weight prior to discharge but would have necessitated a somewhat longer admission. I note that the discharge did not occur until after 7pm and that there was some pressure from the father to be going home. No weight was taken prior to discharge.
The Salmonella infection was not identified until after discharge. I consider that as the baby was afebrile and appeared well it was reasonable not to treat with antibiotics at that stage.[81]

Response by treating clinicians

169. Dr Subo explained in her evidence that, on 19 March 2019, she was aware that Daniel's weight had dropped but thought this expected following the hernia repair, and he was still feeding reasonably well during the admission. She explained that:

…I don't believe there was any indication for me to keep him in just realising that we had a 200 gram weight loss whilst he has that dose, medical interventions and the infection on top of that.
…
…And obviously, he was having upcoming appointments with the paediatrician in a week time and there were arrangements for child health nurse to revisit him for weight checks, growth checks, very sort of soon after being discharged as well, and he was closely linked with a general practitioner, so I was reassured that there are people to further monitor how…how things are going after discharge.[82]

170. Dr Subo was able to advise the court that Daniel's weight had been taken prior to discharge, and that it was 4.7kg. Dr Subo also confirmed that it was her practice to look at the weight trend shown in the growth charts each time she reviewed a patient, and that she did so in Daniel's case.

Conclusions

171. I find that, as at 19 March 2019, Daniel was continuing to fail to thrive. He had had minimal weight gain since his discharge from the MBH nearly three weeks beforehand.

172. Again, there is a disparity between the views of the experts and the clinicians as to whether Daniels' condition required more urgent intervention. Again, however, the disparity may be explained by an overestimation of Daniel's parents' ability to feed him. In addition, there was relevant information and concerns from those visiting Daniel in the community that his treating clinicians did not appear to have access to before making the decision to discharge. Despite there being other reasons that he may have lost weight such as the hernia repair and the salmonella infection, it is still the case that Daniel's weight gain at home was sub-

[81] H2 – Report of Dr Crawford, pp 9 - 10.
[82] Transcript, Day 3, T19L2.

optimal. The adjusted growth charts show that Daniel's weight was still tracking well below the third centile.

173. In these circumstances, I find, on the basis of the expert opinions, that the decision to discharge Daniel on 19 March 2019 was not appropriate given Daniel's ongoing failure to gain weight.

Issue 7 – Was the care and support provided to Daniel and his parents during his admissions to Mackay Hospital and following discharge appropriate?;

In care of parents with Child Safety involvement – 20 March – 29 March 2019

174. On 20 March 2019, a mandatory notification to Child Safety was made by V who had accompanied RN Russell on the home visit on 18 March. This notification included the information that:

> *…V observed during the home visit cigarette butts in a takeaway container next to the dining room table and this raised concerns regarding o2.*[83]

175. V contacted Ms Haratsis who recorded in an ROAI that:

> *V submitted report to child safety and enquiring if a report was put in re: transfer to MBH on Monday. Stated the ED nurse mentioned that father was stepping on oxygen tubing and almost resulted in tubing pulled from babys face (taped). States not documented.*
> *…*
> *V interaction already reported re home visit. Advised V that Family will be discussed at SCAN Tuesday and that I can only present documented notes for discussion – this will be pulled for sharing Monday morning.*[84]

176. On 21 March 2019, Daniel was reviewed at home by RN Russell and was observed to weigh 4520g, which was a drop of 310g from his previous visit. Daniel was lying on the floor on a soiled blanket and towel. The home was dirty. Mr Wright administered vitamin A to Daniel whilst he was on the floor and spoke 'gruffly' to Daniel. RN Russell also noted that the formula was not being correctly made. It was supposed to be 180mL of water per scoop, but they were only using 150mL of water. Mr Wright and Ms Williams had also been giving Daniel custard which caused RN Russell concern. RN Russell noted, and confirmed in her evidence at inquest, that she had "real concerns about his parents' ability to provide appropriate, attentive care to Daniel".[85]

177. RN Russell also said at inquest that, when she attended on 21 March 2019, she was not aware that Daniel had been admitted to MBH on 18 and 19 March 2019, or that his feeding plan had been changed in that time. She emailed RN Richards about her visit. She was not sure, at inquest, why she had not cc'd Dr Gopan on this occasion.

178. RN Richards replied to the email, and cc'd Dr Gopan and Dr Subo:

> *Thank you for the update, Dr Gopan is away at the moment. I have included Dr Subo who is the consultant who saw Daniel on Monday, so she knows what is happening. Yes even with the formula being made incorrectly…it would be more concentrated and*

[83] F3.3 - Records – ICMS, pp 65.
[84] B3.5.10 – Wright Williams Enquiry.
[85] B3.15 – Statement of Janet Russell, paras 40 - 51.

thus have more calories…I'd expect him to be constipated if anything, not losing weight. I wonder if they are really getting in the large volumes they are claiming.[86]

179. RN Russell and NN Breckon contacted Ms Haratsis, who recorded in an ROAI that:

CHN attended home visit – concerns re: parents lack of insight and ability to follow medical needs of the baby. CHN to attend the SCAN Meeting on Tuesday to offer professional insight to the family.
CHN attended with MW Brown due to concerns for her own safety. MW Brown was reported to be quite distressed post home visit.

NN called CPLO advising she was discussing a case with DON and A/NUM Melanie? And Aleisha Johnson MW came in and interrupted angry and upset calling for an immediate MDT and that NN to be involved. NN voiced she does not want to be involved. CPLO discussed with NN that she doesn't case manage this family (apart from 1 review as escort to home visit) and she can make her own decision to not be involved.

CPLO provided education to NN regarding notifying immediate risk of harm to QPS and that MO can take out a treatment order (as can QPS) if warranted to remove the child from the home. CPLO advised that The DON and MW can all call the QPS if they believe this is required and concerns are to be passed through the usual avenues to NQ RIS – as CHN is currently doing. This standard procedure and for any child abuse/neglect case. Reassurance given to NN that a number of people are involved and that Mackay Paed were happy for d/c in care of parents 19/03/2019.
…
CHN advised to submit E-Report to RIS being extremely detailed about observations, interactions and behaviours and her professional opinions regarding the child harm. Any QH Employee can contact CHS to advise concerns or QPS to report immediate risk of harm.[87]

180. Accordingly later that day U made a mandatory notification to Child Safety. She also emailed RN Richards to advise of her concerns and that she had made a notification.

181. CSO Hillery and CSSO Munro conducted a home visit at about 1:00pm that day. Mr Wright was aggressive and greeted them by saying "What the fuck do you want?". He calmed down fairly quickly, and the Child Safety Officers spoke to Daniel's parents about the importance of listening to medical advice, and not looking things up on their phones. They talked about the state of the home, keeping it clean and not having the cats around Daniel. They said they would come back on Monday to check that the home had been cleaned up. In addition:

CSO [Hillery] spoke to Mr Wright and Ms Williams about working with the Department on an Intervention and Parental Agreement (IPA). I explained the IPA to Mr Wright and Ms Williams. [They] said they are willing to do whatever it takes to keep their baby boy at home and will work with the department. Both parents agreed to this and were happy for officers to visit their home.[88]

182. During the inquest, CSO Hillery gave evidence that, when she spoke to Daniel's parents about the IPA, she was aware that Mr Wright had an acquired brain injury, Ms Williams had an intellectual impairment and concerns had been raised about their ability to understand information. She said that she had no concerns

[86] B3.6.8 – GH – 08 to Statement of Dr Gopan.
[87] B3.5.11 – Wright Williams Enquiry.
[88] F2.1 – Statement of Jessica Hillery, para 5fxxii.

when she talked to them, and she thought they were able to understand the concept of an IPA. She said that, before she discussed the IPA with Daniel's parents, she had talked about it with STL Ward, who agreed that it was the most appropriate action for Child Safety to take. CSO Hillery said that STL Ward was the final decision maker.

183. At 2:20pm Ms Haratsis emailed CSO Munro and Ms Atta and forwarded U's notification. In her email she said:

> *There are very real concerns about neglect of this child and the parents ability to provide the most basic of needs.*
>
> *Could you please provide an update on Child Safety's I&A (I understand that we will be discussing it at SCAN).*[89]

184. At 4:00pm that day, Ms Atta forwarded Ms Haratsis' email to CSO Hillery and Ms Ward.

185. Child Safety records show that on 22 March 2019, the notifications of 8, 20 and 21 March were approved as Additional Notified Concerns and given a 5-day response time.

186. On the same day, a QPS representative forwarded additional information from QPS to Ms Scott for circulation at the SCAN meeting. This included background checks on Mr Wright and Ms Williams. Neither had a Criminal History, but there were Domestic Violence (**DV**) occurrences for both. There had been 4 instances in which QPS became involved in altercations between Mr Wright's mother and Mr Wright and Ms Williams. On one of these occasions, Mr Wright's mother told QPS that he had the mental capacity of a 14-year-old. It was noted that there were no current DV orders in respect of either of Daniel's parents.

187. On 22 March 2019, Ms Haratsis sent Ms Roberts an email which was cc'd to RNs Richards and Russell, which said:

> *Daniel Williams is under an Intervention with Parental Agreement.*
> *His Bowen CSO is Casey Soutar [gives email address]*
> *They saw the family yesterday and are planning to check with the family again on Monday.*[90]

188. Ms Roberts gave evidence at inquest that:

> *I did not consider that that was an appropriate intervention. I can remember feeling quite defeated. Following Daniel from – you know, when the concerns were first raised at Mackay Base Hospital and – you know, hearing from staff and – you know, verbal conversations with Kellie about the ongoing concerns, yes, I was concerned that they were considering a IPA.*
> *…*
> *I'm not a child safety officer. I'm not responsible for assessing children and operating – you know, as a statutory body under Child Protection legislation, so I – this would be my opinion. I would have thought that a court order would have been more appropriate.*[91]

[89] F3.3 – Child Safety Records ICMS, p 159.
[90] B.3.14.6 – SR-06 to Statement of Sally Roberts.
[91] Transcript, Day 4, T12L32.

189. When asked whether there was anything she could have done at that point, she said:

> *We did everything we could, in my opinion. We advised all clinicians to report repeatedly. We discussed our concerns with Lucia, the health liaison officer. We were constantly in her ear. I was providing support to Kellie. I'm not aware of any – any way to change Child Safety's decision other than giving them information, staying informed and communicating with them. We had sent the case to SCAN. Kellie had referred the case to SCAN. We provided conf – comprehensive – or Kellie provided comprehensive information in the form of a 159 response as well as the SCAN documentation. Yeah. I don't know what more we can do. We don't have powers to make decisions. All – and we're not encouraged to tell Child Safety what they should be doing.*[92]

190. RN Russell again reviewed Daniel on 25 March 2019 at which time his weight was 4480g, which was a drop of 409g. RN Russell reported that it was difficult to get a clear picture of what was happening with Daniel as by all reports from his parents, he was drinking 180mLs of formula 5 to 6 times a day. RN Russell was aware that Daniel was being reviewed the following day at the Mackay Base Hospital and had warned the parents to expect that Daniel would be admitted. RN Russell emailed RN Richards to this effect.

191. RN Richards forwarded RN Russell's email to Dr Gopan, who replied:

> *I think it's best to admit and review feeding. I think there may be an issue with diluting formula etc. Could you please check with ward regarding bed availability and also with the medical and nursing team.*
> *If there is reluctance to admit in Mackay, maybe admission locally and dietician and allied health input via telehealth. We will need to work with the family.*
> *If admitting will need comprehensive assessment including blood work up- EUC, FBE, vitamin D, iron studies etc. This will give directions on supplements.*[93]

192. RN Russell and NN Breckon contacted Ms Haratsis, who recorded in an ROAI that:

> *CHN reviewed pt this morning – advised weight loss again this week – stated she has emailed Penny Richards and d/w ? admission to MBH. To be discussed with Paed feeding team etc – has a review tomorrow. Janet advised Fa who was in attendance with his mother from Rockhampton to pre-empt admission.*
>
> *Spoke with Shannon Breckon in preparation of SCAN documents – Shannon confirmed that she has no involvement with the family – one occasion of service to weight the child when CHN away and followed up on O2 issues by linking in Airliquide. No ongoing NN .*
> *…*
> *CHN advised to submit E-Report to RIS being extremely detailed about observations, interactions and behaviours and her professional opinions regarding the child harm. Any QH Employee can contact CHS to advise concerns or QPS to report immediate risk of harm.*[94]

193. That day Ms Haratsis forwarded further material for the SCAN meeting to Ms Scott, headed 'Encounters since 13/03/19'. These included concerns raised by staff at Bowen and Mackay on almost a daily basis between 13 March and 25 March 2019.

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[92] Ibid, T13L25.
[93] B1.3 – Medical records, MBH, pp 283 - 284.
[94] B3.5.12 – Wright Williams Enquiry.

194. On 26 March 2019, at around 8:30am Daniel was reviewed at the MBH by Dr Gopan. Dr Gopan noted that the main concern was poor weight gain. He noted that Daniel was now having 200 to 240ml/kg/day "which is huge volumes".[95] Dr Gopan noted that child safety reports had been made, and that his plan was to "await plans from child safety with regards to further plans for Daniel in view of significant concerns raised by multiple health professionals".[96] He recorded that "on examination Daniel appeared clinically well".[97]

195. In his statement, Dr Gopan said that, after spending considerable time with Daniel's parents explaining the feeding plan and how to properly dilute the formula, he "offered an admission for blood tests and to optimize feeding and weight gain, however the family were reluctant, and refused."[98]

196. At inquest, Dr Gopan was asked whether an admission would have been ideal, and he said:

> *And that plan was already made on 25th, that in an ideal, perfect situation that's what I would encourage that baby be admitted. But, again, having said that, if the framework within which I am working is working very closely with intervention with parental agreement, if that is the framework that I'm working with, then there is a bit of flexibility. Of course, if Daniel presented to me with severe malnutrition and is life-threatening, my approach would be completely different.*[99]

197. On 26 March 2019 at 8:59am, RN Alex Berkley of Bowen Hospital contacted Ms Haratsis, who recorded in an ROAI that:

> RN submitted report from ED on 22/03/2019 – in retrospect 18/03/2019.
> CPLO advised I am discussing the family at SCAN this morning and noted that a midwife is noted as secondary contact for RIS regarding family. I enquired re: nature of Maternity's involvement as no record of Aleisha interacting with family or mother was pregnant.
> Alex advised the following:
> Aleisha has attended home visits with the family.
> Aleisha provides diabetes education and often in ED.
> Aleisha is privy to the information regarding what is happening this family.
> Aleisha assisted RN to complete the forms and report.
> Aleisha is directly involved through maternity in providing child health to the family.
>
> CPLO asked if the mother is pregnant or not – advised that the mother is definitely not pregnant and RN advised it is her personal opinion that they should not be allowed to procreate.
> CPLO thanked RN for her information.[100]

198. The SCAN meeting was held on 26 March 2019 at 9:00am. The attendees from Child Safety were Ms Scott, STL Ward, and CSO Hillery, and from Queensland Health were CPLOs Haratsis and RN Richards and Russell. Dr Menezes was unable to attend the meeting, as she usually did so, and Dr Herath Wataliyadda, Advanced Paediatric Registrar, attended in her place.

199. The amended[101] minutes of the meeting record Dr Wataliyadda's contribution as follows:

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[95] B1.3 – Medical records, MBH, p 290.
[96] Ibid.
[97] Ibid.
[98] B3.6 – Statement of Dr Gopan, para 99.
[99] Transcript, Day 5, T80L36.
[100] B3.5.13 – Wright Williams Enquiry.
[101] The amendments to the minutes will be discussed below.

With all this stuff going on, do they really have the capacity to look after this kid? He will have life-long medical issues and we will start to see real picture of his health in a few months. I don't like the way things are going on. They might not be seeing true picture and from what I can gather I don't think they have the capacity to parent this kid.

What about the possibility of removing the child from the parents?

No further information. Agreed to review case at SCAN.[102]

200. In her statement, CSO Hillery said that, during the meeting:

…Several issues were raised and discussed at length and the final outcome of the discussion was for an IPA to be implemented for the family to allow agencies to continue to monitor the situation. There was consensus surrounding the IPA and everyone agreed to have regular meetings and review the case again on 14 May 2019.[103]

201. CSO Hillery clarified at inquest that the consensus that she referred to in her statement was in respect of bringing Daniel's matter back to other SCAN meetings, and not in respect of the IPA. She acknowledged that several attendees had raised concerns during the meeting about Daniel's parent's intellectual ability and capacity to understand. CSO Hillery was asked whether any of the concerns about the capacity of the parents which were raised during the meeting caused her to question whether an IPA was an appropriate intervention, and she said:

No, I don't believe so. We – it was obviously very concerning that we felt that it was reasonable to assume with obviously extensive monitoring and intense services involved that we could – it could be managed under an intervention with parental agreement.[104]

202. Ms Roberts gave evidence of her memory of the meeting:

I have a basic recall and a memory of coming out of that meeting thinking that that was – I was a little bit defeated that – that they sort of weren't – I felt like they weren't hearing us. I felt like the information that we had discussed in the forum was not enough to change their minds, and I do have a recollection that Dr Herath had been quite vocal in expressing her concerns around the safety of the child whilst re – residing in that home.

203. That afternoon, Dr Gopan spoke to the family's GP, Dr Anthony Mallett, and recorded that Dr Mallet "didn't have major clinical concerns other than the slow weight gain".[105]

204. Daniel also had a PFT review that afternoon, which Ms Brittain had arranged as she knew Dr Gopan had a review with Daniel that day. Ms Kibby told the court that, during this review, Daniel was sleeping and she didn't see him feeding. Daniel's parents told her that "he was having five to six bottles a day".[106] Ms Kibby said that, during that review, she and Ms Brittain intended to develop a feeding plan to facilitate weight gain. She said that, if she had had any particular concerns on that day she would have noted them and reported them to Dr Gopan.

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[102] F2.2.15 – CS15 to Statement of Carissa Scott, p 3.
[103] F2.1.1 – Addendum statement of Jessica Hillery, para 13.
[104] Transcript, Day 7, T22L32.
[105] Ibid, p 289.
[106] Transcript, Day 3, T49L25.

205. Ms Brittain gave evidence that she did have concerns about Daniel's weight loss on this day and said that "I believe we were at the point where an inpatient stay could be warranted".[107] She said that she had a vague recollection that planning for another inpatient stay was discussed with the paediatricians that day, but that Daniel was not at the point which would have "require[d] me to take action to make sure that this patient stayed in hospital".[108]

206. On 27 March 2019 CSO Hillery and CSSO Munro visited Daniel's home again, and afterwards CSO Hillery completed a second Safety Assessment which was approved by STL Ward. Daniel was again found to be safe, with the following rationale:

> *Nil immediate harm indicators at this time. Whilst both parents suffer from an intellectual impairment there is no evidence to suggest that this has impacted on their parenting of Daniel at this time. During the investigation the parents accessed medical advice when needed, attended all medical appointments, were able to clean the home in the given timeframe and demonstrated they were able to follow directions/recommendations made by health staff and the department. The parents agreed to an intervention and parental agreement to ensure this is maintained over time.*[109]

207. RN Russell visited Daniel at home on 28 March 2019 where she observed Daniel's weight was documented as 4350g, which represented a loss of 130g from his last weigh. The house was observed to be clean and the bottles sterilised. It was reported that Daniel had already had 840mLs of formula and had lots of wet nappies. RN Russell emailed Dr Gopan. She didn't cc RN Richards as she knew she was on leave at that time. RN Richards said at inquest that she does not recall receiving any reply from Dr Gopan to her email.

208. Dr Gopan was asked at inquest whether the reported further weight loss was not a reason for intervention, and he said:

> *If the weight decline was associated with clinical symptoms of dehydration, baby not being active, baby being lethargic, that would be an absolute indication for admission. But if the baby continues to be active, is moving around, there are no signs of dehydration, that essentially would've been an absolute indication for admission. But having said that in a perfect world, Daniel would ideally be in the hospital. I'm not denying that that is not the ideal plan, but, again, we were working within the framework of the – working with the parental agreement and having all those supports in place of review for Daniel in the community.*

209. Dr Gopan was asked whether he would consider a 10% weight loss within the last 10 days of Daniel's life to be a medical emergency, and he explained that:

> *I wouldn't say it is a medical emergency. We consider that semi-urgent admissions and looking into factors what might be the reason for weight loss…*
> *…*
> *So say I reviewed Daniel on 25th and made an assessment, and within the framework of working with a parental agreement there was a bit of flexibility, but there was a plan to review, I believe, in a week's time and that will be an opportunity to admit Daniel. And also if any of the community staff raised a concern that – well, that is very significant and it is not safe any more to care in the community, then my response to*

[107] Ibid, T76L10.
[108] Ibid, T77L14.
[109] F3.3 - Records – ICMS, pp 53 - 55.

that would be that baby be admitted straight away. And if the baby – if there is a reluctance in admitting, then it will be escalated further.[110]

210. Dr Gopan was asked how the parental agreement affected his clinical care, and explained that:

So the – my understanding is that if the child safety believes that there is capacity of Daniel to be cared at home, there is enough community support to look after him, then, from a physician perspective, that is a framework that I would work with, including some flexibility, unless I believe that Daniel needs urgent care. And that – can I cite an example where I would escalate it further?
…
…If I were to see – I have been in that situation where there was resistance for a baby to be resuscitated and that would result in death of the baby, then that was a time when I would call for – I would escalate it to child safety and will get a care and protection order, because that will result in imminent death of the baby.

211. On Friday 29 March 2019 CSO Hillery finalised the I&A and "determined that the most appropriate intervention for this family at the time was an Intervention with Parental Agreement".[111]

212. CSO Hillery identified one of the 'intense services' as a Relationships Australia family intervention service. She also said that:

Some of the other services we identified that we wanted to be involved with the family was a capacity assessment. Due to long waiting lists that wasn't able to occur in the investigation and assessment period but we had discussed plans for that to happen during the ongoing intervention phase.[112]

213. CSO Hillery explained that the type of capacity assessment she was considering was an assessment to determine whether Daniel's parents were able to care for him. She said that she didn't think they needed an assessment of their capacity to enter into an agreement and understand what that agreement meant, as from her conversations with the parents, she had no doubt in her mind that they understood the IPA.

214. CSO Hillery explained further that, in her current role as an STL, she was aware that she could seek advice as to the legal capacity of parents to enter into an IPA from the Office of the Child and Family Solicitor or the Director of Child Protection Litigation. She said she was not aware of those options at the time and could not recall STL Ward discussing these possibilities with her.

215. That morning, CSO Casey Soutar, who was in the Ongoing Intervention Team, was assigned Daniel's case. Ms Soutar had only been working at Child Safety (excluding a training period) for around 5 weeks. When she received the case she reviewed the electronic records to familiarise herself with the case, and sent an email to CSSO Heidi Wrathall asking her to show her how to complete a referral to the Family Intervention Service at Relationships Australia for Daniel's family. It was anticipated that CSO Soutar would receive a handover from the I&A team the following week.

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[110] Transcript, Day 5 T82L43.
[111] F2.1 – Statement of Jessica Hillery, para 6.
[112] Transcript, Day 7, T27L37.

216. At about 4:30 that afternoon Ms Souter heard Ms Ward take a phone call from the RIS. CSO Joanne Hatch from the RIS advised Ms Ward that she had received a notification from a person who identified herself as T. CSO Hatch made the following record of the notification:

> *The notifier is aware that baby Daniel was born premature with lots of health issues. He is currently at home with his parents but is still on oxygen. Today Daniel was observed in the care of his father, Benjamin (unclear if Zara was present too) they were sitting in the car with all the window up and the bay had several blankets on him, he was visibly sweating.*
> *Benjamin has reported to the notifier that he did not believe the doctors knew what they were talking about. He would be taking the baby off the oxygen 'no matter what the hospital says'. He appeared to believe that he knows more than the doctors and reported that her (sic) had recently (unknown when) taken the baby off the oxygen for a half hour period before putting him back. Nothing happened and this indicates to the father that the baby does not need the oxygen. Notifier additionally reported that the car smelt like 'tom cat piss and shit' and was filthy.*[113]

217. Initially, Ms Ward said that they would follow up with the family on Monday (only she and CSO Soutar were in the office), but CSO Helen Dawe and CSSO Heidi Wrathall returned to the office and it was decided that CSO Soutar and CSSO Wrathall would visit the family that afternoon. They left the office for the home visit at 4:45pm. They agreed that CSSO Wrathall, who was far more experienced than CSO Soutar, would lead the conversation with the family.

218. CSSO Wrathall and CSO Soutar arrived when the family was just coming home. They observed Daniel in his car seat. They then went inside and spoke with Mr Wright and Ms Williams around their dining table. Ms Soutar noted that "the house was clean and tidy however there was a strong smell of cat urine present when you walked through the door".[114] Daniel's parents were surprised to see the Child Safety officers, but said that was because they were told they would meet the new IPA officers the following week. They were polite and willing to discuss the notification, and said that when Daniel was in the car seat he had a light blanket on him and the car aircon was on. Daniel was not sweating. If he had a temperature they always took him to the hospital. In respect of the oxygen they said he was always attached unless they were changing the bottles over. They also discussed Daniel's feeding plan, his weight, tummy time, and the fact that they were seeing the health nurse twice a week.

219. The Child Safety officers both observed Daniel while they were at the home. In her statement to police, given about 2 and a half weeks after Daniel's death, CSO Soutar said:

> *Zara was holding Daniel in her arms whilst she [connected Daniel's oxygen to the tank in the bedroom]. Zara held Daniel chest down on her arm with his head over her elbow. I did notice that Daniel vomited twice while she did this. The vomit was a milky consistency and I saw a bit go on his face and most on the carpet.*[115]
>
> *I remember looking at Daniel and thinking "You look like a sick boy". His eyes looked a bit tired. However I'd never met or seen any of the family before so I didn't have anything previous to compare this to.*[116]

[113] F3.3 – Child Safety records ICMS, p 19.
[114] F2.3 – Statement of Casey Soutar, para 25.
[115] E1.15 – QPS Statement of Casey Soutar, para 23.
[116] Ibid, para 29.

220. CSO Soutar said in her statement to the Coroners Court that:

> *Daniel presented like a sick child, however, I was not expecting a healthy looking baby as I was very well aware he had significant health needs since his premature birth. I was aware Daniel required regular health appointments, had several surgeries, went back to the hospital several times and that community nurses were also coming out to the home frequently.*[117]

221. The Child Safety record of the visit, which was entered by CSSO Wrathall, included the following observations:

> *On entry to the home Zara made her way to the master bedroom with Daniel whilst CSSO Wrathall, CSO Soutar and Ben sat at the dining room table. Zara had just made it to the doorway of the bedroom and Daniel vomited twice. CSSO Wrathall asked Zara if he was ok and Zara stated that he doesn't like the car. Zara asked Ben for a towel which he went and got and gave to Zara.*
> *Ben sat back down at the table, Zara wiped up the vomit and made comment that she would need to change bub as he smelt like vomit. Zara however stood near the dining table holding Daniel. Daniel was awake, however looked tired and was grey in colour.*
> *…*
> *Daniel was dressed in a long sleeve romper and was attached to his oxygen the entire visit. CSSO Wrathall made a note that Daniel was greyish looking in appearance and his hands were cold.* [118]

222. In her police statement CSSO Wrathall said:

> *During our visit I observed that Daniel was dressed in a long sleeve blue romper with some patterns. I also noticed that he was grey in colour that his hands were cold. When I touched Daniel he didn't respond or smile. He looked tired…*[119]

223. In her evidence at inquest, CSO Soutar said that, despite these observations, neither she nor CSSO Wrathall considered it necessary to raise concerns with a superior and/or seek medical help for Daniel. They returned to the office and advised Ms Ward that they "did not assess any immediate harm indicators to be present that would have required further Departmental action".

224. CSO Soutar gave evidence that she was now familiar with the current Child Safety practice guide for high-risk infants. She was asked whether, with this additional knowledge, she would have done anything differently that day, and she said that they did discuss the home visit with Ms Ward when they returned to the office but she "wouldn't have changed what happened that day based on the information we had before us, no".[120]

225. In cross examination, Ms Soutar said that she did not recall observing that Daniel was grey, and that she would have had concern if he had appeared that way. She told the court that she hadn't had any medical or first aid training for her role as CSO.

<u>Expert opinion as to appropriateness of care and support provided to Daniel and his parents during his admissions to MBH and following discharge</u>

[117] F2.3 – Statement of Casey Soutar, para 27.
[118] F3.3 – Child Safety records ICMS, pp 11 – 12.
[119] E1.16 – QPS Statement of Heidi Wrathall, para 33.
[120] Transcript, Day 6, T11L35.

226. The opinions of Assoc. Prof McEniery and Dr Crawford in respect of the care during Daniel's admissions to the MBH have been outlined in the sections above.

227. The comments by the experts below focus on the period following Daniel's second discharge on 19 March 2019.

228. Dr Crawford has advised that she is of the view that:

> *The presentation to [MBH] on 26th March, following referral by GP for admission because of weight loss, should have allowed an additional opportunity to intervene. The weight loss of 490gms from peak of 4900gms on 15th March, i.e., 10 percent of body weight, was known, but the severity was not emphasized. Parents were also reporting suboptimal feed intake of 75mls x 5 – 6 when the expected was 850-900mls/day. While admission was considered, the RCA would indicate that the parent's resistance swayed the treating team. There is no suggestion that a care and treatment order was considered at that time, but there were SCAN discussions on that day.*
>
> *In my experience, in this setting where the concerns are of a predominantly of a medical nature, Child Safety Department will take a lead from the level of concern and advocacy by medical staff re risk of harm and therefore the nature of intervention required. While a Temporary Assessment Order, taken by Child Safety, is a preferred intervention, Queensland Health retains the ability to take a Care and Treatment order to retain a child in hospital, where there a concerns of immediate harm. While I acknowledge hindsight bias, I also believe that a weight loss of 10% which is not clearly explained, and with reported suboptimal intake, and in a setting with known family vulnerabilities, indicates a child at immediate risk of harm and would have justified an order to ensure hospital admission if the parents could not be persuaded to stay.*
>
> *I wonder if there may have been a lack of clarity between Child Safety and the Paediatrician as to who carried responsibility to intervene. Additionally, the fact that the baby reportedly did not look unwell in appearance likely weighed as a positive and overcame concerns about recorded weight.*[121]

229. In her evidence at inquest, Dr Crawford was asked whether, if action had been taken in the last few days of Daniel's life, the outcome may have been different for Daniel, and Dr Crawford said "I think it's possible".[122] She explained that:

> *It think the appropriate action would have been to talk to the family and to indicate that the baby was losing weight, they had been sick and they should have been admitted and observed for a period of time and investigated as to the cause of the weight loss and observed to ensure that the weight trajectory was remedied so that the baby was regaining weight and heading back upward on a weight trajectory.*[123]

230. Dr Crawford gave evidence that, in her view, it was the role of the treating practitioners to be more assertive and to advocate for Daniel where the concerns are predominately of a medical nature, which was the case here where "nutrition…was compromised".[124]

231. Dr Crawford was asked at inquest to give her opinion in respect of some of the answers given by Dr Gopan in his evidence including that, on 26 March, Daniel was not facing any life threatening issues, that a 10% weight loss was not a medical emergency, and that, although it would have been ideal to admit Daniel on the 26th, there was a bit of flexibility as he was working closely with the IPA.

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[121] H2 – Report of Dr Crawford, p 10.
[122] Transcript, Day 7, T5L46.
[123] Ibid, T6L1.
[124] Ibid, T13L41.

Dr Crawford explained that, although she accepted that Daniel may have "looked ok on examination", and there may be differences in their definitions of 'emergency' her view remained that she would have had concerns about Daniel on that day and, given his weight loss, history, and his parents' limitations, "I think the total scenario indicates a need for some intervention".[125] Dr Crawford also said that, in her view, the IPA was irrelevant, and that considering whether Daniel should have been admitted on that day was a medical decision.

232. Dr McEniery has advised, in respect of the 26 March review of Daniel, that:

> *I am concerned that admission did not take place. I acknowledge this may be with hindsight bias. Again, the framing of Daniel's problem was "weight loss", without reference to the centile chart for corrected age, which I believe would have triggered a reframing to "critical and worsening malnutrition" from an undiagnosed cause in a fragile infant. Either of the causes – underfeeding by parents, or bowel pathology (infection, dysmotility, malabsorption) warranted investigation.*
>
> *I am concerned that the decision to admit was turned around by Daniel's mother who was documented as saying it was not a good week for an admission for Daniel as she had a GP appointment later in the week, showing that she could not prioritise Daniel's health needs.[126]*

233. In respect of subsequent home visits, Dr McEniery has advised that:

> *I am concerned that the Child Safety and Nursing visitors were reassured by the parental efforts in cleaning and complying with sterilising the bottles, to the point where the further weight loss was overlooked. I am concerned these were "cosmetic" improvements implement by his parents under the duress of the Child Safety visit, and am also concerned that no material improvement in his care and feeding had occurred. Again there seemed no shared understanding of the importance of the critical weight loss. 10% weight loss over 10 days in an infant is a medical emergency.*
>
> *The unanswered question for me is, was Daniel being fed properly, a little or even at all, in that final week?[127]*

<u>Response by treating clinicians</u>

234. Dr Menezes was asked at inquest whether she would consider a 10% drop in body weight to be a medical emergency in Daniel's situation and said:

> *I would – I would look at the child. It's a medical emergency, yes. I would definitely bring the child – if I see this, I'll bring them to the hospital, keep them for a little observation and see the trend and try to sort out what is causing it.*
> *…*
> *I would look for infections, specially urinary infection, and any other stool or bowel infection, gastro, any – just overall well - well – wellbeing of the child. Even viral infections can also cause weight loss in little children.[128]*

235. Asked the same question, Dr Subo said:

> *So it - it would have been a medical emergency if Daniel exhibited some clinical symptoms and signs of being dehydrated, significant weight loss, whether he was compromised in terms of his hydration levels, or his circulation levels. Again, it depends*

[125] Ibid, T16L6.
[126] H1 - Report of Dr Julie McEniery, pp 10 - 11.
[127] Ibid, p 12.
[128] Transcript, Day 5, T15L31.

on the clinical assessment.

…

[Weight loss] will be a component, but you have to consider multiple factors when you make that decision.[129]

236. Dr Menezes was asked what, in her opinion, was the probable cause of the 10% weight loss, and she replied:

There –because the child is otherwise well, once I've – as you said, once I've excluded there is no infection, child appeared well, it was to be low intake – it has to be only two causes: one is low intake and excessive loss. If excessive loss has been reported as no diarrhoea and – sometimes they pass a lot of urine, but in this child that's not relevant – but, basically, diarrhoea or a lot of vomiting. So if that is ruled out then we are left with he's not having that intake, would be what I consider, and along with infection being ruled out.[130]

RCA Report

237. Following Daniel's death, the MHHS conducted a Root Cause Analysis (**RCA**) of the circumstances of the death. The Report of the RCA was provided to the Coroner in October 2019. The RCA report authors noted that:

Numerous clinicians expressed frustration with the perceived subdued response from [the Department] as the primary decision makers for cases of child neglect. The MBH Child Advocacy Service (CAS) team described health services as focusing on the risk factors presented to this infant, with multiple ongoing risks identified despite the intense level of support for the family. This seemed to contrast to the [Department's] response which placed greater consideration on protective factors. The level of support in place from [MHHS], IFS services and other community agencies was viewed by [the Department] as protective, with [the Department] advising that the infant had not been hurt and the family were willing to engage with support services. The Child Safety Hospital Liaison Officer was a key stakeholder, ensuring timely information-sharing with the [Department] and participated in several formal/informal meetings with the CAS team and MBH clinicians. [131]

238. In respect of SCAN involvement, the RCA Report notes that:

A [SCAN] meeting was also held at [the Department] on [26 March] and plans were put in place for Child Safety home visits 2 to 3 times weekly to monitor hygiene and interactions with the baby, and 6 weekly SCAN meetings were scheduled.[132]

239. The authors of the RCA found that, although they did not consider it a direct contributing factor to Daniel's death:

Ideal infant care did not occur as a result of the failure of pathways and/or processes for the escalation of ongoing significant child safety concerns from clinicians to continue to escalate continuing concerns when the prescribed usual processes were failing.[133]

240. In response to the RCA report, Dr McEniery made the following comments:

I agree that by the time of the final week of life, an enforced admission of Daniel to hospital for urgent care, likely tube feeding, would have been appropriate. The RCA did

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[129] Transcript, Day 3, T27L30.
[130] Transcript, Day 5, T34L34.
[131] B2.2 – RCA Report, pp 6 – 7.
[132] Ibid, p 3.
[133] Ibid, p 3.

not identify what the factors were that inhibited staff from taking this action, as the legislation and processes are well defined.

I could not find in the documentation, what it was that the health professionals wanted the Child Safety team to do. There was no documentation of any decision making process around the pros and cons of securing a "Care and Treatment" order when his parents declined admission. In addition, to immediately enact this does not require interaction with the Department of Child Safety, as a Senior designated person within the hospital is authorised to issue this order.

My alternative view is that perhaps staff did not consider this step as they were not of the view that Daniel's ongoing weight loss was life threatening.[134]

241. Overall, Dr McEniery's concern was that:

…the decisions made by the Health Professionals and the Child Safety staff looking after Daniel, leaned towards an overly optimistic view of his parent's capacity, giving his parents many chances and the benefit of the doubt repeatedly, to the detriment of a primacy of duty of care to Daniel, who had no other advocate to represent his best interest.[135]

242. As a result of their review, the authors of the RCA Report made the following recommendations:

I. An Escalation Matrix is developed by MHHS CAS to escalate child protection concerns to [the Department] where ongoing significant concerns have not been adequately addressed through usual escalation processes when a Care and Treatment Order is not appropriate;

II. Information on Care and Treatment orders should be added to the Mandatory Child Protection Education Module learning objectives on [MHHS]'s Mylearn system to increase staff awareness regarding Queensland Health's policy position [as to when] a Care and Treatment Order for a Child can be invoked…;

III. The designated medical officer (Child Protection Advisor) for the [HHS] is a clearly identified, subspecialist position which is backfilled during periods of leave…Escalation of child protection concerns by clinicians to the designated medical officer provides a determination whether a child protection matter reaches the threshold to invoke a Care and Treatment Order;

IV. Consideration should be given to the development of an additional Child Protection Advisor role to act as Deputy to the current child protection lead;

V. A Briefing Note should be presented to the Statewide Child Protection Clinical Partnership for the development of state-wide processes for a top-down approach to managing significant child safety concerns where usual pathways/processes are exhausted and ongoing child safety conditions exist.[136]

243. Recommendations I, II and V and were implemented by 28 February 2020.

Conclusions

244. There is a great deal of evidence before the court which shows that the staff at the MBH made enormous efforts to provide Daniel and his family with every

[134] H1 - Report of Dr Julie McEniery, p 18.
[135] H1 - Report of Dr Julie McEniery, p 13.
[136] Ibid, pp 9 - 11.

possible support during his admissions to MBH and following his discharge to the care of his parents on 28 February and 19 March 2019.

245. Overall, the view of the experts is that appropriate medical care was provided to Daniel by MBH, with the exception that his failure to thrive and the dramatic weight loss towards the end of his life was not properly identified or addressed by the Staff Specialist Paediatricians involved in his care.

246. In his evidence Dr Gopan admitted that, in a perfect world, Daniel would have been in hospital to support his weight gain. However, Dr Gopan was of the view that, once Child Safety decided that the appropriate intervention for Daniel's family was an IPA, then Dr Gopan had to "work within that framework" unless Daniel's condition was so dire that his death was imminent. Dr Gopan did not consider Daniel's ongoing failure to thrive and his significant weight loss by 26 March 2019 to have been a medical emergency warranting admission, as Daniel appeared otherwise to be clinically well. Dr Subo expressed essentially the same view in respect of whether Daniel's weight loss was a medical emergency.

247. The view of both experts, in contrast, was that the bigger picture should have been considered and that, in Daniel's case, his continuing downward trajectory was so serious that he required urgent care. Dr Menezes' evidence was in agreement with this view: she explained that she would have brought Daniel in for observations and investigations as to the cause of the ongoing failure to gain weight and the recent significant weight loss.

248. The discussion above considers only the clincial reasons for which Daniel should have been admitted. In addition to his clinical condition, the treating team at the MBH was acutely aware of the issues with Daniel's parents and, particularly, with their ongoing challenges with his feeding.

249. I note the submissions made by MHHS and THHS in respect of Dr Gopan's evidence at inquest which included:

- the identification of a number of factors, such as Dr Wataliyadda's comments during the SCAN meeting, and the number and frequency of concerns which had been raised about Daniel by different staff, which would have affected his decision not to admit Daniel had he been aware of them;
- Dr Gopan's knowledge of changes to ieMR which now allow him to access Child Safety Reports;
- Dr Gopan's own changes in practice since Daniel's death:
    - to institute direct contact between himself and Child Safety to discuss the care and the Child Safety framework the child is under; and
    - to escalate to the Clinical Director where he remains worried about a child.[137]

250. This evidence not only shows Dr Gopan's commendable efforts to develop his own practice to better care for his patients who are involved with Child Safety,

[137] Submissions on behalf of MHHS and THHS, paras 44 - 48.

but also confirms that a knowledge and understanding of what Child Safety is doing and what concerns have been raised about the child is relevant to his medical care of that child.

251. I find that Daniel should have been admitted on 26 March 2019. If his parent's consent could not be obtained for his admission, a Care and Treatment Order should have been sought by Daniel's treating team. I also find that the home support provided to Daniel by MHHS was extensive but was inadequate in the context of Daniel's continuing failure to thrive and his parents' continuing inability to care for him.

Issue 8 – Were the actions of Child Safety appropriate?

SPR Report

252. Following Daniel's death, Child Safety conducted a Systems and Practice Review (**SPR**) of its service delivery in relation to Daniel. The report of that review was discussed at a meeting of the SPR Committee on 26 August 2019. The SPR Report records that:

> *On 1 March 2019, CSO2 completed the intake as a Notification with a 10 day response priority timeframe assigned and [a Senior Team Leader] approved the Notification on the same day.*[138]

253. The authors of the SPR Report initially questioned the decision to assign a 10-day response priority timeframe, rather than a shorter response time. However, after discussion with the relevant staff of the RIS, they accepted that the mandatory notifiers had given "somewhat conflicting" information as to whether the parents would be able to meet Daniel's needs with the support to be provided to them at home by the multidisciplinary team, and whether Daniel would, in fact, be at immediate risk of harm upon discharge. There were also some difficulties experienced with staff going on leave and new staff commencing work. Ultimately, the authors advised that:

> *The Review Team were of the view that it was reasonable to assign a 10 day response priority timeframe to the Notification due to the supports that were in place at the time Daniel went home which meant daily home visits were occurring to the family and the family friend had told staff of [MBH] that they would report any concerns they had to [MBH].*
>
> *The Review Team also acknowledged the complexities in decision making due to what seemed to be a delay in contacting the department. The Review Team noted that staff of all four hospitals, who worked with the family, could not agree if the concerns they held reached the threshold for tertiary involvement. Further it was found during review discussions that miscommunication amongst Queensland Health staff led to a delay in contacting the department in that staff, who were of the view that the concerns met the tertiary level threshold, thought that the department had already been contacted while Mother was pregnant.*
>
> *The Review Team were of the view that this would have impacted on departmental staff members' decision making as it would seem that the concerns for Daniel were not immediate and could be responded to after Daniel went home rather than immediately at the time of notification to the department.*[139]

[138] F1.1 – SPR Report, p 14.
[139] Ibid, p 16.

254. In respect of the Safety Assessments, the SPR Report notes that:

> *During review discussions with staff of CSSC1 the Review Team asked about the Safety Assessment completed on 5 March 2019 and if consideration had been given to marking Immediate Harm Indicator (IHI) number eight which reads,* Parent's mental health concern, emotional instability or intellectual or physical disability results in behaviours that create imminent danger to the child. Parent expects the child to perform or act in a way that is impossible or improbable for the child's age or developmental stage (e.g. babies and young children expected not to cry; expected to be still for extended periods, be toilet trained, eat neatly, care for younger siblings or stay home unsupervised). Due to an intellectual disability, the parent demonstrates a lack of basic parenting skills.
>
> *Staff of CSSC1 said that at the time the Safety Assessment was completed they did not believe that either Mother or Father's impairments impacted on their ability to provide care to Daniel. Staff said that Mother and Father needed ongoing support to meet Daniel's care and protection needs, but could meet Daniel's needs with support. Some staff of Hospital held this view as well and said that Mother and Father were able to talk through what they would do in an emergency which was usually to take Daniel to hospital, the reasons Daniel needed to be on oxygen and attend his medical appointments, how to maintain a routine for Daniel and how to meet Daniel's basic needs. Staff of all of the hospitals who interacted with the family said that Mother and Father took Daniel to all of his medical appointments and were on time for all of them and engaging throughout all appointments. Mother and Father could also tell all staff members when all of Daniel's appointments were.*
>
> *Staff of CSSC1 said that they had concerns for the hygiene of the home and Father seeking medical advice from Siri, however Mother and Father both acknowledged the home needed to be cleaned and gave an undertaking to clean it. Staff of CSSC1 and Hospital3 said that after the initial home visit CSSC1 staff conducted, the home was always clean and the hygiene of the home did not present as a concern again. Father also engaged in conversation regarding the use of Siri for medical advice and said he would do whatever he needed to do to ensure Daniel's needs were met.*[140]

255. The SPR Report made the following findings with respect to the I&A and the decision to open an IPA:

> *The Review Team were of the view that the assessment and decision making during the I&A was sound. Staff of [Child Safety] gathered sufficient information of Mother and Father's ability to meet Daniel's care and protection needs. The Review Team agreed with the decision to finalise the I&A as Substantiated for risk of neglect, and that it was reasonable to assess that Mother and Father could meet Daniel's needs with the support provided to them from Queensland Health and Child Safety. The Review Team also agreed with the decision to open an IPA and that an IPA was appropriate to assist Mother and Father in developing their parenting skills and knowledge, oversee their engagement with Queensland Health and to continue to assess Daniel's safety and wellbeing while in his parents' care.*
>
> *The Review Team acknowledged the difficulty of long waiting periods for assessments and agreed it was reasonable to close the I&A with the view of requesting the parents to participate in capacity assessments during the period of the IPA. The Review Team were of the view that the capacity assessments would have assisted in departmental officers' ongoing assessments of Mother and Father's ability to continue to meet Daniel's needs into the future. The assessments would have also assisted staff to refer Mother and Father to appropriate services that could support them as needed. If Daniel had lived it may have been assessed that Mother and Father could not continue to meet his needs, however during the period of the I&A there was enough evidence to support*

[140] F1.1 – SPR Report, p 27.

the assessment that Mother and Father could meet Daniel's needs at that time. The IPA would have provided the opportunity for ongoing assessments to be made about whether Daniel could remain safely in Mother and Father's care.[141]

256. Finally, in respect of the home visit on 29 March 2019 by the CSO and CCSO, and Daniel's condition on that day, the Review Team said that:

…it was appropriate to assess the concerns via the IPA rather than to record a Notification. The concerns were addressed thoroughly and other than Daniel presenting as grey in colour there was nothing to indicate that he should have been seen by medical staff immediately. Daniel had a scheduled medical appointment on 2 April 2019 and therefore would have been seen by medical staff four days after this home visit. It was reasonable for CSSC1 staff to believe that if Daniel was significantly unwell Mother and Father would have taken him to Hospital3 immediately given their prior actions in doing so or that this would have been found during his medical appointment on 2 April 2019.[142]

Child Death Case Review Panel Report

257. Daniel's death was also reviewed by the Child Death Case Review Panel, which is established under the *Child Protection Act 1999* to review child death and serious physical injury in order to promote ongoing learning, development and accountability of the Department. The Panel made the following conclusions in respect of Daniel's case:

- *Considering Daniel's extensive and multiple medical issues, and all of the objective evidence available, the Panel was of the view that Daniel's safety and wellbeing were highly likely to be significantly compromised in the care of Mother and Father.*
- *The Panel agreed that capacity assessments [which were not undertaken due to long waiting lists of local clinical psychiatrists] may have identified significant issues, including whether Mother could sufficiently assert her authority to ensure Father followed medical advice and whether either parent was displaying safe parenting practices and had the capacity to meet Daniel's daily care needs.*
- *The Panel was of the view that the relevant departmental staff did not have an adequate understanding of domestic and family violence perpetrator behaviours.*
- *The Panel was of the view the delay, [from birth to 23 February 2019, by Queensland Health Staff] in reporting the concerns [about the parents' challenges and Daniel's vulnerability] resulted in a missed opportunity for the department to engage with Mother and Father prior to Daniel's discharge. The Panel was of the opinion early and constructive engagement with the parents would have given the department the opportunity to develop a comprehensive understanding of the challenges confronting the family.*
- *The Panel was of the opinion this case highlighted the need for comprehensive interagency consultation and enhanced information gathering with a number of stakeholders, particularly Queensland Health.*
- *The Panel discussed that there was an overreliance by CSSC1 on unsupported, subjective information regarding both parents' capacities. This and the delay receiving information from Queensland Health very likely impacted on the ability of the department to undertake sufficient contingency planning should there be the need to secure a family-based or an out-of-home care arrangement for Daniel.*
- *The Panel noted that the Family Risk Evaluation (FRE) completed on 29 March 2019 was completed on the basis of Mother being identified as the 'primary parent'. The Panel noted that this resulted in a risk score for neglect that was low and an overall moderate risk level. The Panel considered that the outcome of the*

[141] Ibid, pp 29 - 30.
[142] F1.1 – SPR Report, p 32.

FRE tool was incorrectly finalised by the department as 'moderate risk' and was of the view this was in part due to the lack of identification of the Father's significant presence in the household and strong views about parenting. The Panel was of the view that the circumstances and constellation of features, including the complex relationship dynamic between the parents and two parents with significant issues, should have resulted in a final risk evaluation of 'high risk'.

- *The Panel acknowledged the department wanted to partner with the family through an IPA and, while accepting that it had the benefit of hindsight, nevertheless the Panel was of the view that the decision not to take a more intrusive approach reflected a flawed risk assessment.*
- *Some Panel members were of the view that all of the objective evidence suggested Daniel was at imminent risk and the department should have sought a more intrusive order to secure Daniel's immediate safety. Overall, the Panel considered that the department failed to appreciate how a vulnerable child with complex medical needs required consistent, high level care. The Panel considered that the department appeared to give priority to what it perceived to be Mother's and Father's needs over the needs of Daniel. For the Panel, decision-making during departmental intervention with the family was not child-focused and lacked consideration of Daniel's needs and his best interests.*[143]

258. I note that the Panel did not specifically consider or comment on the home visit by Child Safety Officers on 29 March 2019.

259. The Panel made two recommendations to the Department following their review:

    a. *It is recommended the department investigate and strengthen current methods of information sharing across agencies to establish a more efficient and effective pathway for information gathering and sharing; and*

    b. *That the department provides a de-identified copy of the report to Queensland Health to assist with information sharing between the department and treating medical professionals to ensure that all relevant information about a child's medical needs, prognosis, family vulnerabilities and any discharge considerations are shared in a thorough and timely manner.*

<u>Evidence of Chief Practitioner of the Department</u>

260. Dr Meegan Crawford is the Chief Practitioner of the Department, which is a senior executive role with responsibility for practice quality, staff capability and child operational policy and procedure. Because one of the medical experts in this matter is also a Dr Crawford, to avoid confusion I will refer to Dr Meegan Crawford as the Chief Practitioner.

261. Having reviewed documents relevant to Daniel's case, the Chief Practitioner provided a statement to the Coroner and gave evidence at the inquest. In her statement, the Chief Practitioner gave her views of the Department and Queensland Health's handling of Daniel's case

262. In respect of Queensland Health's involvement, the Chief Practitioner made the following comments:

    As noted by the [Panel] there were missed opportunities by Queensland Health staff to notify the department in a timely manner when issues or concerns regarding the safety of Daniel were initially identified by medical and health practitioners…
    …

[143] F1.2 – CDCRP Report, pp 11 – 18.

It is my opinion that there was also a missed opportunity to refer this matter to a SCAN team meeting prior to Daniel's discharge from hospital on 28 February 2019. In this matter it would have been appropriate for a health practitioner to report the concerns and then make the SCAN referral when it was known the matter had screened as a notification. Given that Daniel had been in hospital from the 20 July 2018 to February 2019, the non-referral to SCAN to coordinate information and professional observations and opinions regarding parental capacity and Daniel's significant medical needs, impacted the ability to undertake a rigorous assessment and to determine any necessary Child Protection Order court application…

…

Departmental officers, requested through Queensland Health's reporting of concerns, to determine imminent and future risk, were highly reliant on observations and assessments of the parents by other health professionals across July 2018 to February 2019 timeframe.

…

I note that the department was not notified and departmental staff were not included in [MDT] meetings.

Complicating the department's initial assessment of Daniel's safety, staff of Townsville Hospital and Mackay Hospital had differing views about Mother and Father's ability to meet Daniel's care and protection needs.

…

It would appear that there was a significant focus to the parent's willingness and efforts made to ensure that as parents with an intellectual impairment and an acquired brain injury they were provide with every possible professional support to care safety for their baby…

…

While the [MDT] membership and plan was thorough and seemingly cognisant of Daniel's high vulnerability, it is not clear what consideration was given to the parent's ability to engage and manage information from such a comprehensive network.

263. In her evidence at inquest the Chief Practitioner gave evidence that, in her view, the significance of the late referral to Child Safety was that there was a missed opportunity for Child Safety to conduct a formal parental capacity assessment while Daniel was still safe in hospital.

264. In respect of the Department's involvement, the Chief Practitioner conceded that:

In my opinion the [Panel] report offers a robust analysis of the service offered to the family and I concur with the points raised regarding interaction with Queensland Health, [I&A] and [IPA]. I note the analysis regarding the Structured Decision Making (SDM) [FRE] form, and advise that this tool is no longer used by the department. This SDM tool was retired on 8 August 2022, and departmental staff are now assisted to determine levels of probable future harm with the Practice Guide: Assess harm and risk of harm*.*

…

While I have the benefit of hindsight, and the knowledge that Daniel passed while in the care of his parents, I do believe that information and observation gathered throughout March 2019 and the department's assessment process did suggest that an [IPA] did not offer sufficient protection for Daniel and a more suitable intervention would have been via a Child Protection Order.

265. In her evidence at inquest the Chief Practitioner said that her view was that a Child Protection Order was indicated by the information obtained by Child Safety on both 18 and 21 March 2019. She understood that the Child Safety Officers making the decision that an IPA was appropriate considered that Daniel's parents were willing to care for him and to engage with Child Safety, but said that they needed to focus more on the parents' ability and capacity to do so in order to make their decision appropriately.

266. In cross-examination, the Chief Practitioner said that she respected the CSO's optimism and determination to work with the parents, and to continue to do so despite the obvious risk factors posed by the parents' intellectual challenges and, particularly, the father's aggressive behaviour. She said, however, that those risk factors were not given sufficient weight by the CSO in assessing Daniels' safety.

267. In respect of the retirement of the SDM tool and the new framework to assess harm, the Chief Practitioner explained that there is now "a greater ability to take the unique circumstances of each family into consideration".[144]

268. In respect of the Child Safety home visit on 29 March 2019 and the evidence of CSO Soutar and CSSO Wrathall that Daniel appeared cold, grey, tired and was not responsive, the Chief Practitioner admitted that that evidence 'gave her pause'. She explained that Child Safety staff receive training in dealing with high-risk infants, and that training was in place in 2019. She explained that, in accordance with that training, CSOs are expected to be familiar with child development and milestones, including what might reasonably be expected in premature infants with corrected age. The Chief Practitioner said that CSOs were expected to know "when the expertise of a health professional is required".[145] She agreed with the suggestion by Kings Counsel for the Health Services that, with a complex, high-needs baby like Daniel, a CSO would have erred on the side of caution, saying "Yes, that's right. Because I know how quickly things can change and things can deteriorate for such a young baby."[146]

269. In addition to commenting on these particular parts of the evidence, the Chief Practitioner set out in her statement a number of relevant practice and program changes made by the Department since Daniel's death (and provided relevant documentation). These include, but are not limited to:

- Employing specialist services clinicians in the areas of domestic and family violence, mental health, disability, child sexual abuse and Aboriginal and Torres Straight Islander cultural practices, as well as a national Disability Insurance Scheme interface Team, from 2019;
- Strengthening information sharing between QPS and Child Safety by way of the Self-Service Document Retrieval portal launched in December 2019;
- Publishing a Child Safety disability practice kit in 2020 to increase understanding of how to support and risk assess children and parents with disabilities
- Implementing a Statewide 'Discharge escalation pathway for a child at risk' in co-operation with Queensland Health in July 2021;
- Creating a new team, in 2022, to provide Child Safety Training and support to CSOs in the first year of their service;
- Updating the Department's Practice Guide for Infants at High Risk in September 2022;
- Providing advice and support to Queensland Health to create an online Child Protection Education Module in line with the Queensland Health Child Protection Capability Framework in January 2023;
- Adding mandatory Disability Awareness training to the Department's eLearning module and mandatory face-to-face training on domestic and family violence informed practice in 2023;

[144] F1.2 – CDCRP Report, T123L47.
[145] F1.2 – CDCRP Report, T132L9.
[146] Ibid, T132L17.

- Making upgrades and changes to the CSO-HL role, in March 2023, to strengthen the ability of the role to provide education, information and advice, negotiate and make recommendations and to build relationships between Queensland Health Staff and Child Safety Staff; and
- Building a new client information management system to be rolled out in late July 2024 to support improved information sharing and collaboration between government agencies, social services and the justice system.

270. The Chief Practitioner also advised in her statement that both of the recommendations made by the Panel (see paragraph 260 above) had been accepted by the Department.

Conclusions

271. On the basis of the evidence outlined above, and particularly, the very detailed and frank evidence provided by the Chief Practitioner, I make the following findings in respect of Child Safety's actions in relation to Daniel:

    a. The notifications to Child Safety were properly assessed and Daniel was determined to be a child in need of protection. However, the risk assessments were flawed and did not adequately consider the risk of future harm to Daniel;

    b. Steps should have been taken by Child Safety to conduct a formal parental capacity assessment of Daniel's parents;

    c. The information available to Child Safety by 18 March 2019, and by 21 March 2019 at the latest, indicated that a Child Protection Order was necessary to prevent harm to Daniel;

    d. The decision by Child Safety to enter into an IPA was not appropriate and did not provide sufficient protection to Daniel in the circumstances; and

    e. On 29 March 2019, the Child Safety officers at the home visit should have called an ambulance or encouraged Daniel's parents to seek medical attention for him.

272. In respect of the last finding above, I accept the submission made on behalf of Child Safety that because of the difference between CSSO Wrathall and CSO Soutar's recollections of Daniel's appearance on that day, that "there must be at least some residual doubt as to the observable symptoms being experienced by Daniel during the home visit on 29 March 2019".[147] However, given the evidence of the Chief Practitioner set out at paragraph 264 above, I find that it would have been appropriate for the Child Safety Officers to have erred on the side of caution in Daniel's circumstances on that day.

273. I also accept the submission made on behalf of Child Safety, referring to the evidence of the Chief Practitioner in respect of the optimism and determination of the Child Safety Officers to work with Daniel's parents, that:

[147] Submissions on behalf of the Department of Child Safety, Seniors and Disability Services, para 2(b).

This was a difficult case for these officers to manage and the human experience of the Department's employees is something of substance and should not be forgotten.[148]

Issue 9 – How effective was the information-sharing between MHHS and Child Safety?

274. Over the course of the inquest it became clear that there was a significant disconnect between Queensland Health staff and Child Safety staff as to when a notification should be made, how serious and frequent the concerns of the health staff were, and the ways in which concerns could be escalated if it was felt they were not being addressed sufficiently.

275. It was also clear that there were areas in which the information sharing between MHHS and Child Safety could have been more effective.

Timing of first notification to Child Safety

276. In respect of the Child Safety Notification and the concerns about Daniel's parents' ability to care for him, Dr McEniery said that:

> *The timing of the Child Safety referral was noted by the Root Cause Analysis and by the Child Safety [Review]. The Child Safety Review was critical of the timing, suggesting it was too late to afford adequate opportunity to assess Daniel's parents. The Root Cause analysis suggested that there was some confusion initially about whether an earlier notification had been made by Townsville, but did note that as early as day 6 of the Mackay admission, referral for community based parental support had been made and escalated appropriately as concerns grew. With the benefit of hindsight, it is possible that earlier formal engagement between Mackay Base Hospital health professionals and the Child Safety Service might had led to a clearer shared understanding of the lack of parenting capacity. A different decision might had been reached for Daniel's care (such as a Care and Treatment order).*

277. Ms Thompson and several of the witnesses employed by Queensland Health gave evidence that they did not think that Child Safety would have acted, or acted in a timely way, on a notification made while Daniel was still in hospital, because he would not have been considered at imminent risk of harm. I note the submissions made on behalf of MHHS and THHS that this "collective opinion seems…likely to have been borne from experience, given past interactions with Child Safety".[149]

278. The Chief Practitioner confirmed during her evidence that Child Safety does consider notifications made while children are in hospital, and explained that Child Safety can start an assessment before the child is born. In cross-examination, the Chief Practitioner advised that it was disappointing that the view expressed by Ms Thompson appeared to be shared by other health staff, and agreed that better education by Child Safety about making notifications and the timeliness of those notifications was necessary.

Record of an Inquiry

279. These documents, made by CPLO Haratsis, were provided to the Court at a late stage. Ms Haratsis said in her evidence that they were informal documents which she would use to record conversations or queries that came into the CPU. She

[148] Ibid, para 3.
[149] Submissions on behalf of MHHS and THHS, para 56.

kept them on the server (G: Drive) in a folder accessible to her and to the Mackay CPU. These documents were not available to the treating clinicians, with the exception of Dr Menezes, as she was part of the CPU.

280. Ms Roberts was asked about the ROAIs and gave evidence that she no longer uses them as they were too time consuming. She explained that:

> *So they were – they could be used as a – a record of an – an advice that you had provided, or a consultation that you had provided, to a staff member that may have concerns and was seeking out information from you, so you could document the instance and the information that you gave and any follow-up actions or outcomes. I will either put that in a diary or I will put that into the medical records. I'll make a decision. I can get 30 calls a day. Sometimes I might get five to 30 calls a day, and I'm just absolutely strapped for time. I don't get time to comprehensively document those conversations down. Often it'll be dot points in my diary with follow-up.*[150]

281. The information in the ROAIs kept by Ms Haratsis, however, was more comprehensive than dot points intended for follow-up. It contained information about concerns raised by health staff about Daniel, as well as information about advice given by Ms Haratsis in respect of whether notifications should be made.

282. It was reasonable for Ms Haratsis to have assumed that the health staff would be documenting their concerns in the medical records. However, Ms Haratsis (unlike Ms Roberts) could not herself put any of the information given to her into ieMR, as she did not have any access to do so. Instead, Ms Haratsis sent various emails to health staff and Child Safety staff to convey various information, and obtained information from the medical records to inform the I&A.

283. Notwithstanding these efforts by Ms Haratsis, the evidence was that Daniel's treating practitioners were not aware of some of the concerns noted in the ROAIs, and the frequency of those concerns was not appreciated by Daniel's paediatricians or by Child Safety staff. This is not intended to be a criticism of Ms Haratisis. However it became apparent during the inquest that the information Ms Haratsis kept in the ROAIs was important and useful, but that the systems in place at the time did not allow for that information to be seen by Daniel's treating clinicians.

284. In her evidence, Dr Menezes agreed that the fact that concerns were being raised by health staff with the CPLO every few days was significant, and "should have been brought to the attention of the treating paediatrician".[151] Dr Gopan advised that, having read the ROAIs, he was "very concerned about the things mentioned in the document".[152] He explained that:

> *Well, the overarching theme was that some of the things was directly affecting medical care. There was more objectivity in those reports. In the escalations that I had from the community they were all about weight loss and weight gain and also looking at how the baby looked overall, but I never got a full grasp on how significant they were in none of the email communications or ieMR entry. There was a sense that baby's medical care is directly contributed, for example, the oxygen tubing being stepped on which hampers oxygen being delivered to the baby which can result in life-threatening emergency,*

[150] Transcript, Day 4, T8L8.
[151] Transcript, Day 5, T23L23.
[152] Ibid, T89L26.

given that where Daniel is dependent on the low flow oxygen, so that degree of objective evidence was not available to me.[153]

285. Dr Gopan also confirmed that the frequency of the enquiries was concerning to him. He gave evidence that, if he had known of the number and content of the enquiries prior to 26 March 2019, he would have advocated for a care and treatment order.

286. Dr Gopan advised during cross-examination that clinicians did not, at the time, have access to the detail of the Child Safety notifications, or the matters discussed at the SCAN meetings. He said that the procedure now is that Child Safety notifications are uploaded into ieMR once they are made so "there is visibility to everyone about the concerns". Dr Gopan also explained that his practice now is to have direct contact with the Child Safety CSO who is dealing with a patient and their family, so that he is directly aware of the particular interventions by Child Safety, rather than going through the hospital CPLO.

287. Following the inquest, MHHS was asked to provide information as to what steps, if any, had been taken to ensure that information such as that contained in the ROAIs was communicated to treating clinicians at MBH and Bowen Hospital. MHHS provided the following response (and relevant documentation):

MHHS' "Clinical Documentation Procedure" [V3.0]…which was in effect at the time of Daniel's admission to MBH, provides at [3.2] that "An accurate clinical record is required to maintain/facilitate…Information required by a clinician for review and consultation…[and] A record of all transactions relating to the provision of clinical care." The subsequent version of that policy [V4.0]…states the position even more explicitly at [3.1]: "Keeping separate clinical documentation for an individual patient should be avoided. Health professionals should have access to all clinical documentation in the patient's clinical records for the care of the patient." There are some limited exceptions to this rule – for example information in respect of sexual assault, and SCAN information... Pursuant to the Clinical Documentation Procedure, any clinical information contained in the Records of Enquiry should have been stored in Daniel's clinical record rather than separately on the "G drive".

We also note that MHHS' Information Access Unit has a robust system in place in respect of the assessment and release of information to third parties, such that any confidential child protection information (including information inputted into the ieMR by the Child Protection team) is only released to appropriate parties.

Also…the statewide "Documentation and storage of child protection information" guideline (QH-GDL-979)…recently came into effect on 29 February 2024. The purpose of that guideline is to "outline best practice principles for Hospital and Health Service (HHSs) regarding the documentation and storage of child protection information, and to promote consistency of practice across the State as HHSs increasingly share access to electronic medical records." Amongst other things, this guideline clearly details recommendations for storage of child protection documentation on patients' health records…Relevantly, the guideline recommends that "CPU Child Protection Records of Enquiry" ought to be stored in the "Child Protection" folder on ieMR as a free text note (or as a progress note in the case of paper health records).

We are instructed that statewide messaging was sent to staff responsible for documenting and storing child protection information to familiarise themselves with this guideline, to highlight the importance of these guidelines for those staff. The guideline has also been added to MHHS' QHEPS policy and procedure webpage.

[153] Ibid, T89L30.

288. A related issue which arose in respect of Ms Haratsis' access to ieMR was that in 2019 Bowen and Proserpine Hospitals were still using paper-based records rather than ieMR. This meant Ms Haratsis, who was based at Proserpine, was required to travel to Bowen to view the records in order to provide information to Child Safety in response to s159N requests.

289. MHHS was also asked to advise of any changes in respect of this issue, and advised that:

> *We have been provided the following information by Dr Pieter Nel, Chief Medical Information Officer of MHHS, regarding the implementation of ieMR at MHHS facilities:*
>
> - *Bowen and Proserpine Hospital were not on ieMR in 2019, although a few doctors had "read only" access to the ieMR.*
> - *In 2020/2021 all rural clinicians were given access to the ieMR through the "read only" option.*
> - *Bowen is currently paper only however will move to a fully integrated electronic record on or about 17 June 2024.*
> - *All rural facilities across MHHS will be fully ieMR (read/write/orders) by the end of 2024. Each facility's ieMR module will be tailored to address the service level agreement for that rural facility.*
>
> *…*
> *The rollout of ieMR across all MHHS facilities throughout 2024…will significantly assist with the facilitation of documentation production in response to section 159N requests for information, as all clinicians will have immediate access to the clinical record without needing to physically review a paper record. For completeness, we note that the section 159N request for information issued to MHHS (via Kellie Haratsis) on 5 March 2019 required a response "within 10 days", that is, by 15 March 2019…Kellie Haratsis issued MHHS' 159N response to the Department of Child Safety within the required timeframe on 11 March 2019.*[154]

SCAN meetings

290. In respect of the SCAN meeting held on 26 March 2019, there seems to have been a degree of confusion as to the purpose and function of the meeting. Some attendees at the meeting on were unsure of their role in the meeting. The minutes were taken in such a way that they were not a verbatim record of the conversation – rather they summarised comments made by each attendee. The minutes were sent to attendees for amendment, but the final minutes did not include all of the amendments requested by attendees who reviewed the minutes. The fact that the SCAN meetings are confidential appeared to prevent important information from being passed on to Daniel's clinicians.

291. In addition, in Daniel's case, a SCAN meeting was not held until after he had been discharged from MBH, which limited the opportunity for SCAN team consideration and assessment of Daniel's needs.

Purpose of SCAN

292. Ms Scott advised in cross-examination that SCAN was not a decision-making forum and her role in Daniel's case was not that of a decision-maker. She explained that the purpose of SCAN meetings is to bring key people from Health, Education, Police and Child Safety together to share information, and that it was not intended to be an opportunity for those key people to challenge the decisions

[154] B6.1 MHHS email dated 7 May 2024.

made by Child Safety. Ms Scott said that, if any attendee at the meeting did have issues with the approach Child Safety was taking, then she would expect them to discuss those issues with the STL with carriage of the case (in Daniel's case, Ms Ward), but not with her.

293. Ms Scott also explained that, in accordance with the SCAN escalation policy at the time, the discussion at the meeting did not amount to a disagreement which would have resulted in an escalation process.

294. In her evidence, the Chief Practitioner explained the functions of SCAN as follows:

> *So it is more than an information sharing venue or agenda. There is, and this is why the membership is as it is, there is an expectation that people are bringing their expert knowledge to that meeting in order that an assessment can be made of that child's needs and recommendations can then be made to the chief executive. So I – you will have seen in my last page of my statement that my legal colleagues have been advising me of some of the evidence that has been heard and it has alarmed me. And I have instructed my team to focus very much on what are the functions of a SCAN team, what supports and training are required to our SCAN coordinators and our CPLOs and – not our CPLOs, health CPLOs, so that we can see more effective functioning of SCAN. Because it's not just an information sharing meeting. I expect people to bring their expertise and to offer their opinions about what this child needs to be safe, and I think that's what's been missed in some of the evidence that has come before me.*[155]

Role of attendees

295. Dr Wattaliyadda gave evidence at inquest that she did not know anything about Daniel's case, and did not recall whether she had an opportunity to read documentation for the meeting, or whether she had any conversation with Dr Menezes for the purpose of the meeting.

296. Dr Wattaliyadda described her concerns about Daniel being in the care of his parents as "significant".[156] However, in cross-examination, she said that she was not aware, at the time, that she was at the meeting as a proxy for Dr Menezes – she thought she was there for training purposes. She confirmed that she did not recall whether she had discussed her concerns with Dr Menezes after the meeting, and her understanding was that if Dr Menezes saw the minutes and shared her concerns, Dr Menezes would act on them.

297. In her evidence, Dr Menezes said that she did recollect having a conversation with Dr Herath and providing her with the documents for the meeting, but that she could not recall the specifics of the conversation or if she had any particular concerns that she wanted Dr Herath to raise at the meeting.

298. Dr Menezes also gave evidence that she recalled having a discussion with Dr Wattaliyadda after the SCAN meeting and was aware of the concerns that Dr Wattaliyadda had raised in the meeting. Dr Menezes said that she did not consider it necessary to pass that information on to Dr Gopan, as SCAN meetings are confidential and, unless she was specifically asked to, it is the responsibility of Child Safety to consult the relevant person. She was asked if it would be ideal if she could refer SCAN information to the lead clinician, and said:

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[155] Transcript, Day 7, T119L17.
[156] Transcript, Day 8, T30L34.

Yes, if they had communicated to me that it is detrimental to the welfare of the child and we do need extra support, yes. And I – I did not get that feel.[157]

Minutes

299. The emails attached to Ms Scott's statements show the history of the amendments to the minutes. In particular, they show that Dr Herath had requested that the amendments (in red) below be made:

They might not be seeing true picture and from what I can gather I don't think they have the capacity to parent this kid. I asked about the possibility of removing the child from the parents and then ? Carrissa told that we need to give time to the parents to build up their capacity.[158]

300. Ms Scott removed the phrase "and then ? Carrissa told that we need to give time to the parents to build up their capacity" from the final version of the minutes. She explained at inquest that this was because she didn't understand the meaning of the question mark in the sentence, and that the way the minutes were organised, each person's comments were placed under their name. It was pointed out to her that the comment "Carrissa told [us] that we need to give time to the parents to build up their capacity" had not been included under her name in the final minutes, and said that she thought that it had, and it was not a deliberate omission.

301. The Chief Practitioner commented, in respect of the minutes of the SCAN meeting on 26 March, that they were:

..not a good summary of the child protection concerns and not a good summary of the likelihood of harm and the impacts for this child. That is what I – my hope for SCAN is that people are being brought together to share information so that an assessment can be made. It seemed to me a lot of dot-points without a good assessment being made.[159]

Updates to policies and procedures

302. The Department is the lead agency for SCAN. Through the Chief Practitioner, the Department has provided to the court the most recent version of the SCAN Manual, which sets out policies, procedures relevant to SCAN referrals and meetings, and outlines their function and the way in which information is to be shared and acted upon. The Chief Practitioner noted in her evidence that, since 2019, updates to the SCAN Manual mean that all information brought to SCAN meetings is intended to inform the way in which Child Safety handles the particular case. She said that this reinforces her point that SCAN is not intended to be only an information-sharing forum, but is an active part of Child Safety's decision-making process in each case.

303. In her statement, the Chief Practitioner outlined other changes to the SCAN team system (and provided the relevant documentation), which include:

- Introducing the Unify SCAN Team Product and Portal in November 2022, to enable increased visibility and transparency of information and online access for all agencies involved in SCAN;

[157] Transcript, Day 5, T17 - 29.
[158] F2.2.11 – CS11 to Statement of Carissa Scott, p 6.
[159] Transcript, Day 7, T120L2.

- In collaboration with Queensland Health, QPS and Education, reviewing and updating SCAN team forms in 2002, including an updated minutes form;
- Providing a range of training opportunities to SCAN team Coordinators and administration officers during 2023, and
- Hosting a 2-day SCAN conference for SCAN stakeholders in March 2023.

304. The Chief Practitioner also provided information, in her statement that, as a result of listening to the evidence in the inquest, she had "instructed the team with policy and program responsibility for SCAN to liaise with colleagues in the Queensland Health policy area to coordinate additional training for all [CPLOs] and SCAN coordinators to focus on":

    - The purpose and function of SCAN teams;
    - The role of SCAN Coordinators;
    - Information sharing within and outside SCAN meetings; and
    - The expectation that core member representatives will invite and facilitate contributions that would help assess and respond to the needs of the child, particularly Child Health Nurses involved with the child.

305. MHHS also provided relevant documentation and the following information about their updates to their SCAN policies and procedures:

    [The Queensland Health Electronic Publishing System (QHEPS)] contains information on SCAN and a link to the current [Department of Child Safety] SCAN system manual…[There is also a] SCAN local MHHS policy [which] details confidential storage of documents….

    MHHS' local SCAN policy (referred to above) relevantly provides that most SCAN records (including referrals, agendas, team reviews, team minutes, team recommendations and Information Requests from the Department of Child Safety) are to be stored in the "Child Protection Liaison Folder on G: drive" and accessible to the following authorised users:

    - *Child Protection Advisor;*
    - *Child Protection Liaison Officer;*
    - *Child Protection Social Worker;*
    - *Child Protection Admin Officer; and*
    - *SCAN QH Core Representative.*

    The local SCAN policy also provides that an alert should be entered into HBCIS to alert other staff that a SCAN record exists.

    …[T]he statewide "SCAN: Information sharing processes" guideline…is accessible by MHHS staff via QHEPS.

Conclusions

306. In in respect of the level of effective information sharing between MHHS (and, more widely, Queensland Health) and Child Safety in respect of Daniel, I find that:

    a. Queensland Health staff could have made an earlier notification to Child Safety about Daniel. Ideally, the notification would have been made while Daniel was at the TUH, but could also have been made earlier in his first admission to MBH;

b. The MHHS policies and procedures in place at the time in respect of information obtained by the CPU through the CPLO were insufficient to ensure that:

   i. important clinical information and/or information which had been provided to Child Safety was available to Daniel's clinicians; and

   ii. the frequency and seriousness of concerns raised by health staff was conveyed to Child Safety;

c. The lack of Statewide access to ieMR hampered effective information sharing between MHHS and Child Safety;

d. Queensland Health staff should have referred Daniel's case to SCAN earlier, ideally before his discharge from MBH;

e. When it did occur, the SCAN team meeting was not properly understood or utilised by attendees from MHHS or Child Safety as a forum in which legitimate concerns about Daniel's safety could be discussed, assessed and escalated.

307. I accept what has been put forward in submissions on behalf of MHHS and THHS: that an earlier notification by QH staff may not ultimately have altered the view of Child Safety that an IPA was the appropriate course in Daniel's case.[160] An earlier notification may, however, have given Child Safety more time to explore ways in which to assess the capacity of Daniel's parents to comply with an IPA.

Conclusions

308. The death of an infant such as Daniel is a devastating event for his parents and for those who cared for him, provided medical treatment and/or community support to him and to his family. It is clear that, at all times, those involved with Daniel were doing what they thought was best for him.

309. I am aware of the danger of hind-sight bias in conducting this investigation into the circumstances of Daniel's death, in making findings as to what did occur and in determining whether his death could have been prevented.

310. I have not found that there was any failing by any individual which would have changed the outcome in Daniel's case. Rather, there were a series of lost opportunities to share information about his case between the QH and Child Safety, combined with what was perhaps a global underappreciation of Daniel's vulnerability and fragility.

311. I note that it is submitted on behalf of Ms Williams that the *Human Rights Act 2019* (Qld) (HRA) is relevant to my findings. In my view, that would require an acceptance that a Coroner is not acting in a judicial capacity when making findings in an inquest,[161] I do not accept that as a proposition[162].

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[160] Submissions on behalf of MHHS and THHS, paras 58 - 59.
[161] See s9(4)(b) of the *Human Rights Act 2019* (Qld).
[162] See ss58, 9 and Sch1 to the *Human Rights Act 2019*

312. Regardless of the application of the HRA Ms William's submissions are, ultimately, that the issue of domestic and family violence is relevant to my findings in respect of Inquest issues 4 to 8. I note that Ms William's Counsel canvassed this issue on behalf of Ms Williams during the inquest, and I allowed those questions to be asked of the respective witnesses. It is now submitted that there were significant red flags for QH and Child Safety staff with respect to Mr Wright's behaviour towards Ms Williams, and that the support provided to her was not adequate in the circumstances. Ms Williams submits that there is an opportunity to provide further training to both QH and Child Safety staff in this respect.

313. The ability of both of Daniel's parents to care for him was, in my view, a more relevant factor for consideration by his treating practitioners and by Child Safety. It is possible that an earlier notification to Child Safety would have allowed time for Child Safety to organise assessment of his parents' capacity, both to care for him and to understand, engage in and comply with an IPA. The result of such assessment may have made a difference to whether an IPA was considered appropriate in Daniel's circumstances.

Findings required by s. 45

Identity of the deceased – Daniel Thomas Wright

How he died – Daniel was a high-needs infant who had been born four months premature. He had spent most of his short life in hospital in Townsville and Mackay. Daniel's parents, Ben Wright and Zara Williams, both live with intellectual disabilities. Concerns by hospital staff as to Mr Wright and Ms William's ability to properly care for Daniel once he was discharged from hospital led to a number of reports to the Child Protection branch of what is now known as the Department of Families, Seniors, Disability Services and Child Safety. Daniel was eight months old[163] and had been discharged from hospital into the care of his parents when he died at his home in Bowen.

Place of death – 45 Fairway Drive BOWEN QLD 4805 AUSTRALIA

Date of death– 30/03/2019

Cause of death – The cause of Daniel's death was determined to be prematurity-associated lung and bowel disease.

[163] This was Daniel's chronological age at the date of his death. His gestational age (adjusted for his prematurity) was four months old.

Comments and recommendations

314. In accordance with s46 of the Act, a Coroner may, whenever appropriate, comment on anything connected with a death investigated at an inquest which relates to public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in the future. Comments may take the form of recommendations to government or to particular agencies to make or consider systemic changes or amendments to existing policies or procedures.

315. In my view, given the evidence which has been put before the court in respect of the changes which have already been made by Townsville Hospital and Health Service, Mackay Hospital and Health Service and Child Safety since Daniel's death, there are no practical recommendations which I could now make to prevent similar deaths in the future.

I close the inquest.

Stephanie Gallagher
Deputy State Coroner
BRISBANE