QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INVESTIGATION

CITATION:	**Non-inquest findings into the death of a two year old girl whose family was known to Child Safety**
TITLE OF COURT:	Coroners Court
JURISDICTION:	BRISBANE
DATE:	14 July 2025
FILE NO(s):	2022/3943
FINDINGS OF:	Ainslie Kirkegaard, Coroner
CATCHWORDS:	CORONERS: child death; young child; medical versus developmental delay concerns; child's diet; iron deficiency; parental substance use; methylamphetamine; parental overwhelm; Child Safety involvement; medical input to Child Safety assessment and decision making; "halo effect"

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Background

1. D was a two year old girl who died at the emergency department of a metropolitan public hospital on Monday 8 August 2022.

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

3. Coronial autopsy revealed the cause of death to be complications of severe anaemia and SARS-CoV2 (COVID-19) infection.

4. D's parents clearly loved their children. They were worried about her developmental delay and her extremely limited diet. They both struggled with mental health issues and methylamphetamine use and were trying to raise their children in poverty. They were open to all the support they could get but this constellation of factors limited their capacity to action recommendations that D be medically investigated for iron deficiency.

5. D's family was known to both Child Safety and the Child Development Service at the time of her death. These findings examine whether there may have been an opportunity to have identified she needed urgent medical assessment prior to her death.

6. Child Safety's service delivery to the family was examined by the child death review process under the *Child Protection Act 1999*. This identified the systemic need for Child Safety officers to seek a medical assessment during an Investigation & Assessment to ensure a child's health and safety and to inform the Investigation & Assessment outcome when there are concerns about the health of a young child.

D's family history

7. D's parents met when they were teenagers and had been together for 14 years when she died.

8. Her mother M was 16 years old when the couple's first child S1 was born in 2011. There was period when S1 remained with his paternal grandparents due the poor living conditions of the share house the young couple were living in at the time. He returned to his parents' care once they moved into more appropriate accommodation. M then fell pregnant with the couple's second child S2. The young family moved interstate where S2 was born in 2013, returning to Queensland when he was four months old. They moved to Brisbane when the children were aged 5 and 3.

9. M's pregnancy with D was unplanned. She had low iron and was taking iron supplements during the pregnancy.

10. While pregnant with D, M became concerned their housemate was sexually abusing S1.

11. Both parents struggled with mental health issues. M is the victim-survivor of childhood sexual abuse and had diagnoses of post-traumatic stress disorder, borderline personality disorder and anxiety. D's father F also reported a history of childhood sexual assault and lifelong anxiety.

12. F was a casual employee earning on average about $400 per week.

Concerns about D's developmental delay and possible iron deficiency

13. D was born following a pregnancy complicated by hyperemesis gravidarum. She was delivered by caesarean section at 39 weeks gestation and born in good condition. She was breastfed for the first three weeks of life, but M stopped producing milk, so D was commenced on formula (Aptamil Gold Plus).

14. M started introducing D to solids at around six months of age, but D struggled, gagging and vomiting and refusing food. The only thing she liked was tinned banana custard. D would not feed herself. She would close her mouth tightly when being fed, and spit food out if M managed to get any into her mouth. D remained very particular, not taking food if it was too smooth or too rough. Up until 12 months of age, D reportedly gagged whenever she saw M eating, so M would hide from her to eat.

15. According to M, F wanted to swap D onto cow's milk at 12 months because it was cheaper. D did not like cow's milk, so M insisted she stay on the Aptamil Plus formula. By 12 months of age, D would only take yoghurt and banana custard mixed together.

16. M reintroduced cow's milk when D was 18 months old. D took it, so they stopped the formula. Her diet was now cow's milk and yoghurt. M continued trying to introduce other foods such fruit pieces in yoghurt. D would swallow the yoghurt but spat out the fruit. The only way M could get any food into D was to mix a small amount of banana yoghurt with another pouch of baby food and feed it to her. They tried watering down her milk to try to increase her water intake.

17. M was concerned about D not meeting her milestones or putting on enough weight. She was non-verbal (saying only Ma, Da and yes), not yet walking and spent most of the time sitting or lying. She developed behaviours including scratching the bed frame, walls and door edges when she wanted something (for example, food, sleep or a nappy change). She gagged if she touched grass or particular surfaces or textures. She was very pale.

18. D presented to the GP for her 18 month check-up and vaccinations on 30 August 2021. The GP noted she was gagging after food. Her physical examination was normal. M says the GP reassured them D had textural food aversion, something she would eventually outgrow. He wasn't concerned about D's weight at that time. D's growth measurements that day were weight 11.2kg (between 50th – 85th percentile), height 84cm (between 50th and 85th percentile) and head circumference 46cm (50th percentile).

19. D was seen by a nurse practitioner at the medical practice on 1 November 2021 with a mouth ulcer. No growth measurements were recorded and there are no comments regarding her development at this time. This the last time she was seen at the medical practice.

20. She was up to date with her scheduled immunisations.

The family's financial situation

21. A statement provided by the family's rental property manager explains the family's rent payments were made regularly and on time during the first 12 months of their tenancy. They started to fall behind in December 2021 after which their rent payments were always late.

22. F's work slowed right down in January 2022, meaning there was less money coming into the household. They were borrowing a lot of money from family and friends to get by.

Things became harder when M fell out with F's parents about 4-5 months prior to D's death, as they reduced the amount of financial support they were providing to the couple. The couple were arguing a lot.

23. The family's rent increased from $700 to $750 in July 2022.

24. F's employer was advancing his wage $50-$100 a week over about three months preceding D's death because he was telling her the children didn't have milk, nappies or needed medication because they were sick.

Home visit by school staff in May 2022

25. S2 was being assessed by the Child Development Service during 2022. The couple took him to multidisciplinary assessments with the local Child Development Service teams.

26. In late April 2022, the school principal met with the couple at their request to discuss concerns about the boys' poor school attendance. They disclosed information about S1's sexual abuse, navigating the criminal justice process and his reluctance to come to school. They were very forthcoming with information about S1's court matter and their family history.

27. S1 and S2 continued to miss a lot of school.

28. In around May 2022, the Child Development Service contacted the school requesting assistance to engage with the family. During this conversation, the school guidance offer relayed the parents' concern that D might be autistic, and asked whether the Service was also seeing D, advising the school would like to commence an Early Childhood Development Plan with her when she turned three.

29. On 19 May 2022, the school guidance officer wrote to the couple about them having missed appointments with the Child Development Service. The following day, 20 May 2022, the school principal and the school guidance officer visited the family home to discuss the boys' poor school attendance and the missed appointments. They recall the front yard and porch were very messy. F opened the door and was initially aggressive but then calmed down. He was not wearing a shirt. There were a lot of sores on his arms, torso and back which he volunteered were from sensitivity to house cleaning chemicals. Both parents were speaking very quickly, talking constantly, and providing a lot of information about why the boys weren't at school.

30. The school visitors could see into the loungeroom from the front door. There was mess everywhere with rubbish and food packets on the floor. The couple told them they had no food, were having trouble paying the rent and the boys had anxiety and didn't want to go to school. They were offered some support options including food hampers and uniforms. F could not stand still, moving around and ended up going into the front yard picking up toys. The school visitors were both concerned the parents might be substance-affected.

31. During the visit, the school guidance officer observed D was very pale, floppy, and listless. She had very poor muscle tone. She did not respond when the school guidance officer said hello. M mentioned they were concerned D might be autistic. When asked whether they had taken her to a paediatrician, one of the parents advised they were going to take her soon. M made a comment about D being unwell with a cold or a virus. The couple were invited to bring D to the school's playgroup. The school principal offered them help making a paediatrician appointment for her. The school guidance officer returned to the

house later than afternoon with donated food for the family.

32. On the morning of 23 May 2022, the school guidance officer phoned M to remind her of S2's Child Development Service appointment that morning. The appointment was then cancelled because the paediatrician was unwell. The school guidance officer reminded M to bring the boys to school and meet with her so she could help them get a paediatrician appointment for D. The couple met with her that day and discussed their concerns about D's developmental delay. The school guidance officer typed a letter for the paediatrician and gave M a copy so she could give it to her GP to prepare a referral for D to the Child Development Service. With M's consent, the school guidance officer contacted S2's speech pathologist at the Child Development Service. They spoke about S2 and her concerns about D.

33. The couple took S2 to see the Child Development Service speech pathologist that day. M showed her the letter regarding D and gave permission for the speech pathologist to send it on to their GP. The speech pathologist recalls M appeared genuinely concerned about D's developmental delay. The speech pathologist phoned the GP clinic to check their fax number and let them know a letter was coming through on the family's behalf to facilitate a referral for D to the Child Development Service. The speech pathologist emailed the school guidance officer later that day advising what she had done.

34. The GP was aware of the letter requesting a referral for D to the Child Development Service. He explains the usual procedure is to send an automatic recall message to the parents to attend the medical practice to discuss the referral. This is because parental consent is required for the referral. The GP told police the medical practice was experiencing issues with the recall system around April 2022 with some patients were reporting they had not received a recall message. To his knowledge, neither parent ever responded to any recall message they might have received from the medical practice and did not ever contact the practice to follow it up.

35. The couple were very reluctant to accept a Family and Child Connect referral at this time because it required them to agree to say they were at risk of entering the child safety system if they didn't get support.

Advice to D's parents from the Child Development Service

36. S2 attended his paediatric review with the Child Development Service on 3 June 2022. D was present.

37. D was present for S2's second appointment with the same paediatric Fellow. She was in the consultation room for about an hour. S2 was the focus of the appointment but some of D's behaviours caught the paediatric Fellow's attention during the session. She noted D had no words, just crying with minimal interest in the doctor or toys (all of which were out of character for typically developing 2.5 year old) and she had very pale skin and looked to have decreased fat stores.

38. The paediatric Fellow took the opportunity to ask D's parents if they could tell her a bit more about D. They shared their concern D had autism spectrum disorder. They described her not using any words to communicate, instead using pushing and repetitive movements. They told the paediatric Fellow about the school guidance officer's letter requesting GP referral to the Child Development Service for D. From her limited observations of D, the paediatric Fellow agreed D warranted developmental assessment by the Child Development Service.

39. D's pale skin led the paediatric Fellow to wonder whether she might be anaemic, so she asked about D's diet. The couple told her D only ate pureed foods, minimal iron rich foods and drank almost 2.5L of milk each day (far above the recommended intake for a 2.5 year old). She gave them some information about anaemia and its dietary causes, and advised D would need a blood test to investigate it. She also advised them to reduce her milk intake and try to increase the amount of iron rich foods she was eating.

40. When asked about D's weight, they said she had recently been weighed at a GP and her weight wasn't a concern.

41. The paediatric Fellow spoke to the parents about her concerns about D's pale skin and her impression of D's weight.

42. The paediatric Fellow provided M with a detailed letter for the family's GP recommending medical follow up and referral into the Child Development Service for D. The Fellow's letter advises they shared the parents' concerns regarding D and requested the following:

    (a) referral to the Child Development Service for D "*specifically about her language delay (no words at 2.5yo), repetitive behaviours, concerns of Autism Spectrum Disorder, oromotor delays (only eating puree, restricted diet (minimal iron intake, 2.5L milk/day)*".

    (b) investigate D's likely iron deficiency ("*very pale, minimal iron intake high milk intake and maternal iron deficiency*") through a full blood count, iron studies and if blood tests confirmed this, to prescribe an iron supplement (6mg/kg per day iron) until she was seen by the Service.

    (c) support the family to increase D's iron level with referral to a dietician publicly or privately through a Chronic Disease Management Plan. The Fellow advised they had recommended a gradual weaning down of her milk, decreasing the amount of liquid in her bottles and also watering down the milk in the bottles, aiming for her to have around 250mL milk per day.

    (d) monitor D's growth parameters to ensure she was not failing to thrive.

    (e) check D's hearing with referral for community audiology.

    (f) assist the family to access the Early Access Scheme through NDIS for speech pathology and feeding support at a minimum.

43. That afternoon the paediatric Fellow sent M an email attaching a fact sheet on iron rich meals and the letter for the GP. The paediatrician later told police at no stage did she feel that D's health was an immediate concern warranting acute medical attention. Rather, she felt the plan was safe and reasonable and that both parents were understanding, appreciative and capable of taking the next steps as discussed with them.

44. I accept there were no urgent clinical issues warranting D's immediate referral to the emergency department at this time. It was appropriate for the paediatric Fellow to write a detailed letter for the family's GP setting out the specific clinical concerns needing investigation and referral.

Concern about parental substance use

45. On 7 June 2022, the property manager attended the house for a routine inspection. The lawn was overgrown. M and the children were at home. On entering the house, there

were clothes, towels and toys all over the lounge room. It smelt like wet towel. M was given an opportunity to clean up and the property manager rescheduled the inspection.

46. The school guidance officer recalls contacting F several weeks later and asking whether the GP had referred D to a paediatrician. He advised they hadn't taken D to the GP because they didn't like that GP and were looking for another one. The school guidance officer spoke to the boys that day about why they were always late for school. The boys told her it was because they were sharing a bed and didn't sleep well, and their parents slept a lot. The school guidance officer phoned M offering to get a bed supplied. M explained they were using S2's mattress for D.

47. The property manager returned to the house on 21 June 2022 for the rescheduled inspection. F was outside smoking. She observed open sores on his face which made her think he might be a drug user. The lawn was still overgrown. The property manager advised she was tired of breaching them and was sending them a notice to leave. F started crying.

48. On entering the house, the property manager saw D lying under two light blankets on the lounge. She thought the little girl looked sick as she was very white and appeared cold. She told the parents they could turn on the heater for D. M told her the power had been off for a few days because they had no money to pay the bill. The house smelled like there was a lot of off food in the fridge and there were little flies everywhere. The house was unclean, the laundry was 'disgusting with mould', the bedrooms were messy, and the beds had no sheets but otherwise everything was in good order. The property manager was so worried about the children not getting fed, she packed up a box of food from her pantry at home and delivered it to the family's front door after work.

49. School staff visited the family at home that day to discuss the boys' poor school attendance. The couple were distressed about having received an eviction notice, the electricity recently being cut off and not having food. M told them she could not afford medication for her ongoing mental health issues. She was currently involved in interstate court proceedings against a family member for childhood sexual abuse. They weren't coping with S1's disclosure of sexual abuse and did not know what to do. Both parents were observed to have open sores on their face, arms and legs. F's eyes were red-rimmed and sensitive to light outside. There were significant concerns about D's development, but the parents hadn't actioned the Child Development Service referral because they didn't like their GP.

50. The family were sent a notice to leave the property on 22 June 2022. This was emailed to M's email address. The notice gave them two months to vacate the property. Later that day F's father contacted the property manager advising he would pay the rent arrears ($750) and the water bill ($288.45).

51. In a telehealth appointment with the same Child Development Service speech pathologist and the paediatric Fellow on 22 June 2022, M mentioned everyone in the household was sick, struggling to wake up and go to school and the family was experiencing significant financial strain. She said she was trying to find a GP she felt comfortable with but was struggling to find one. She had a previous female GP with whom she had developed a good rapport, but she had moved practices and M did not know where she was now practising. The paediatric Fellow sent M another email with details for this GP.

52. On 22 June 2022, the school guidance officer spoke with the school engagement officer, expressing her concerns for the family. The school engagement officer submitted a Family and Child Connect referral requesting intensive family support.

53. There was no further discussion of D during the family's subsequent appointments with the Child Development Service team. M was unwell and not able to attend a goal setting appointment for S2 on 12 July 2022, so F attended alone. The paediatrician who wrote the letter regarding D was not present at this appointment. The school guidance officer had phoned M that morning to remind her about the appointment. She sounded vague and 'spacey'. The school guidance officer attended the appointment. F told her the couple were having problems.

54. D's parents had not actioned getting the referral to the Child Development Service prior to her death. M later told police they were going to make an appointment for D to see a GP to check her iron levels but "*we just didn't have time*". M says she made an appointment once but then D became unwell with the flu "*and because of the whole COVID stuff and I didn't end up making another appointment*." She says she couldn't have a telephone appointment because the doctor wanted to see D in person.

55. The paediatric Fellow later told police that both parents presented as loving and caring parents who were trying their best to support their children. Both were very open with her about their own mental health challenges. Overall, they seemed very open to supports. Her perception was that despite the magnitude of stressors the couple were facing overall, they were managing well to continue advocating and providing for their children.

Child Safety involvement with the family

56. Child Safety was made aware of concerns about the family in June and July 2022 including concerns about D's development, noting the parents had not yet actioned the referral letter they were given for her.

57. A Notification was recorded (neglect – inadequate basic care) and transferred to the local Child Safety Service Centre on 22 June 2022 with a 10 day Recommended Response Priority timeframe.

58. There was delay in commencing an Investigation & Assessment. This was in the context of the receiving Child Safety Service Centre having 166 open Investigation & Assessments at that time. There was a region-wide backlog strategy in place which involved all staff at that Centre being allocated one Investigation & Assessment to complete. The Investigation & Assessment regarding D and her family was transferred to the Intervention with Parental Agreement team on 7 July 2022. It was allocated to the most experienced Child Safety officer in the team on 14 July 2022.

59. The allocated Child Safety officer recalls speaking with the school guidance officer on 21 July 2022. They discussed her concerns about the family and her request that she be sent a formal notice for information about the family. The school guidance officer recalls receiving this notice by email on 25 July 2022.

60. The Investigation & Assessment commenced with a home visit on 29 July 2022 because this was the first available time for the two Child Safety officers who attended to discuss concerns about the boys' school attendance. Apart from an unkempt lawn, the house appeared to be in a normal state of cleanliness and maintenance. They heard a young child crying as they approached the house. F opened the door, indicating M was just putting D down. The parents both stepped outside to speak with the Child Safety officers.

61. F became emotional and started crying as the Child Safety officers explained why they were there. He told them there were lots of struggles in their life, mostly surrounding the ongoing matters regarding S1.

62. Both parents said they were in contact with the school guidance officer about the boys' school attendance and trying their best to get the boys to school but they sometimes struggled, primarily due to S1's reluctance stemming from him not coping with what had happened to him, saying he was afraid he would 'teleport'. F said he was getting less and less work, so there was less money coming in. He also spoke about the relationship break down with his mother, who had stopped paying for S1's private psychology appointments.

63. F talked about issues with the real estate agency, having fallen behind on their rent and threatened with eviction but they were now paid up.

64. F described his mental health as not good, and having missed a recent psychology appointment because he didn't wake up for it. M also spoke about her own mental health struggles and involvement in a police investigation regarding her experience of childhood sexual abuse. She said she was foregoing her mood stabiliser medications because they needed the money for food.

65. Both parents spoke about being overwhelmed by appointments required for the children, including a paediatric assessment for their youngest son to assess him for autism spectrum disorder, counselling for their eldest son and their own mental health appointments. They were both overwhelmed by their situation, crying during the interview. F said they struggled to get out of bed some days but did not want to lose their kids.

66. They spoke about their concerns for D identifying their 'big' concern about her diet and aversion to textured foods, taking only yoghurt and milk. They talked about how D wouldn't sleep at night, just scratching the paint on the wall in one spot. M reported D was only sleeping 1-2 hours a night and crying a lot.

67. The Child Safety officers suggested formula milk may provide more vitamins including iron. F agreed this could be something to try. M explained that D was not going to daycare or playgroup because M's childhood sexual abuse left her not trusting anyone else to care for D.

68. M initially said they had an appointment at a developmental clinic and were waiting to hear back but later in the conversation mentioned they were yet to make an appointment for her.

69. The primary Child Safety officer recalls both parents were engaging with them, F a little more so than M. He was emotional throughout the entire interaction. M became emotional when discussing her own and S1's sexual abuse.

70. The Child Safety officers observed both parents had small sores and scabs on their bodies including their hands, arms and face. When questioned, both parents initially denied using drugs, but F said he smoked weed when he was stressed. His eyes were red, but otherwise neither parent seemed to be drug affected.

71. The Child Safety officers then went inside to speak to the boys. They were wearing clean school uniforms and had clean hair which appeared to have been cut recently. The boys both appeared healthy and well. S2 was wearing prescription glasses that were in good condition. When asked about why they weren't going to school every day, the boys spoke about not liking their teachers. S2 mentioned being bullied, sometimes because he doesn't have lunch. Both boys spoke about having friends and interests at school. The boys told the Child Safety officers they were tired after not sleeping well at night because D would cry and keep them awake. They said they could not wake M before school time.

72. The primary Child Safety officer asked to see D. F told them she was asleep, but they insisted. As they made their way to the main bedroom at the back of the house, the Child Safety officers observed the boys' bedroom was messy but not unhygienic.

73. D was lying on the bed. The Child Safety officer could see she was very pale and long. They observed her half get up from lying down. F picked her up. D smiled when the Child Safety officer said hello. The Child Safety officers could not see any prominent bones or anything else to suggest she was very underweight.

74. They went back into the loungeroom. The other Child Safety officer was speaking with M in the kitchen, looking in the freezer. It was full of veggies, red meat, chicken and frozen meals. M indicated she made food for the children, but they don't like it and don't eat it.

75. D reached down to the floor as if she wanted to get down. F put her down on the floor. She was seen to take two or three wobbly steps before crouching down and crawling to a pile of toddler toys in the corner. The primary Child Safety officer expected a two year old to walk a lot better and be livelier and noisier than D. She could see that something didn't look quite right, "*there seemed to be something off about her developmentally*." She voiced these concerns to the parents who agreed, stating that was why they were talking to the Child Development Service.

76. The primary Child Safety officer asked F about D being pale. He lifted his shirt to demonstrate how pale he was, saying words to the effect of "*She's always been this pale, like me.*" There were scabs and sores all over his torso.

77. D seemed to be interacting with M who was playing with her on the floor. The Child Safety officers did not hear D make any noise at all while they were there, no speaking or verbalisation of any kind.

78. The subsequent record of this home visit documents D as being "*extremely pale and almost blended into the bed sheet…[D] was wearing an oversized shirt and her skin was almost grey, she appeared very thin.*"

79. The house was observed to be clean and there was sufficient food.

80. F told the Child Safety officers he would take any support he could get. The Child Safety officers spent a lot of time speaking with the parents about support services.

81. The primary Child Support officer says her intention at that point was to get the family onto an Intervention with Parental Agreement.

82. The initial safety assessment completed that day identified no immediate harm indicators and the safety decision outcome was recorded as Safe. This assessment was approved by a Senior Team Leader on 1 August 2022.

83. The Child Safety officer received further information from an extended family member on 3 August 2022 about the family including that M had always been very protective of D, they were very concerned because they had never seen D eat a solid meal in her life, she was underweight and anaemic and screams all night.

84. The allocated Child Safety officer was about to commence two weeks leave on 5 August 2022 (one week after the initial home visit) and after speaking with a Senior Team Leader, completed a referral for a practice panel to be convened with a Senior Practitioner to plan for the Intervention with Parental Agreement. The referral was completed as a priority as the allocated Child Safety officer did not want to wait until her return from planned leave.

It was intended to complete a SCAN referral for D which could have been prioritised if it had been able to be completed prior to D's death.

The events of 7-8 August 2022

85. D went to bed fine on the evening of Saturday 6 August 2022.

86. F describes her as a bit sleepier than usual the following day, Sunday 7 August 2022. She ate only half her food, gagging as she was eating. She was given yoghurt and custard for lunch and dinner, with mashed banana as well at dinner. She was drinking milk and water regularly through the day.

87. D was tucked into bed with bottle at around 9:00pm that evening. She fell asleep at around 10:00pm. M woke to a gargling noise coming from D at around 1:00am. She sat her up and rubbed her back. D vomited on herself. It was chunky white vomitus, possibly milk or yoghurt. She appeared a bit paler than usual. M took her into the shower while F stripped the bed. D's colour returned after the shower. F thought D felt warm to touch so M took her temperature. It was 37.1C. M watched television with D to help her settle. D refused a bottle of milk. They all then returned to bed sometime between 2:00am – 2:30am. F felt she was still hot to touch.

88. D woke and vomited again at around 3:00am, mostly phlegm with a bit of curdled milk. M noticed she was paler again. She took D into the shower while F stripped the bed. Again, her colour returned after the shower. D took half a bottle of milk and was placed back to bed.

89. D was awake playing with her toys and trying to wake the boys at around 4:00am.

90. F left for work at around 6:30am. His employer picked him up from home. F told her D had been vomiting overnight. M says she made D a 250mL bottle of milk, but she took only a quarter of the bottle and went back to sleep with M.

91. M spoke to F in the morning about not having any Nurofen or Panadol at home for D. At around 8:20am he asked his employer to advance him $50 so M could buy medication for D. She transferred the money to M's account that morning.

92. M phoned F at work at around 9:00am telling him she was vomiting too. F's employer recalls thinking thank goodness M was awake and could care for D and get her some medication.

93. M says she woke to D kicking her in the face at around 10:00am. She put D on the couch. She says she made D some breakfast, but she only ate about half. M says she didn't think much of this given D had vomited and then some milk earlier in the morning. She thought her tummy might be a bit off.

94. M says she went to the chemist across the road to buy Nurofen at around 10:30am but it was closed due to the public holiday. There wasn't enough petrol in the car for her to drive to another chemist, so she had to wait until F came home from work because he had their only bank card.

95. The boys were home from school because it was a public holiday. D was watching television and playing marbles with S2.

96. D started scratching the bottom of the laundry cupboard at around 12:30pm. M says she

and D slept on the couch together while the boys played in their rooms.

97. F arrived home from work at around 2:00pm. M and D were asleep on the couch. He sent his employer a text message saying words to the effect of "*the girls look so freaking bad but they are both asleep*." F says he kissed D, who woke and smiled at him and then went back to sleep. She looked under the weather, clammy and tired. F lay down in the bedroom, leaving M and D on the couch.

98. F says M woke him at around 2:30pm. She had not bought the Nurofen. He found a chemist that was open, but M told him she was unwell. He walked across the road to buy cigarettes. On returning to the house, the couple smoked a cone. They started arguing while they were smoking.

99. M says she woke at around 2:55pm and woke F. D was lying on the couch watching television. She was lying her right side facing away from the couch, covered by a blanket tucked under her arms and resting her head on a pillow. She had a dummy in her mouth.

100. M says she was outside smoking when she saw D's throat pulsing and her breathing had become irregular. She immediately alerted F and they went inside. D's lips were turning blue. M started rubbing her back while F phoned 000. Queensland Ambulance Service records show the 000 call was received at 3:14pm. The Emergency Medical Dispatcher advised them to try and keep D alert. M picked her up and tried to engage her with toys and the television. D went limp, unable to hold up her head. Her eyes were open, and she was making sighing noises.

101. Paramedics attended soon afterwards. D was in M's arms, pale and floppy with increased work of breathing. M told the paramedics D had been unwell since 1:00am when she had a vomit and had been sleeping on and off since then. She said that around midday D began to become more pale, floppy, and worsened. She said she phoned for ambulance when the colour disappeared from her lips.

102. On examination D was floppy, profoundly pale with decreased responsiveness. She was warm to touch, tachycardic, tachypnoeic and hyperglycaemic. Her pupils were sluggish. M said she was less responsive and more floppy than usual. She had taken less oral intake, but her output was normal during the day.

103. D was transported urgently by ambulance under lights and sirens to the local hospital emergency department.

104. D arrived in the emergency department at 4:08pm in a critical condition. She was extremely pale, lethargic, and floppy with minimal tone. She was clinically shocked with hypotension (55/32), hypoxic with low blood oxygen levels (85% on room air) and cold peripheries. She was unresponsive apart from moaning and crying. The paediatric team and an intensive care consultant were notified of her critical condition.

105. Mobile chest x-ray showed changes in the lung consistent with aspiration pneumonia. Venous blood gas results revealed severe acidosis with a significantly elevated lactate and profound anaemia with critically low haemoglobin (33; normal range 115-135g/L). D was diagnosed with presumed septic shock secondary to aspiration pneumonia. She was treated with intravenous fluids, intravenous antibiotics, blood products and supplemental oxygen. Her fluid and medication doses were calculated on an estimated weight of 12kg. D went into an asystolic cardiac arrest at 4:28pm. She could not be revived despite prolonged emergency resuscitation efforts.

106. The treating team queried a possible background of severe anaemia, possibly diet-related, followed by an aspiration event overnight. D's critically low haemoglobin level was such that she would not have been able to tolerate the hypoxia associated with developing aspiration pneumonia.

107. Police attended the hospital and were satisfied there were no suspicious circumstances.

108. Officers from the QPS Child Protection Investigation Unit attended the family home and were satisfied there were no suspicious circumstances. They located sharps containers containing needles in the kitchen bin. M initially denied using drugs, but the couple subsequently admitted to having been using methylamphetamine and cannabis regularly in the home. They were smoking or injecting methylamphetamine away from the children. They told police sourced their drugs on loan from dealers, paying for it after they paid for rent and food. While M said she was not using every day, F says they were injecting each other up to three times a day.

109. F expressed concern M may not have been feeding D when he was away from the house as he would come home from work to find her asleep on the couch and no dishes in the sink or empty pouches of baby food. He told police he didn't speak to M about his concerns because he didn't want to argue with her, and he hadn't come to a decision about what to do about it all. He admits to not having done enough for D and could have taken her to the doctor given his concerns about her but did not do so.

110. F's employer told police that about two months earlier F confided in her that M was injecting methylamphetamine and admitted he had used it too but said had gotten clean and was begging M to do the same. This is when the boys weren't going to school much. About two weeks prior to D's death, F told his employer the boys were having to get themselves ready for school but could not get there because M would not wake up. F was worried that Child Safety would take the boys.

111. Review of photos and videos of D taken over the 18 months preceding her death show a decline in her ability to move unassisted, going from being able to pull herself up and take steps in December 2021 to becoming unable to stand in late July 2022. There was also a loss of muscle definition, and she became paler.

Autopsy findings

112. External examination including full body CT scan revealed no significant injuries and no developmental abnormalities. D measured on the 3rd percentile for weight and the 75th percentile for height. There was mild prominence of the ribs and apparent muscle wasting of the lower limbs, most prominent in the thighs.

113. Internal examination revealed minimal subcutaneous fat, normal anatomical configuration of the organs, patent foramen ovale, two small foci of intussusception in the small bowel with no evidence of associated complications, faecal loading in the rectum and pericardial, pleural and abdominal effusions (possibly related to fluid resuscitation).

114. Microscopic examination showed changes in the heart consistent with perimortem hypoperfusion injury, abnormalities in a coronary artery suggestive of dysplasia, reactive changes in lymph nodes and mild to moderate chronic inflammation in the airways suggestive of recent respiratory tract infection, no obvious evidence of pneumonia or pneumonitis, reduced intracellular lipid in the adrenal glands and involution of the thymus (non-specific but may be due to physiological stressors) and patchy mucosal haemorrhage

in the rectum.

115. Specialist neuropathology examination of the brain and spinal cord revealed a small cervical spinal epidural haematoma of uncertain significance. Skeletal muscle examination noted mild atrophic fibres with type 2 fibres smaller than type 1 but preserved checker-board pattern.

116. Biochemical analysis of vitreous humour showed mildly elevated 3-hydroxybutyrate (a ketone body) and mildly elevated chloride and urea (possibly impacted by resuscitation efforts including fluid administration). Serum ferritin (a blood protein which contains iron) was markedly elevated. The pathologist explained interpretation of this result is limited by the nature of the sample tested (obtained from bone marrow and also haemolysed) and because it is an acute phase reactant that can be elevated in acute illnesses such as COVID-19.

117. Coronavirus COVID-19 was detected in lung tissue. No other viruses were detected. Whooping cough and toxoplasma were not detected. Microbiology was unremarkable. Faecal testing was negative. Molecular testing was normal. Metabolic screening was unremarkable.

118. Toxicological analysis of hospital admission samples detected no alcohol or drugs.

119. Having regard to these findings and the documented clinical history, the pathologist determined the cause of death to be complications of anaemia and SARS-CoV2 (COVID-19) infection. D had a low body weight, minimal subcutaneous fat, muscle atrophy and hypoperfusion injury of the heart. There was mild to moderate chronic inflammation in the airways and COVID-19 detected in the lung tissue. There was mild rectal mucosal haemorrhage associated with firm faeces but no other obvious explanation for D's severe anaemia or presenting condition on 8 August 2022.

120. Anaemia is a condition in which there are insufficient blood cells or haemoglobin to carry oxygen to the organs and other tissues of the body. Features of anaemia include pallor, pale conjunctivae, tachycardia, lethargy, poor growth, and signs of cardiac failure. D was profoundly anaemic and presented with these symptoms. The presence of acidosis and changes in the heart at autopsy were in keeping with hypoperfusion injury of the organs. The pathologist advised the presence of COVID-19 infection would have placed additional strain on D's cardiorespiratory system and increase her risk of death in the setting of severe anaemia.

121. The pathologist explained there are numerous causes of anaemia but in children it is most commonly a nutritional disorder of iron deficiency. Risk factors for iron deficiency including late or insufficient introduction of iron rich solids, excessive cow's milk consumption, vegetarian or vegan diet and some gastrointestinal disorders. In the context of D's diet based largely on milk and yoghurt and absence of other clinical history or autopsy findings to suggest another underlying haematological or bleeding disorder, the pathologist felt diet-related iron deficiency was the most likely cause of D's severe anaemia, with other vitamin and nutritional deficiencies also likely from her limited diet.

122. There was evidence of failure to thrive. The pathologist observed that while D's growth in height remained constant, her weight which had been between the 50th – 85th percentile from 18 weeks to 20 months of age, had fallen to less than the 3rd percentile at the time of her death with an overall weight loss of approximately 520g in the 11 months preceding her death. Consistent with this is the finding of minimal subcutaneous fat and muscle atrophy. The pathologist advised that while diet likely played a role, it was not possible to exclude other possible causes including malabsorption and some metabolic syndromes.

123. The underlying cause of D's developmental delay was unclear. There were non-specific neurological findings. The pathologist advised that iron deficiency may have exacerbated her condition.

124. D's brothers subsequently underwent cardiology assessment which was reassuring. The clinical geneticist reviewed the D's autopsy report noting she may have had '*an inborn error of metabolism' advising many such conditions are autosomal recessive disorders. There is also a chance than malnutrition contributed to death*.'

Forensic physician opinion regarding the toxicology results

125. Postmortem hair sample testing detected methylamphetamine, amphetamine, Cannabinol and delta-9-tetrahydrocannabinol.

126. It is only possible to state D was exposed to these substances. Neither the route of exposure nor the quantity of drugs she was exposed to could be determined. The absence of drugs detected in the hospital admission blood samples excludes a very recent ingestion.

127. Children can be exposed to drugs in different ways including contacting surfaces contaminated with drug residue, accidentally ingesting substances, exposure to smoke and contact with family members who have been exposed to or use substances that may result in drug exposure via contaminated sweat or other body fluid. The absorption, distribution, breakdown, and clearance of drugs by children's bodies differs from adults.

128. While it was difficult to determine what specific effect exposure to illicit drugs may have had on D, exposure of young children to methylamphetamine and cannabis has been associated with detrimental effects on cognitive function, behaviour, and development.

Was there a missed opportunity by Child Safety to arrange medical assessment for D?

129. The Child Safety officers later told the Systems and Practice review team that neither parent appeared substance affected, the home was clean and tidy, both parents were emotional when speaking about their current circumstances saying they were overwhelmed and open to receiving any form of support, acknowledging they were a family who obviously needed support. Both parents were happy to speak with them and were not defensive, easy to talk to and open. The primary Child Safety officer had completed a police check and was aware neither parent had any drug or criminal history.

130. In any event it was not possible to seek a drug screening test given it was a Friday and tests needed to be completed within 24 hours, meaning one could not be done until the following week. The Child Safety officers told the internal departmental review team drug use was a matter they planned to address with the parents during the Investigation & Assessment.

131. The Systems and Practice Review considered whether the Child Safety officers should have sought a medical assessment for D. The Child Safety officers both recalled the boys looked slightly smaller but did not look sick at all. They were happy, engaging and showed off tricks on their bikes outside. The Child Safety officers were aware the notified concerns indicated D was unwell but her presentation that day appeared to them to be related to a developmental delay rather than an immediate harm concern. She was smiling, appeared alert, interacting and playing and did not appear lethargic. The parents voiced their worry she was not eating food or meeting developmental milestones.

132. The review team considered that while the notified concerns appeared to be developmentally related, after sighting D who was extremely pale and thin, and hearing from the parents she was not eating sufficiently, an expedited medical assessment was needed to confirm if D was unwell or developmentally delayed or both.

133. The review team considered further discussion was needed with D's parents to explore whether they had sought medical advice regarding their concerns about D's developmental delay, sleeping and eating problems, and when D had last been seen by a medical professional. It did not appear they had sought medical attention for D despite their own concerns regarding her development.

134. The review team identified a missed opportunity leaving the parents without a definite plan for when D would be seen by a medical professional to gain insight into what may be impacting her health and development, especially regarding her nutrition and reported eating difficulties. Given their own admissions of being overwhelmed and unable to get to appointments, including the not yet actioned referral for developmental assessment for D, it appeared that an explicit plan for agreed follow up was necessary.

135. Systems and Practice Review Committee members agreed D required a medical assessment in the context of the worries regarding her health and presentation clearly outlined by a non-professional notifier, the professional notifier who had seen D and the parents' and siblings' accounts of D being unable to sleep, her undereating and only being able to tolerate certain soft foods without vomiting, incessant crying and obvious developmental delay. This constellation warranted seeking an undertaking from the parents that they would have D medically assessed.

136. The relevant Child Safety Regional Director acknowledged that assessments of non-verbal infants, toddlers and children and understanding their vulnerabilities and fragility, and how quickly they can deteriorate leading to serious injury or death, was a key area of practice for the Region requiring further development. The Region's workers were subsequently referring to Suspected Child Abuse and Neglect (SCAN) to raise the visibility of a case with regional health colleagues.

137. The Child Death Review Board also agreed D warranted an expedited medical assessment.

138. In the Child Death Review Board: Annual Report 2023–24, the Board acknowledges that "*child protection practitioners are not expected or supposed to make health and development related assessments, nor decisions on whether a child is experiencing medical, health or developmental issues. The Child Safety Practice Manual directs that during any investigation, a medical examination or assessment by a health professional may be considered necessary to inform the investigation outcome. In determining whether neglect is occurring and/or a child is experiencing medical, developmental or health issues, seeking expert advice is essential to inform risk assessments. Ultimately [D] was assessed as safe, despite her meeting all of the vulnerability criteria and some of the immediate harm indicators*."

139. In March 2025, Dr Meegan Crawford, Chief Practitioner, provided a statement explaining how the practice guide *Assess harm and risk of harm* clearly outlines the child, parental, family, and environmental factors that may increase a child's vulnerability and risk of harm. Of relevance to D's situation were her young age, dependence on her parents, limited ability to communicate, feeding difficulties/food aversions and developmental concerns. The practice guide explains how the stresses and higher demands of managing a child with significant needs may the parent's ability to meet the child's need. The relevant

parental risk factors were parental substance misuse and mental health, parents' own experience of childhood abuse, parental stress, and unrealistic parental expectation. The practice guide explains how the presence of parental factors may increase the risk to a young child when a parent's inability to prioritise the child's needs over their own needs is diminished.

140. Further the practice guide highlights the need for practitioners to use extra vigilance when undertaking an assessment to identify the presence of any immediate harm indicators and ensure the immediate safety of an infant or young child if the risk indicators are identified.

141. Dr Crawford considers that application of the practice guide would have supported Child Safety officers to consider medical neglect and medical concerns as a possible explanation for D's presentation and consider seeking medical advice on the day of the home visit.

142. Dr Crawford's statement also explains how the Child Safety Practice Manual procedure *Investigate and Assess* guides department staff to gather information from medical or other agencies as the first step of the Investigation & Assessment. It outlines the need to consider in the planning process whether medical assessment or treatment might be needed for a child and if so to consult with the appropriate health or medical services. The procedure provides guidance about when a medical examination or specialist assessment may be necessary to ensure the child's immediate health and safety or inform the investigation and assessment outcome including to assess the impact of long term neglect, the child's development or to diagnose a suspected disability. The procedure guides departmental officers to arrange immediate medical examination of any child who appears ill, is in a poor physical condition or is dehydrated or in the case of a young child or infant who displays poor feeding or lethargy, preferably by a paediatrician with child protection experience.

143. Dr Crawford advises this procedural advice does not differ significantly from that in place when D died. In her opinion, the Child Safety officers' observations of D as extremely pale, very thin and taking small shaky steps warranted expedited medical assessment particularly given the family's financial difficulties and the older children's disclosures of missing meals. One option available to Child Safety officers was to transport D and her parents to hospital.

144. The *Investigate & Assess* procedure also sets out when a SCAN referral should be considered. The Systems and Practice Review noted the Child Safety Officers had intended to complete a SCAN referral. Dr Crawford considered that given the concerns about D's presentation, ongoing concerns reported by a family member and the possibility of an underlying developmental delay or a medical condition, a SCAN referral should have been prioritised for D. A SCAN team discussion would have provided an opportunity to share information among SCAN team members, inform Child Safety's assessment of future harm and facilitated medical assessment of D. Dr Crawford considers that application of the current SCAN procedure for a child in D's situation should result in an expedited health assessment through negotiation with the parents and support to them to enable a medical examination to occur. In the event parents refuse or fail to follow through, the current practice advice asks departmental officers to consider seeking an assessment order to facilitate medical examination.

145. Dr Crawford advised there was a comprehensive review of the SCAN team system in 2024 following several Systems and Practice Reviews and coronial inquests which highlighted missed opportunities to utilise this system.

146. Dr Crawford acknowledges that despite the availability of all this written guidance, Child Safety did not facilitate assessment of D's medical needs. This highlights the need for Child Safety to train, support and reinforce with its practitioners when to seek medical assessment. This includes through training, regular professional supervision and frequent case consultation with senior practitioners, practice leaders, specialist services clinicians and other stakeholders.

147. I note that prior to D's death Child Safety had 12 Health Liaison Officers across the State. These positions have since been reclassified as Senior Health Liaison roles with greater emphasis on building the capacity of Child Safety staff to understand and navigate the health system and establish local health sector networks. Child Safety also has 17 specialist services clinicians who provide advice and support to practitioners regarding the early identification of disability, health, mental health, and behavioural support needs.

148. At the time of D's death, there was a non-mandatory 120 minute eLearning module on child development in child protection. Dr Crawford observes that guidance around the stages of child development and child development theories assists staff to access the course to understand the difference and/or intersection between developmental and medical concerns. There is a practice guide within the Child Safety Practice Manual providing guidance to practitioners on the expected physical and cognitive developmental milestones for children from birth to 17 years.

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

150. I acknowledge Child Safety has invested in recent years to provide increased support for and build the capability of its workforce through the Child Safety Learning Support Team, and by establishing Practice Leaders in Domestic and Family Violence, Mental Health, Disability, Child Sexual Abuse, Alcohol and Other Drugs and Aboriginal and Torres Strait Islander cultural practices. Practitioners are supported by practice kits within the Child Safety Practice Manual addressing these subject areas. The Disability Practice Kit includes a link to a developmental screening tool for practitioners to assist in the early identification of developmental concerns for a child. In 2023, Child Safety introduced a new mandatory five hour face to face workshop for new Child Safety Officers on understanding disability and how to access supports in the child protection context.

151. The Child Death Review Board observed that D's contact with Queensland Health was almost entirely through her brother's engagement with the Child Development Service. It recommended Queensland Health develop guidelines for clinicians to promote a family centred approach to the provision of health services to children and young people, such that clinicians consider the wellbeing of siblings and can directly refer siblings into the health service, or to the clinician, if risk or health concerns are identified.

152. Children's Health Queensland (CHQ) has since advised it has not actioned this recommendation and following further review and discussion by key stakeholders within the health service it was determined the recommendation was not consistent with the intent of the Queensland Health Specialist Outpatient Services Implementation Standard (March 2023) which states that an internal referral should only be generated where the

patient's condition is deemed likely to result in an Emergency Department presentation or unplanned readmission to an inpatient unit if the patient is not reviewed by a specialist within 30 calendar days (Category 1). Where an appointment is not required within 30 calendar days, the patient's care is to be returned to the nominated GP for assessment and management. If the patient still requires specialist assessment, the nominated GP generates a new referral to the appropriate specialist service as per standard referral pathways. CHQ considers the same principles apply to a sibling who is not a patient of the health service.

153. The Systems and Practice Review also recognised that when parents present as willing and open to help, Child Safety officers can become overly optimistic about their ability to recognise their children's needs based on their positive engagement.

154. The Child Death Review Board's Annual Report identifies the need for child protection practitioners to apply critical thinking even when families are open and engaging because the risk of neglect or harm to a child may still be present.

155. Dr Crawford's statement explains how a new practice guideline *Bias in child protection decision making* alerts practitioners to how cognitive biases may influence assessment and decision making. Of relevance to D's family, the 'halo effect' describes how practitioners who perceive parents who are open and engaging as trustworthy and are reassured by the parents' cooperativeness can overestimate a parent's capacity or miss parental deception. This practice guide is available in the Child Safety Practice Manual.

156. I anticipate these aspects of Child Safety practice will be examined by the recently announced Commission of Inquiry into Queensland's Child Safety system.

The impact of parental methylamphetamine use

157. The circumstances in which D died are yet another tragic illustration of the impact of problematic parental substance use on children and the challenge for frontline child protection practitioners in recognising harmful parental substance use.

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

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

160. The Board's findings highlight the importance of equipping frontline staff with guidance and support to recognise parental substance use and understand its impact on children. It recommended the Queensland Government invest in a practice guide to support frontline practitioners in their risk assessments of children whose parents have problematic substance use. The recommendation highlights the need for the practice guide to

incorporate a framework of identifiable risk indicators, the safety planning mechanisms and wraparound services that must be implemented to ensure a child's safety and clear definitions of the thresholds for intervention types.

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

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

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

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

165. I anticipate this aspect of Child Safety practice will also be a focus of attention for the forthcoming Commission of Inquiry.

Findings required by s.45

Identity of the deceased: [deidentified for publication]

How she died: D died from complications of severe anaemia due to malnutrition and SARS-CoV2 (COVID-19) infection. Her parents were worried about her developmental delay and extremely limited diet. Their concerns were validated by the Child Development Service paediatric Fellow who opportunistically spoke with them during an appointment for D's older brother in early June 2022. There were no indications for urgent clinical review at that time, so the family were given a letter to take to a general practitioner of their choice to arrange tests to investigate D's iron levels and formally refer her to the Child Development Service for developmental assessment. Overwhelmed by their life circumstances including their methylamphetamine use, D's parents were unable to action these steps on their own.

Child Safety became involved with the family over a month later at a time when D's parents were overwhelmed with housing, financial and mental health pressures, and the challenges of raising three children. D's

parents were open about the fact they were not coping. They were not open about their methylamphetamine use. While there were concerns by school staff about parental substance use, this was not identified by the Child Safety officers who visited the family at home on 29 July 2022.

There was a missed opportunity for the Child Safety officers to have identified the need to expedite medical assessment for D given it was evident her parents were clearly struggling and had not yet actioned the letter they were given nearly two months earlier for D. Their openness to whatever support they could get belied their inability to make this happen for D themselves before she became unwell with COVID 19 which tipped her already compromised physiological reserve over the edge. Medical review would have identified D needed treatment for severe anaemia. High caseloads delayed commencement of the Investigation & Assessment. Had the resources been available to commence this phase sooner than occurred, it is possible the Child Safety officer's intention to make a SCAN referral for D could have achieved an expedited medical assessment.

The circumstances in which D died demonstrate the ongoing challenges for Child Safety and other agencies supporting families where parents have problematic substance use. Ds death highlights the need for child protection practitioners to recognise the need for medical assessment during the Investigation & Assessment phase when there are concerns about the health of a young child. Training, professional supervision and access to specialist support are pivotal to equipping child safety practitioners to properly apply the written guidance provided in the Child Safety Practice Manual.

Place of death: [deidentified for publication]

Date of death: 08/08/2022

Cause of death: 1(a) Complications of anaemia and SARS-CoV2 (Covid 19) infection

I close the investigation.

Ainslie Kirkegaard
Coroner
CORONERS COURT OF QUEENSLAND
14 July 2025