QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

Ruling regarding scope of inquest (including by calling additional witnesses and obtaining additional evidence)

CULTURAL WARNING

Aboriginal and Torres Strait Islander readers are advised that this ruling contains the name of a deceased Aboriginal person.

Readers are warned that there may be words and descriptions that may be culturally distressing.

CITATION:	**Inquest into the death of Tristian James Frahm**
TITLE OF COURT:	Coroners Court
JURISDICTION:	BRISBANE
FILE NO(s):	2021/5271
DELIVERED ON:	12 May 2025
DELIVERED AT:	Brisbane
HEARING DATE:	Application on the papers
PIC DATE:	7 April 2025 (Brisbane)
INQUEST DATES:	2 – 6 June 2025 (Toowoomba)
RULING OF:	Ainslie Kirkegaard, Coroner
ORDERS:	Application refused

REPRESENTATION:

Counsel Assisting:	Sarah Ford
Kerrod Frahm:	Andrew Bale, A W Bale & Son Solicitors
Samantha Skerritt & Shanade Thorley	Aboriginal and Torres Strait Islander Legal Service (Qld) Ltd

Background

1. Tristian James Frahm ('Tristian') was an 11-year-old First Nations boy with striking blue eyes who felt a deep connection with animals and loved spending time in nature. He was full of energy and adventure. Tristian died unexpectedly on 21 November 2021 after becoming unwell while spending a weekend with family members at his father's rural property in Murgon, Queensland.

2. Coronial autopsy revealed Tristian died from complications of brown snake envenomation.

3. Tristian's passing is reportable as an unnatural death under section 8(3)(b) of the *Coroners Act 2003*.

4. I am holding an inquest into Tristian's passing under section 28(1) of the Coroners Act to examine the circumstances surrounding Tristian's death and to bring awareness to the signs, symptoms, and necessary treatment of snake envenomation. This will involve examining the actions of adults including his father who were present at the property when Tristian became unwell over 20-21 November 2021.

5. Tristian's maternal family seek to broaden the scope of the inquest to examine Child Safety's failure to remove Tristian from his father's care before a serious incident occurred. Tristian's father opposes broadening the scope of the inquest.

6. It is not the purpose of this ruling to make findings on the allegations raised in the maternal family's submissions. My task, at this juncture, is confined to considering whether the proposed additional issues for inquest are necessary, desirable and proportionate so as to enable the discharge of my statutory functions as Coroner.

7. The key issue to be determined is whether there is a sufficient causal connection between Child Safety's involvement with the paternal family and Tristian's death from snake envenomation while in his father's care.

The scope of an inquest

8. A decision about the scope of an inquest '*represents a coroner's view about what is necessary, desirable and proportionate by way of investigation to enable the statutory functions to be discharged*.'[1]

9. While the Coroners Court may inform itself in any way it considers appropriate, a coroner's powers are not 'free ranging',[2] nor is an inquest a

[1] *Sharon O'Brien v. HM Assistant Coroner for Sefton, Knowsley and St Helens* [2025] EWHC 362 citing *R(Hambleton) v Coroner for the Birmingham Inquests* (1974) [2018] EWCA Civ 2081 at [48].
[2] *Harmsworth v State Coroner* [1989] VR 989 at 990.

roving Royal Commission.[3] Ultimately, it is for the Coroner to determine the scope and breadth of an inquest.[4]

10. In *R v Doogan; Ex Parte Lucas Smith & Ors* [2005] ACTSC 74 the Full Court of the Supreme Court (Australian Capital Territory) said this in relation to the nature of the coroner's inquiry:[5]

> *The [Coroners] Act is generally concerned with the resolution of relatively straightforward questions such as "what was the cause of this death?" or "what caused this fire?". It does not provide a general mechanism for an open ended inquiry into the merits of government policy, the performance of government agencies or private institutions, or the conduct of individuals, even if apparently related in some way to the circumstances in which the death or fire occurred.*

11. Using the example of a cyclist's death, the Court went on to explain:

> *… [A] coroner might well hear evidence suggesting that a cyclist's death had been caused not merely by a collision with a motor vehicle, but also by the antecedent conduct of the driver of that vehicle in failing to stop at a stop sign adjacent to an intersection. However, the limited jurisdiction conferred... would not authorise the coroner to inquire into any perceived failures in relation to general policy relating to the siting of stop signs or the enforcement of traffic regulations. The particular siting and design of the relevant intersection may be a different matter. The application of the common sense test of causation will normally exclude a quest to apportion blame or a wide-ranging investigation into antecedent policies and practices.*

12. The 'common sense test' is well-established. To bring a matter within the scope of an inquest, there must be a causal connection between the death and the matter under investigation.

13. Put another way, an inquest should be confined to those circumstances that are sufficiently proximate and causally relevant to the death.[6] To do otherwise could cause an inquest to become wide, prolix, and indeterminate.[7]

To what extent should the inquest examine the 'immediate circumstances of death'?

14. Paragraph 30 of the maternal family's submissions sets out seven specific matters they consider relevant to the immediate circumstances of death. All of them clearly sit squarely within a proper examination of the circumstances surrounding Tristian's passing, including why Tristian's

---

[3] *Doomadgee & Anor v Deputy State Coroner Clements & Ors* [2005] QSC 357 at [29]. See also: *R v Doogan; Ex Parte Lucas Smith & Ors* [2005] ACTSC 74 at [31].

[4] *Sharon O'Brien v. HM Assistant Coroner for Sefton, Knowsley and St Helens* [2025] EWHC 362 at [8].

[5] At [15].

[6] See for example: *Harmsworth v State Coroner* [1989] VR 989; *Sharon O'Brien v. HM Assistant Coroner for Sefton, Knowsley and St Helens* [2025] EWHC 362.

[7] *Harmsworth v State Coroner* [1989] VR 989 at 997.

father's partner received medical attention after sustaining an injury at the property on 19 November 2021 and Tristian did not when he became unwell over 20-21 November 2021.

15. These matters can be adequately explored in the ordinary process of examining the agreed witnesses, with the addition of Sharon Frahm.

16. Paragraph 27 of the maternal family's submissions proposes the inquest consider '*whether there should be a positive duty to provide first aid as currently provided for in the Northern Territory but not in other states or territories'*. I am satisfied the current scope of the inquest to examine the circumstances surrounding Tristian's death by snake envenomation and whether any recommendations can be made which could prevent future deaths from happening in similar circumstances already captures this consideration.

Is there a sufficient causal connection between Child Safety's involvement with the paternal family and Tristian's death from snake envenomation while in his father's care?

17. In essence, the maternal family submissions infer that Tristian's passing is a foreseeable manifestation of '*a substantial chance that a child would be killed or seriously injured by misadventure'* while he remained in his father's care, and by extension, his death would have been prevented had Child Safety removed him from his father's household.

18. They allege that Tristian and his brother were exposed to dangerous objects and unsafe behaviours with a disregard for his safety – not wearing shoes in bushland, not wearing helmets when riding motorbikes and doing risky manoeuvres, and lack of supervision when the children were using the John Deere mower, gun/gel blaster, bows and arrows - and medical care, first aid or preventative health measures (such as an asthma puffer, shampoo or ringworm treatment) relied on as support for this proposition.

19. On this basis, the maternal family submit the inquest should also examine:

    (a) '*the ongoing exposure of the children to misadventure in their father's household and the disparity between safety for the adults and lack of safety for the children'*; and

    (b) *'systemic failures to remove the child from the household before a serious incident occurred*' including:
        (i) *the gap in the system when the child is dependent on an adult to take out a domestic violence order or family court parenting orders;*
        (ii) *inconsistencies in the child safety system which failed to look at the ready availability of alternative carers for the boy; and*
        (iii) *whether there should be a positive duty to provide first aid as currently provided for in the Northern Territory but not in other states or territories.*

20. They submit this would extend to examining structural and systems barriers including:

    (a) a purported lack of agency on the part of Tristian and his brother to remove themselves from their father's household. Tristian had explicitly expressed a wish '*not to be in his father's household*' and due to his exposure to violence in that household, his mental health was deteriorating;

    (b) inadequate mental health care (described as: *'the removal of mental health supports for the child'*);

    (c) a misapplication of framework by Child Safety resulting in an incorrect conclusion that Tristian's only options were to live with his biological mother or father (despite having 'rights for other connections to kin'); and

    (d) an absence of structural barriers to an effective Child Safety response in circumstances where a child is reluctant to *'get a parent in trouble*'.

21. They suggest that broadening the scope of the inquest to include these issues will allow for a complete examination of issues that have 'clear connections' to Tristian's passing, and which could form the basis for appropriate preventative recommendations.

22. The evidence before me reveals significant disharmony between the maternal and paternal sides of Tristian's family. Family members from both sides levelled accusations against each other in relation to domestic and family violence, substance misuse, excessive discipline, and child neglect.

23. Tristian and his younger brother experienced significant trauma and disruption during their young lives due to domestic and family violence and parental alcohol and drug misuse in both parents' households. They lived variously between their biological parents and maternal and paternal grandparents over time with significant disruption to their schooling. Concerns about their physical safety and emotional wellbeing, particularly Tristian's, while living with their mother in 2019 - 2020 led to family members taking the boys out of her care during 2020. This occurred without Child Safety intervention.

24. The boys were living with their father, his First Nations partner, and her three children in Murgon at the time of Tristian's death. They had regular contact with their paternal extended family, particularly their paternal grandparents, some contact with their maternal grandmother, and no contact with their mother while living with their father.

25. During 2020 – 2021, Child Safety responded to concerns reported by community and professional notifiers regarding the boys' safety in their mother's care, their exposure to domestic and family violence and

substance abuse in both households, and exposure to emotional harm in the father's household. There was also some police involvement in respect of reports regarding each parent's behaviours.

26. As at March 2021, Child Safety assessed the boys as not being at an unacceptable risk of harm in their father's care but there would be significant concerns for their safety and wellbeing if they were to return to their mother's care.

27. In late May 2021, the father physically assaulted his partner while they were both drinking. Her daughter was injured when she intervened to protect her mother. This led to police and further Child Safety involvement with the paternal family. However, as at August 2021, Child Safety assessed the other children (including Tristian) as not being in need of protection. The family was referred for intensive family support.

28. The systemic child death review process undertaken following Tristian's passing identified missed opportunities for child safety officers to better understand the dynamics of domestic and family violence in the father's household and address the significant risk if his domestically violent behaviours continued unaddressed. It did not conclude there were grounds warranting the boys' removal from their father's care.

29. Tristian's death by snake envenomation occurred in the context of three adults (including two non-family members) not identifying he needed medical treatment when he became unwell after an initial suggestion he had been bitten by a snake on 20 November 2021.

30. The snake bite tragically occurred in the context of a young boy who was enjoying his time with family on the property, doing something that made him happy. A young boy who, according to the maternal family's Family Statement, was known for his deep connection to the earth, and his love of outdoor activities including riding bicycles and motorbikes. It occurred on a property where the children regularly spent weekends enjoying what pre-teenage boys like to do in a rural environment without previously coming to any significant harm.

31. Tristian's death did not occur in the context of repeated failures by his father to seek medical treatment for a potentially life-threatening condition or injury for any children in his household. It is unrelated to Tristian's state of mind while in his father's care. It did not occur because of his father's domestically violent behaviours. Moreover, while two of the adults (including Tristian's father) had been drinking alcohol, there was a sober adult present throughout the events of 20 - 21 November 2021.

32. The child death review reports produced by the Department of Education, Queensland Police Service and Child Safety detail the nature of the notified concerns about the father's behaviours during 2021. They are such that none of these agencies could have reasonably suspected Tristian was at 'a substantial risk' of death by misadventure, let alone by

snake envenomation, due to disregard for his safety and medical care while in his father's care.

33. There is no evidence before me that any of these agencies received notifications or concerns from the maternal family about the boys' safety and wellbeing while they remained in their father's care. I observe that despite seeking to rely on Tristian's education and unspecified additional medical records, the maternal family is not seeking to rely on the Child Safety records, nor do they propose that a representative from that agency (or any of the agencies involved with Tristian) be called to give evidence.

34. The Department of Education's child death review report documents Tristian's love for his father, his good (and protective) relationship with his father's partner, the boys' excellent school attendance record and observations by school staff that Tristian arrived at school fed, tidy and in clean uniforms. This evidence, from the agency with external oversight of the boys on a weekly basis during the school term, is consistent with positive statements Tristian made about his experience living with his father during an interview with Child Safety in March 2021. Tristian also reported he was seeing someone in the community from a mental health perspective.

35. On the evidence before me, I consider the additional potential systemic issues proposed by the maternal family lack sufficient proximity and causal relevance to the circumstances in which Tristian passed. It is difficult to conceive how an exploration of these issues could lead to anything beyond an '*open ended inquiry into the merits of government policy, the performance of government agencies or private institutions, or the conduct of individuals'.* [8]

36. For these reasons, I decline to broaden the scope of the inquest to explore the issues set out in paragraphs 19 and 20 above. I have already addressed the extent to which the current inquest scope enables examination of the '*the disparity between safety for the adults and lack of safety for the children'* as this relates to events at the rural property over 19-21 November 2021.

Is there a need to hear evidence from the additional witnesses and/or obtain the further material proposed by the maternal family?

37. The inquest will hear evidence from the three adults present at the property (including Tristian's father) when Tristian became unwell over 20 - 21 November 2021, the investigating police officer, the forensic pathologist who performed the autopsy, and two emergency physicians.

[8] At [10].

Additional witnesses

38. The maternal family has provided a list of additional witnesses they propose should be called to give evidence at the inquest without any submissions as to why those witnesses should be called or what information those witnesses could give that would assist my investigation.

39. Having determined the inquest will not examine the additional potential systemic issues proposed by the maternal family, it is not necessary to call the following witnesses:

    (a) Shanade Thorley (Zaulich) – she provided two statements to police, the first of which outlines her history with Tristian's father (and his family) and matters generally pertaining to Tristian's care. These statements are already within the proposed brief of evidence. As Ms Zaulich was not involved in the boys' care during 2021, I am not satisfied she can provide any further evidence that would assist me.

    (b) Gemma Thorley.

    (c) Witness(es) from the Queensland Aboriginal and Torres Strait Islander Child Protection Peak on the exercise of delegated authority by 12 different organisations in 20 different locations working with 20 Child Safety Service Centres for culturally capable placement of children.

Phone records

40. On receipt of the maternal family's submissions, I authorised the addition to the proposed brief of evidence of the stored communications data for the mobile phones of Tristian's father, Ms Dorman, and Mr Bryant.

41. Tristian's father opposes the release of these records on the basis of relevance. I do not accept that submission. The actions of the adult witnesses between 20-21 November 2021 are relevant to the circumstances surrounding Tristian's passing.

Medical records

42. The proposed brief of evidence already contains Tristian's historical records from Children's Health Queensland, Toowoomba Health Service, and the Logan, Murgon, and Cherbourg hospitals. These records document Tristian's contact with these health services over an 11-year period, including while under his father's care. I also have the benefit of Queensland Health's Child Death Review Report.

43. In the absence of submissions as to what additional medical records should be obtained and how those records would assist my investigation, findings and any recommendations, I am satisfied the medical records already obtained are sufficient to enable proper examination of the circumstances surrounding Tristian's passing.

Education records

44. I already have the benefit the Department of Education's comprehensive child death review report. In the absence of submissions supporting the maternal family's request to obtain Tristian's school records and how those records would assist investigation, I am not satisfied that obtaining them will better inform my investigation, findings or any recommendations.

What *Human Rights Act 2019* considerations apply to my decision not to broaden the scope of the inquest (including by calling additional witnesses and obtaining additional evidence)?

45. I have had regard to the *Human Rights Act 2019* (HRA) in making my decision about these matters.[9] I am to make my decision compatible with human rights and not place limitations on a person's human rights unless there is a reasonable and demonstrably justifiable basis to do so.[10]

46. The maternal family submit that for me to carry out my functions under ss45 and 46 of the *Coroners Act 2003*, consistently with the HRA, '*the scope of the inquest ought to encompass consideration of both the immediate cause of the child's passing, as well as the potential systemic causes'*.

What human rights are engaged by my decision?

47. The right to recognition and equality before the law, the right to life, and the rights for children to protection in their best interests are potentially relevant to this decision.[11]

48. The maternal family also point to the application of the following rights under the Convention of the Rights of the Child:[12]
    - *the right to develop to the fullest;*
    - *the right to protection from harmful influences, abuse and exploitation;*
    - *family rights; and*
    - *the right to access health care, education and services that meet their needs.*

49. The maternal family's submission identifies the right to security of person[13] as potentially relevant given their application to extend the inquest scope to examine their allegations of Tristian's ongoing exposure to risk of harm by misadventure while under his father's care. I disagree. The explanatory notes for the Human Rights Bill 2018 make it clear that this right protects

[9] Section 58, *Human Rights Act 2019*
[10] Sections 8 and 13, *Human Rights Act 2019*
[11] Sections 15, 16 and 26, *Human Rights Act 2019*
[12] Section 12 of the *Human Rights Act* 2019 allows me to consider the Convention of the Rights of the Child in addition to, or as a part of, the rights of children to protection.
[13] Section 29, *Human Rights Act 2019*

personal liberty with a focus on the requirement that due process is followed when state authorities exercise their powers of arrest and detention.[14] Rather, the relevant right is Tristian's right to special protection as a child afforded by his family, society and the State.[15]

Does my decision not to broaden the scope of the inquest (including by calling further witnesses and obtaining additional evidence) limit any of these rights?

50. Although the maternal family's submissions outline the human rights engaged by my decision, the submissions do not detail *how* a decision not to broaden the scope of the inquest would limit those rights.

51. Nonetheless, my decision not to broaden the scope of the inquest has the potential to limit the rights to life and the rights of children to protection in their best interest, and certain rights under the Convention of the Rights of the Child.

52. Having decided to hold an inquest to examine the circumstances surrounding Tristian's passing, I am satisfied my decision to confine the scope of the inquest does not limit Tristian's right to recognition and equality before the law.

Are the limitations reasonable and justifiable?

Right to life, rights to protection of children in their best interest, and certain rights under the Convention of the Rights of the Child

53. These rights, inter alia, protect a child's right not to be arbitrarily deprived of life. The positive obligation imposed by these rights includes the requirement that states take steps to prevent the arbitrary deprivation of life.

54. My decision not to broaden the scope of the inquest to include '*the potential systemic causes*' raised by the maternal family limits the Court's ability to identify systemic and individual failures in system contact with the paternal family prior to Tristian's death. This will, in turn, limit the Court's capacity to hear certain evidence and make associated findings or preventative recommendations which in turn may prevent future arbitrary deprivation of life.

55. I am satisfied these limitations are warranted because Tristian passed in an isolated incident in which three adults did not identify he needed medical treatment. The purpose of limiting these rights is to avoid the inquest becoming a 'roving Royal Commission' and to ensure that the public interest in holding the inquest is upheld.

[14] Human Rights Bill 2018 explanatory note p.24
[15] At [47].

56. In the context of the Court's finite resources, I consider broadening the inquest scope to address '*the potential systemic causes'* weighs against the public interest because there is insufficient connection between them and the circumstances surrounding Tristian's passing. The public interest in Tristian's passing is served by examining why the three adults present did not identify Tristian needed medical treatment, and by doing so, raising public awareness about the signs, symptoms, and necessary treatment of suspected snake bite.

57. By not imposing these limitations, the Court would be required to explore allegations and 'potential systemic issues' which lack sufficient connection to Tristian's risk of death by snake envenomation. This carries the risk of obfuscating the purpose for which this inquest is being held at a cost to the public outweighing the public interest in holding the inquest.

58. There is no less restrictive or reasonable available way in which to achieve the purpose of these limitations.

59. For these reasons, I consider that the limitations on these rights are reasonable and demonstrably justifiable.

Rulings

60. The inquest will not examine the additional issues set out in paragraphs 19 and 20 above.

61. Aside from Sharon Frahm, no additional witnesses will be called to give evidence at the inquest.

62. The inquest is to proceed as listed on 2 June 2025 and in accordance with the list of issues as outlined at the Pre-Inquest Conference.

Ainslie Kirkegaard
Coroner
BRISBANE

12 May 2025