QUEENSLAND COURTS

OFFICE OF THE STATE CORONER
FINDINGS OF INQUEST

CITATION:	Inquest into the death of C a 15 month child
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Brisbane
FILE NO(s):	24/2005
DELIVERED ON:	24 June 2011
DELIVERED AT:	Brisbane
HEARING DATE(s):	31/8/09,14/12/09,4/5/10,7/7/10,3/8/10-6/8/10, 9/8/10-10/8/10, 19/10/10
FINDINGS OF:	Magistrate John Lock, Brisbane Coroner
CATCHWORDS:	CORONERS: Burns, trauma, Communications between government agencies
REPRESENTATION:	
Counsel Assisting:	Ms J Rosengren
For the parents, S and H:	Mr G Bursey, South Queensland Law
For NSW Police Commissioner:	Mr P Saidi and Mr P Aitken instructed by the NSW Crown Solicitor's Office
For NSW Department of Human Services:	Ms D Ward instructed by the NSW Department of Human Services
For Queensland Health, Royal Children's Hospital, Toowoomba Base Hospital and staff:	Mr B Farr SC instructed by Minter Ellison
For Queensland Department of Communities (Child Safety)	Mr P Munro instructed by Queensland Department of Communities (Child Safety)

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Glossary

CDCRR:	Queensland Child Death Case Review Report
CDCRC:	Queensland Child Death Case Review Committee
CSO:	Child Safety Officer
CN:	Clinical Nurse
NSW DOCS:	Department of Communities New South Wales
NSW WPP:	The NSW Police Force Witness Protection Program[1]
QHMHS:	Queensland Health Mental Health Service unit at Toowoomba Hospital
QLD DOCS:	Department of Communities (Child Protection) Queensland, formerly known as the Department of Child Safety
RN:	Registered Nurse
TACT:	Triage Acute Care Team of the QHMHS

Family

C: the deceased child aged 15 months and born on 6 June 2004
D: his almost 3 year old brother
T: his 4 month old brother
H: his mother
S: his father

[1] The findings record the evidence from officers of the program in the order of their appearance eg Officer 1, Officer 2 and Officer 3

Introduction

1. C was 15 months old when on 30 October 2005 he was left unsupervised by his parents in a bath of scalding water and suffered burns to 55 % of his body. He died on 1 November 2005.

2. Prior to C's death, C's family was known to the child protection authorities in New South Wales ("NSW DOCS"). His mother, H, also suffered from a mental illness but was non-compliant with treatment.

3. In 2004 the family were placed on the NSW Witness Protection Program ("NSW WPP") as the father S had been involved in serious criminal activity. The family was given a new identity. In 2005 the family were relocated from NSW to Toowoomba for security reasons.

4. H first came to the attention of Queensland Health Mental Health Services ("QHMHS") and then later to the Queensland Department of Child Safety ("QLD DOCS"). Workers with both Queensland Departments became aware of the involvement of NSW WPP and that the family were under witness protection, but they were not aware of the family's NSW DOCS history. At the time of C's death neither QHMHS nor QLD DOCS had any active engagement with the family.

5. After he received the burns C was transferred from Toowoomba to a major tertiary hospital in Brisbane. Despite expert medical treatment, C's condition deteriorated, but in a manner his treating clinicians considered not in keeping with a typical burns patient. The presence of internal injuries were identified. Some form of severe trauma other than from the burns was considered a possible cause of the internal injuries.

6. An autopsy examination confirmed the clinical findings however the pathologist indicated there had been rare reports of internal injuries such as found in C occurring in severe burns cases. The cause of death was opined to be due to complications from burns.

7. During an extensive police investigation C's mother H, gave a number of inconsistent versions as to the events that resulted in C suffering the burns. She tried to blame his 3 year old brother D. His father, S, gave relatively consistent versions. The Queensland Police Service ("QPS") charged both parents with offences including causing grievous bodily harm. These charges were later reduced to child neglect charges for which they received a good behaviour bond.

8. The main issues for the inquest were:

    a. what impact did the actions/inactions or breakdown in communication between the various government authorities in New South Wales and Queensland have in relation to the circumstances leading up to the death of C;
    b. how did the burns and/or trauma occur; and

c. determining the medical cause of death and whether it was due to burns, trauma or a combination of both; and
d. could any recommendations be made which may help to prevent deaths happening from similar causes in the future.

9. Prior to the inquest, and again at the commencement of the inquest QLD DOCS and the NSW Police Commissioner sought orders prohibiting the disclosure and publication of any information that may tend to identify C, members of his family or their current location and the identification of officers of the NSW WPP. I made those orders which are to remain in force indefinitely. For completeness my findings de-identifies all witnesses who gave evidence in the proceedings other than QPS officers and medical witnesses.

10. Section 45 of the Coroners Act 2003 ("the Act") provides that when an inquest is held into a death, the coroner's written findings must be given to the family of the person who died and to each of the persons or organisations granted leave to appear at the inquest. These findings will be distributed in accordance with the requirements of the Act and also placed on the website of the Office of the State Coroner.

The scope of the Coroner's inquiry and findings

11. A coroner has jurisdiction to inquire into the cause and the circumstances of a reportable death. If possible he/she is required to find:-

    a. whether a death in fact happened;

    b. the identity of the deceased;

    c. when, where and how the death occurred; and

    d. what caused the person to die.

12. There has been considerable litigation concerning the extent of a coroner's jurisdiction to inquire into the circumstances of a death. The authorities clearly establish that the scope of an inquest goes beyond merely establishing the medical cause of death.

13. An inquest is not a trial between opposing parties but an inquiry into the death. In a leading English case it was described in this way:- "*It is an inquisitorial process, a process of investigation quite unlike a criminal trial where the prosecutor accuses and the accused defends… The function of an inquest is to seek out and record as many of the facts concerning the death as the public interest requires*." [2]

14. The focus is on discovering what happened, not on ascribing guilt, attributing blame or apportioning liability. The purpose is to inform the family and the public of how the death occurred with a view to reducing the likelihood of similar deaths. As a result, the Act authorises a

[2] *R v South London Coroner; ex parte Thompson* (1982) 126 S.J. 625

coroner to make preventive recommendations concerning public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in future.[3] However, a coroner must not include in the findings or recommendations, statements that a person is or maybe guilty of an offence or is or maybe civilly liable for something.[4]

The admissibility of evidence and the standard of proof

15. A coroner's court is not bound by the rules of evidence because the Act provides that the court "*may inform itself in any way it considers appropriate*."[5] That does not mean that any and every piece of information, however unreliable, will be admitted into evidence and acted upon. However, it does give a coroner greater scope to receive information that may not be admissible in other proceedings and to have regard to its origin or source when determining what weight should be given to the information.

16. This flexibility has been explained as a consequence of an inquest being a fact-finding exercise rather than a means of apportioning guilt; an inquiry rather than a trial.[6]

17. A coroner should apply the civil standard of proof, namely the balance of probabilities but the approach referred to as the Briginshaw sliding scale is applicable.[7] This means that the more significant the issue to be determined; or the more serious an allegation; or the more inherently unlikely an occurrence; then in those cases the clearer and more persuasive the evidence should be in order for the trier of fact to be sufficiently satisfied that it has been proven to the civil standard.[8]

18. It is also clear that a coroner is obliged to comply with the rules of natural justice and to act judicially.[9] This means that no findings adverse to the interest of any party may be made without that party first being given a right to be heard in opposition to that finding. As *Annetts v McCann*[10] makes clear, that includes being given an opportunity to make submissions against findings that might be damaging to the reputation of any individual or organisation.

19. If, from information obtained at an inquest or during the investigation, a coroner reasonably believes that the information may cause a disciplinary body for a person's profession or trade to inquire into, or

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[3] Section 46 of the Act
[4] Sections 45(5) and 46(3) of the Act
[5] Section 37 of the Act
[6] *R v South London Coroner; ex parte Thompson* per Lord Lane CJ, (1982) 126 S.J. 625
[7] *Anderson v Blashki* [1993] 2 VR 89 at 96 per Gobbo J
[8] *Briginshaw v Briginshaw* (1938) 60 CLR 336 at 361 per Sir Owen Dixon J
[9] *Harmsworth v State Coroner* [1989] VR 989 at 994 and see a useful discussion of the issue in Freckelton I., "Inquest Law" in *The inquest handbook*, Selby H., Federation Press, 1998 at 13
[10] (1990) 65 ALJR 167 at 168

take steps in relation to, the person's conduct, then the coroner may give that information to that body.[11]

Events leading up to 30 October 2005

20. C was aged 15 months when he died in November 2005. He had been living with his mother, H and father, S. He had two brothers, T who was aged 4 months and D who was nearly 3. There was some confusion, as a result of conflicting statements by H, as to whether S was D's biological father. This is not an issue I need to resolve, although the evidence was informative in relation to issues of credit, particularly in relation to H.

21. The family had been residing in Toowoomba since April 2005. Prior to this they had been living in NSW at two regional locations.

22. C's family was known to NSW Department of Communities (NSW DOCS). There were in total 5 separate notifications made to NSW DOCS between February 2003 and September 2003 in respect to D. The notification made in September 2003 raised the possibility of sexual and physical abuse of D and neglect concerns. Although substantiated as child protection concerns the cases were closed due to "competing priorities".

23. In 2004, C's parents applied to became eligible for protection under the NSW Witness Protection Program (NSW WPP).

24. As part of the assessment process the parents were interviewed by a psychologist. It was noted H had a history of borderline personality disorder bordering on schizophrenia and was non-compliant as to treatment. The psychologist recommended that NSW WPP have regular contact with H.

25. NSW WPP did not support the application by S as it was thought the level of threat was such that alternative avenues could be used. The matter proceed to an appeal to the NSW Ombudsman who overruled the objection, requiring S to be placed on the NSW WPP.

26. In April 2004, C's parents were offered and accepted full protection on to the NSW WPP.

27. Once the family were accepted it is abundantly clear NSW WPP gave them significant support. The evidence of NSW WPP Officer 1 is that their records indicate almost 800 computer database entries record contact with or issues relating to C's family of which 750 relate to the period prior to C's death. The contact made with the family and government agencies is set out in his statement. It is quite extensive with most records on their database made contemporaneously and the

[11] Section 48(4) of the Act

involvement corroborated by evidence from other agencies involved with the family.

28. Once the NSW WPP became involved, the management of the family through NSW DOCS became more complicated because they had been provided with new identities. An arrangement was made between NSW WPP and NSW DOCS that if a notification regarding the new family identity was made, the NSW DOCS file would be flagged so that contact would be made with NSW DOCS employee Mr G (who would have access to the family's previous NSW DOCS history). It is apparent meetings were held with NSW DOCS as early as 23 April 2004 however Mr G thought it was a few months later. Given the contemporaneous files notes of NSW WPP, I accept they are more reliable than Mr G's memory of events over 5 years back.

29. Mr G considered it was inevitable the family would come to the attention of child protection authorities and said as much to Officer 3 of NSW WPP as early as July 2004.

30. Mr G agreed the previous notifications over 2003 contained serious allegations. He was not able to say why the cases had been closed but most likely it was due to "competing priorities" (a reference to other cases requiring more urgent attention and resource issues). He told NSW WPP the previous notifications were too old to now reconsider the information.

31. It is apparent there were two notifications to NSW DOCS about the family under its new identity in late 2004 and early 2005 in NSW. Another report was made to Mr G in 2005, which ultimately was found to be not related to this family but another with the same surname.

32. Mr G was contacted in late December 2004 in relation to an approach to a regional office where the family was living for the installation of an air conditioner and which was not welfare related.

33. However, the evidence supports a finding that the flagging arrangement did not work uniformly well. It would appear from the evidence of Mr G that the alert for D and the alerts for other family members were set up slightly differently on the computer database, probably in error. Whether that was the reason or not, no contact was made with Mr G relating to the family about the February 2005 notification.

34. The 2005 notification concerned allegations that C had serious sun burn, that H may have a mental illness and the state of the family home may pose a risk to the children. The case was closed because of "competing priorities", not because the case was unsubstantiated or had been adequately assessed. At that time the case manager would not have been aware of the previous history of the family because of the change in identity and presumably because no contact was made

with Mr G. Mr G agreed the 2005 risks of harm notification were serious enough that he should have been contacted.

35. In April 2005 the family were relocated by NSW WPP to Toowoomba for security reasons. NSW DOCS was informed of the move by NSW WPP on 5 May 2005, but neither department made any contact with QLD DOCS. It is apparent the reason why NSW WPP informed NSW DOCS was to determine what protocols would be in place if child protection concerns became evident in Queensland.

36. Mr G, without the knowledge of the 2005 notification, told NSW WPP that on the basis any current notifications had been closed in NSW there would not be an automatic disclosure to QLD DOCS by NSW DOCS and there was no obligation for NSW WPP to inform QLD DOCS. Mr G gave evidence that if he had been aware of the February 2005 reports he may have provided that information to QLD DOCS, given the information was only 3 months old, although he was not sure what QLD DOCS would have done with that information.

37. I will at this point mention issues surrounding the state and condition of the family home. Rather than repeating it at length it should be noted that its state was a common and frequent observation made by numerous government employees throughout the extensive records in New South Wales and Queensland. Many witnesses make comment about the uncleanliness and unsanitary condition of the house, wherever the family was residing. It is fair to say most of those witnesses, although concerned enough to make a note of their observation, did not consider the state of the house per se warranted direct intervention as a child protection issue.

38. I accept that if government agencies felt compelled to intervene every time there was a report about a family because of low standard housing conditions then the capacity for agencies to cope would be unsustainable and in any event may not necessarily be evidence that children are at risk.

39. Each witness who gave evidence about the state of the house when they had observed it at their earlier visits was shown photographs of the interior of house taken by Police on the day C was burnt. Without exception, each witness stated the condition of the house was much worse than was evident at earlier visits. Most of the witnesses agreed the substandard state of the house on the day C was burnt could be an indicator of some deterioration in the capacity of the family to cope. It is uncontroversial to say any objective view of the state of the house would consider it appalling.

40. Below are examples of the condition of the house as photographed immediately after C suffered the burns. There are numerous other photographs contained in exhibit E8.

41. About 5 weeks after arriving in Toowoomba, H became a client of the QHMHS. On 10 May 2005 a member of the Triage Acute Care Team ("TACT") was contacted by H to see if her GP had sent a referral as she reported she was feeling weird, having mood swings and feeling paranoid. A TACT team meeting decided an urgent home assessment should be made.

42. Registered Nurse ("RN") Y and Clinical Nurse ("CN") M made a home visit to conduct a mental health assessment the next day. They noted the house was filthy with black smears along the wall, bits of rice on the floor and rotting tomato underneath the table. D and C seemed well fed and clean. H provided a history suggestive of paranoid schizophrenia with depressive features, as well as agoraphobia with panic disorder. H reported hearing voices and eating only white bread for a year as she feared coloured food was poisoned. H advised she was a drug user in the past and a victim of sexual assault. CN M believed H had a debilitating psychotic illness and was concerned as H stated she was pregnant however she had not received any antenatal care and was potentially consuming a diet inadequate to support pregnancy. An urgent medical assessment was arranged for 12 May 2005. When driving home on 11 May 2005, RN Y saw the parents, D and C walking on the street. When CN M was told this, he thought this was grossly inconsistent with the version H had supplied him with, namely a fear of not being able to leave the house.

43. RN Y and Dr D attended the home to conduct an assessment for about an hour on 12 May 2005. The house was observed to be in a filthy state with food and clothing on the ground and it smelt. Very loud music was playing on arrival. A child was wearing only underpants on a cold day outside but did not appear cold. The children otherwise appeared reasonably well cared for. They spoke to H about maintaining an adequate diet while she was pregnant and said they would contact her about prescribing medication and ongoing management.

44. A provisional diagnosis of paranoid schizophrenia with mild depressive illness was made. H also described agoraphobia with panic disorder and social phobia. It was also considered that in the context of an unplanned pregnancy, recently moving to Toowoomba, limited social supports, caring for two small children, serious financial difficulties and a background of thyrotoxicosis with no recent monitoring, that a differential diagnosis included an organic cause for her problems.

45. Dr D's case notes recorded: "there is a risk of neglect toward the unborn child and the current children although at present they appear to be well cared for physically. They should be closely monitored and may need to be reported to DOCS/SCAN."[12]

[12] Exhibit I1.1 page 20

46. The management plan was to include home visits every second day with phone calls on alternate days. There was to be further investigation of organic and medical causes of H's presentation including CT scan, thyroid function tests, full blood count, electrolytes, liver function tests, vitamin B12 and folate assays and serology for HIV, HBV, HCV and syphilis. A prescription was written for antipsychotic medication (Risperidone 1mg every night) and this was to be handed over to H on the next home visit. An admission to hospital was to be considered if clinicians thought there was an increasing level of distress or risk or if H did not respond to medication.

47. A home visit was conducted on 13 May 2005 and the script handed over. The house was again observed to be untidy and odorous.

48. At this point the father S was to travel to NSW to face criminal charges and it was thought he may go to prison. There were concerns expressed to NSW WPP that H may not cope on her own with the children.

49. On 17 May 2005, CN M, Dr P (senior psychiatric registrar) and Dr V (observer) conducted a further home visit. The house was still very untidy. A dark substance was smeared over the walls. An old apple or tomato was under the table and rice and oil were on the floor. H blamed D for the mess. H had not filled the prescription for Risperidone. S advised he had a court matter set down for 2 June and he was going to NSW. The children otherwise appeared cared for.

50. On 19 May, CN L and RN M conducted a home visit. The house was again filthy with food spills on the table, chairs and up the walls. There were old vegetable peelings sitting on the sink and a white powdery film covering the surfaces in the lounge and kitchen. H advised D had thrown milk formula around the house. Clothes were all over the floor in the bedrooms and bathroom. H described cramping in the lower abdominal/pelvic region with lower back pain. H had not obtained any antenatal care other than an interview with a midwife on 16 May. H agreed to go to hospital for an assessment by an obstetrician and gynaecologist. A pile of dirty nappies was in the baby bath. C did not smell particularly clean and his clothes were a bit soiled. D was hyperactive and not doing what he was asked.

51. H was brought in by ambulance to Toowoomba Hospital. She could not manage D's behaviour whilst there. Whilst at the hospital, H was observed eating sandwiches with a variety of different fillings (contrary to her statement she only ate white bread). A social worker was contacted due to concerns about how H would cope generally on account of her mental health issues. There was consideration it may be necessary to arrange emergency care for the children if H needed to stay in hospital. The social worker recommended to TACT that it consider whether psychological and emotional abuse was occurring

plus neglect and whether S was able to perform a protective function to address these factors. H was discharged back home.

52. A home visit by CN M and RN L took place on 22 May. The house was a mess. The huge TV screen was covered in cornflour. H and S blamed D for making the mess the night before, however confirmed they had made no attempt to clean this up. A chair appeared to be wet with liquid that smelt like urine. When the parents were asked about this they did not seem to react. D was running around inside and outside and throwing things into a wheelie bin and the parents did not react to this. CN M challenged H regarding inconsistencies in the information she was providing and her behaviour. The plan was that the case would be discussed with the consultant psychiatrist to consider hospitalisation for diagnostic clarification away from her partner and children to see if paranoia was evident in the hospital setting.

53. On 24 May Dr P and RN L made a further home visit for further assessment and to clarify H's diagnosis. The house was filthy. Dr P could not observe any obvious psychotic symptoms and was of the opinion the symptoms were more in keeping with a neurotic basis, repeated betrayal of trust and low self-esteem. Dr P's view was that H did not have a psychotic disorder but was more likely to be suffering from a mixed anxiety and depressive disorder.

54. Dr P later discussed this diagnosis with the consultant who agreed. The antipsychotic treatment was stopped. A referral to a psychologist was made and antidepressant medication (Fluvoxamine) was to be commenced with a recommendation for an occupational therapist assessment to be conducted to measure H's functioning. Over the next few days various people from TACT made repeated telephone calls and visits to the family home and eventually contact was made.

55. Up to this time it is apparent H and S had been keeping NSW WPP informed of the involvement of QHMHS. Various requests were made by NSW WPP to QHMHS for a report to be provided for S's upcoming court case. It is not clear whether QHMHS were told they were on witness protection but it is most probable that issues concerning witness protection would not have been raised for security reasons. In any case QHMHS decided a report would not be given. H was at this time seeing the hospital for antenatal care.

56. There were a number of further visits by psychiatrists and the TACT team. The house was again in a bad state and there were concerns about how H would cope if S was imprisoned. The case was adjourned but the TACT team arranged for a food parcel to be delivered to H as S was away. By 4 June 2005, CN M was considering a referral to QLD DOCS.

57. NSW DOCS, NSW WPP and the QHMHS did not provide QLD DOCS with any information about the family. However, the family came to the attention of QLD DOCS on 8 June, about 5 months prior to C's death. A report was made to QLD DOCS that a motorist had seen D running around unsupervised on the road.

58. On 9 June Child Safety Officers ("CSO") B and J attended the family. They did not carry out any previous history checks on the family. They could see into the house, which was untidy, with clothes scattered around and full ashtrays. They did not enter the house and later agreed that may have been appropriate. H appeared angry and distressed, whereas S appeared calm and cooperative. During the interview they gathered H had mental health issues, was pregnant and S may be facing incarceration in NSW for traffic offences. The parents advised D was difficult to care for and he had a habit of getting out of the yard. They were advised to contact the Department of Housing about a higher fence. S advised it was difficult to manage H and D and if he was incarcerated H and the children would live with his parents in NSW. CSO B telephoned the Department of Housing about the fence.

59. CSO B then spoke with CN M from QHMHS. CN M confirmed fortnightly visits by himself. CN M admitted he had previously had some concerns about the untidiness of the home and was considering calling QLD DOCS. Of greater concern to CN M was H being almost due to have her child and her capacity to cope with parenting three children. CN M advised H was medicated but there was some question over the regularity of her use of medication. H had been exhibiting a number of concerning traits lately including increasing paranoia and agoraphobia.

60. On 11 June CN M and an occupational therapist conducted a home visit to discuss an occupational assessment to see if H could do tasks like cooking. The house was again very untidy. H and S stated D had messed up what they had cleaned. QLD DOCS involvement was discussed. The parents were happy to receive home support with chores around the house but refused parenting advice. H's prescription for medication had still not been filled because of lack of money. The parents were adamant S's parents would help look after the children if or when S was imprisoned. QHMHS spoke with H regarding non-compliance of medication, and not attending pre-arranged tests (e.g. an ultrasound). This information was passed on to CSO B who had experienced difficulty in contacting and visiting the family on a couple of occasions. CN M tried to take H to her appointments but she told him she could not make them.

61. On 20 June CSOs B and J visited the family home. At that time D had got out of the house yard and H was down the street and screaming. H abused the QLD DOCS workers, clearly distressed. D eventually returned. H continued to abuse them. S advised QLD DOCS that D and C were going to NSW the next day for an indefinite period to be cared

for by their grandparents because H and S were struggling. The case workers again did not enter the home and remained on the verandah. Based on the advice of CN M they spoke to S regarding the dangers of leaving food scraps and nappies around the house as this compromised the health of the children. S stated it would be very rarely those sort of things would be accessible to the children. S was asked to contact QLD DOCS in the event the children did not go to the grandparents. CSO B confirmed this latest information with CN M. This was the last involvement of CSO B until after C's death.

62. CSO B did not on any of the visits actually enter the house and relied on the information from CN M. He knew the family were from NSW but he made no attempt to check with the NSW DOCS as to any history even though there were procedures in place for the exchange of such information. He agreed the child protection history in NSW would have been relevant to how the case would have been managed. He determined there was a substantiated risk of physical harm to the children if S was unable to care for the children. The plan was QLD DOCS would continue monitoring the family situation, both directly and in liaison with the QHMHS. As H was due to give birth to her third child, QLD DOCS sent an unborn child alert. This was to enable QLD DOCS to further assess safety issues when the new child was born. The alert notification was sent but due to time constraints the notification information was not entered in the QLD DOCS database until 18 October 2005. This was just before C died.

63. A SCAN referral was not made. QLD DOCS policy required a referral to SCAN where there was a substantiated risk of harm and no adult was willing or able to protect the children. CSO B was satisfied H was unable to do so and S was a significant risk of going to prison and would be unable to care for the children. His case manager Ms R was of the opinion a referral should have been made.

64. Ms L took over from CN M on 6 July. She was an occupational therapist with QHMHS. She had a handover from CN M. She contacted H and made an appointment to see her. She also attended a Child at Risk group meeting at "paediatrics outpatients". The family was mentioned because H had come to "their" attention because of the unborn child alert and a need for QLD DOCS to be involved. There was a discussion with regards to the safety of the unborn child, issues at hand and the need for QLD DOCS to be involved. Ms L's role was to explain the role of QHMHS and that it was not in a position to perform the role of QLD DOCS.

65. When T was born on 10 July 2005 QLD DOCS was notified by the Toowoomba Hospital. By this time QHMHS and QLD DOCS were aware the family was on some witness protection program but not aware of any previous child protection history.

66. CSO L thought she attended the Hospital on 10 July but it is more likely to be 11 July as this accords with the hospital records and the evidence and records of NSW WPP. A hospital social worker, Ms B advised CSO's L and R that H was showing psychotic symptoms but was not under the care of mental health practitioners as she had been assessed as non-psychotic by medical staff. Ms B advised H was suffering from depression however she had not been prescribed any medication as the doctors were not worried. Ms B also reported H was frustrated with T crying and/or being unsettled and H would walk away from him.

67. S advised CSO's R and L that he was the primary carer of the children and there was a safety plan in place if he was imprisoned. S advised if this occurred, H would be admitted to hospital under the Mental Health Act provisions and he would take T to NSW to reside with his parents. S also stated his parents would bring the three children to Toowoomba and reside with H to help her care for the children. S advised he would contact mental health if he had concerns H was not taking her medication. H advised she could not leave the house and suffered from agoraphobia, depression and was a paranoid schizophrenic. H said she had been on medication for these but had stopped whilst she was pregnant however planned to resume medication again.

68. Prior to concluding there was an unsubstantiated risk of harm to the children, CSO L had two discussions with NSW WPP officer 3, on 11 and 12 July respectively. CSO L was told the family were relocated for security reasons. NSW WPP confirmed D and C were with the paternal grandparents however QLD DOCS could not be provided with names, addresses or contact numbers. CSO L recalled NSW WPP voiced concerns regarding H's ability to care for children if S was imprisoned. The officer advised NSW DOCS were aware of the family.

69. CSO's supervisor, Ms R gave evidence her recollection was that CSO L conveyed to her NSW WPP officer 3 had indicated the NSW WPP would take over QLD DOCS statutory responsibilities in protecting the welfare of the children. CSO L denied this. She and NSW WPP officer 3 gave evidence the effect of their discussion was simply that the NSW WPP would ensure a "safety plan" for the children (the children would reside with the grandparents) was put in place if S was incarcerated.

70. There is some confusion as to the discussions between NSW WPP officer 3 and CSO L regarding the provision of contact details for CSO L to have undertaken inquiries with NSW DOCS. NSW WPP officer 3's evidence was he could not recall whether he provided Mr G's contact details to CSO L. CSO L was certain on neither occasion when she spoke with NSW WPP officer 3 did she request he provide her with contact details to any person from NSW DOCS. She also denied that NSW WPP officer 3 provided her with Mr G's contact details or anyone else's from NSW DOCS. She also refuted that on the second occasion she spoke to NSW WPP officer 3 she indicated to him she no longer

required the contact details for the relevant person from NSW DOCS. This evidence is consistent with the fact CSO L said she thought there were impediments to her obtaining the necessary information from NSW DOCS.

71. A few days later NSW WPP contacted CSO L and confirmed the children were with the grandparents who were prepared to care for the children if there was no other option. CSO L apparently told him she was happy with this. CSO L also spoke to a nurse at Maternity Home Care who said she had been in contact with H and would weigh T each second visit and check he was on the right formula.

72. The records of NSW WPP are well documented and were usually made contemporaneously or shortly after. I agree it is somewhat surprising NSW WPP officers 1 and 2 would consider it appropriate to put together their statements to the police in Queensland in almost identical terms and after consulting with each other and their respective statements. Added to this they also discussed together the evidence of one between adjournments and the giving of evidence of the other, a practice that would ordinarily be criticised. That being said I do not consider the overall integrity of their evidence was impacted as much of it was corroborated and contained in the records of the WPP which I accept were comprehensive.

73. I accept the evidence of NSW WPP officer 3 and CSO L that at no time did he suggest to CSO L that NSW WPP would look after the child protection issues. I accept CSO L was probably told about the existence of a contact person from NSW DOCS but not his details and she may not have followed that up given her unfamiliarity with the NSW WPP. If she had asked I would have fully expected that NSW WPP would have provided these details to her. In saying that CSO L was a frank and honest witness who made concessions in her evidence and any lapses in her memory are explainable due to time between these events and the inquest.

74. In either event it is apparent NSW DOCS were not contacted by CSO L and were not informed of the QLD DOCS interest by NSW WPP. CSO L did not contact NSW DOCS. Her supervisor Ms R agreed they should have been. As to what information she would have been provided, it is somewhat speculative given the evidence of Mr G from NSW DOCS. It is likely even if such an inquiry had been made of NSW DOCS, QLD DOCS would not have been provided with the entire previous history because Mr G would not have known of the February 2005 report. His evidence was had he been aware of the February 2005 reports he would have taken steps to have communicated this information to QLD DOCS.

75. Whether he would have given any information about the earlier 2002/2003 history is also speculative. He may have considered the information "*too old to worry about*" when he spoke to NSW WPP in

May 2005, but I accept that was in a different context to potential later discussions with child protection officers from within NSW or interstate.

76. Whatever may be the case there was, in my view uncontroversial evidence given by the witnesses from QLD DOCS that such information would have been relevant to their assessments and decisions. This is because it could have demonstrated a pattern of behaviours and may have caused them to question the appropriateness of S assuming the primary care giving role for the children.

77. At the time of completing her assessment, CSO L was not aware of the previous NSW DOCS history. Nor was she aware of the notification and assessment of substantiated risk of physical harm made by QLD DOCS a few months earlier by CSO B because that information had not been updated on the system by him. However, her supervisor Ms R gave evidence that had CSO L undertaken a search of the family, information would have been available to the effect a notification had been made and the assessment remained open. For reasons not explained, such a search was not undertaken. Further CSO L was certain she did not discuss the case with CSO B.

78. CSO L finalised her assessment and this was written up on 24 July 2005. CSO L concluded the risk of harm to the children at this time was unsubstantiated and the only ongoing concern was if the children were left in the sole care of H. CSO L was satisfied this would not occur as a safety plan was in place for the children to live with the grandparents in NSW, in the event S was incarcerated. CSO L's assessment was approved by Ms R on 25 July 2005.

79. CSO L conceded that prior to closing the case she should have undertaken an assessment of the home. One of the factors CSO L placed reliance on in concluding the risk of harm to the children was unsubstantiated was that H had told her she received regular visits from "mental health". This was inconsistent with information provided by a social worker at the hospital, to the effect there was no such involvement. CSO L accepted it would have been appropriate to have made contact with CN M to ascertain his level of involvement. When questioned regarding this issue, Ms R stated she had thought CSO L had made contact with CN M. It is unlikely this occurred.

80. CSO L also conceded the case was closed prematurely in that there were inconsistencies between information being provided by H and S and other persons involved with the family and also the fact S's possible incarceration was less than a month away. She agreed there was no reason why the case could not have remained open for continuous monitoring.

81. QLD DOCS had no further involvement with the family prior to C's death. It appears the reason for this was that it was their

understanding NSW WPP and QHMHS were going to continue monitoring the family. There is some suggestion in the QLD DOCS records that NSW WPP were obstructing further investigations. Indeed the Child Death Case Review Report ("CDCRR") found the assessment by CSO L was restricted by NSW WPP officers. There is no basis for that assertion.

82. It was CSO L's perception that the involvement of the NSW WPP impaired to some extent, her assessment of the family and the decisions she made relevant to the welfare of the children. The evidence would support that this perception could not be said to arise out of any information directly provided to her by NSW WPP. Rather, it seems to have arisen as a consequence of CSO L's understandable unfamiliarity with the operations and responsibilities of witness protection programs. She had not previously been required to conduct assessments where witness protection was involved and does not recall receiving any guidance from Ms R as to how to manage such cases.

83. The consequence of CSO L's perception in this regard was that she did not undertake relevant inquiries which she would ordinarily have done. For example, she made the assumption she could not obtain criminal history checks or child protection history checks from NSW DOCS.

84. QHMHS continued providing assistance to H until 11 days prior to C dying. The records indicate the QHMHS made frequent contact and home visits over this period. H was evidently not taking her medication and continued to miss appointments. The house continued to be messy with food on the floor, toys on the floor and many dishes in the sink. A letter was written on 20 September advising H that unless she made contact she would be discharged from the service. RN Y conducted a home visit on 7 October and described the house as a "bombshell" and smelly.

85. On 19 October a case conference determined she should be managed by her GP as she did not engage with the QHMHS when offered appointments unless they were home appointments. QHMHS contacted the GP to make the arrangements and advised S.

Conclusions about the interactions of Government Agencies

86. Overall it is considered the NSW WPP provided substantial support to this particularly difficult family. The family was suspended from the WPP on 2 November 2005 and terminated on 1 December. At first glance this may seem to be a hasty step but the file of NSW WPP and other evidence is redolent with examples of continued breaches of the program by the family which would have clearly compromised the security of the program and by the time of C's death there would have been little point in continuing.

87. I accept there is a difficult balancing act between the need to protect information from becoming public which would reduce the possibility of risk to the security of those on witness protection and to ensure other relevant information which may impact upon how other government agencies would deal with child protection or mental health concerns is disseminated.

88. I accept NSW WPP was proactive in its contact with other government agencies including QHMHS and QLD DOCS. The security of the program would also no doubt be an important matter for its officers. Whilst I accept there was no direct impediment made by NSW WPP to the supply of relevant information if requested, the fact there was a witness protection issue did create a misconception on the part of some individuals within QLD DOCS as to what information could be made available.

89. It is apparent the arrangement put in place with NSW DOCS was flawed, although that would seem to be a systems issue with NSW DOCS rather than to do with the NSW WPP.

90. The CDCRR found there were no existing protocols for confirmation of a parent's criminal and child protection history where their former identity is protected under a witness protection order and there were no existing protocols for communication between QLD DOCS and witness protection authorities in relation to the sharing and management of information between these entities. I would agree this is the case and recommendations will need to consider how this should be addressed. The sharing of information appears to be on an ad hoc basis and it is important the witness protection agencies consider how the sharing of information in the future should be better facilitated.

91. The CDCRR made a recommendation that QLD DOCS investigate and develop, as necessary, a protocol for the sharing of child protection information with agencies responsible for the WPP in Queensland.

92. In a response to a request made by me about whether this recommendation had been implemented, the then Director-General stated the recommendation had been conditionally endorsed and completed.[13] QLD DOCS had liaised with the QPS Child and Sexual Assault Unit in considering the level of advice to be provided to QLD DOCS when investigating and working with a family who were subject to the WPP. QPS stated the witness protection program was administered by the Crime and Misconduct Commission with the operation of the program occurring within the Witness Protection Unit of QPS. It noted QPS Standing Procedures outlined rigid guidelines for ensuring the safety and well-being of a child and family subject to the witness protection program. These procedures include daily welfare checks with the family in the first three months of the program, and

[13] Exhibit H3

regular visits to assess medical and mental health. The procedure also included the need for police to ascertain whether the subject family had contact with other authorities, including child protection, and if so, a police officer was to make direct contact with the authorities.

93. The response also noted the issues outlined involved an interstate witness protection program. The host state retains case management authority for the family. Cross jurisdictional issues had been placed on the Witness Protection Program National Meeting agenda, and internal operating procedures are in place for QPS to liaise with other states.

94. In submissions for the Commissioner of NSW Police Force it was noted the safety of the witnesses and their families is the priority of such programs and preventing the disclosure of personal details of protected witnesses is the primary concern. Witness protection legislation in all jurisdictions contains substantial penalties to discourage disclosure of any information that may jeopardise individual witnesses or the integrity of the witness protection program itself. The submission was there needs to be a great deal of flexibility and adaptability built into any processes developed for the dissemination of information to other agencies, rather than running on a strictly formulated set of guidelines.

95. Given the diversity of cases that may be the subject of such programs, I accept a formal protocol or guideline may not be appropriate. However, the evidence does support that on a national basis, this case be considered at the National Meeting to consider how a more effective exchange of information and communication with other government agencies could be put in place. How that is done would be best left to the witness protection programs. It may already have been considered.

96. It is apparent NSW DOCS had resource issues concerning the investigation and assessment of child protection notifications which may have impacted in this case, but NSW is not alone in that respect. It is also accepted there is a finite pool of funds and how that is best allocated is a matter for government to determine. Of significance for NSW DOCS is that in 2008 Justice Wood conducted a Special Commission of Inquiry into the NSW Child Protection System. The final report made many recommendations on areas which no doubt coincided with the issues identified in this case, but also took a much broader scope in relation to the child protection system generally. Cross-Jurisdictional issues aside, it is not considered this inquest could possibly make any meaningful recommendations concerning NSW DOCS which have not already been considered by the Commission of Inquiry.

97. The CDCRR unsurprisingly found the information provided in relation to the 8 June 2005 notification by mental health services should have triggered a more comprehensive investigation of the home environment. It found there was insufficient coordination with TACT in clarifying QLD DOCS' role with the family in the investigation and

assessment. It was thought QHMHS did not fully appreciate that QLD DOCS was not actively involved with the family and were relying on QHMHS to provide updates about the parents' resumption of care. The review found there was a misapprehension by both services about the nature and level of the other services' involvement with the family.

98. The CDCRR found the 8 June assessment was inadequate in its scope as it did not consider relevant criminal history or thoroughly investigate concerns about environmental hazards to which the children were exposed. It found the case notes were not completed to allow access to the information during subsequent investigations and assessments.

99. The CDCRR considered CSO B required additional training in conducting thorough assessments. It also noted the Structured Decision-Making Tools which have since been introduced, including Risk Evaluation, Safety Assessment and Safety Planning, increase the opportunity for processes to be well managed. In relation to that issue the Child Death Case Review Committee ("CDCRC") and QLD DOCS noted the staff concerned had attended further training in Structured Decision Making and record keeping training.

100. The CDCRR recommended QLD DOCS consider increasing resources to the child safety service centre in question to ensure all investigations and assessments were completed in accordance with procedural guidelines. It was noted the recommendation had been completed and six extra staff plus a backlog team were employed subsequent to the review albeit noting final resources were subject to budget availability.

101. The CDCRR also found the investigation and assessment of the 10 July notification was inadequate in its scope and inconsistent in its detail. It also contained inaccuracies in the recording of dates. It found CSO Ms failed to consider the home environment, ascertain the role of mental health service or assess comprehensively S's capacity to care for the children. It also noted the intervention of NSW WPP restricted CSO L's enquiry into the child protection concerns. Subject to the finding already made on the last issue I agree the evidence supports those findings.

102. The CDCRC recommended QLD DOCS give further consideration to the adequacy and appropriateness of QLD DOCS' protocols in relation to communication and cooperation with external agencies, particularly with mental health services and take appropriate action to address any deficiencies identified. QLD DOCS advised governance arrangements and guiding principles are dictated by an inter-agency Memorandum of Understanding with QLD DOCS, Disability Services Queensland, Queensland Health, Queensland Police and noted the existence of a number of interagency steering committees from the level of Directors General and Child Safety Directors through to local interagency steering committees, all of which were critically considering those issues.

103. There was also a recommendation QLD DOCS give further consideration as to whether any departmental staff performed their duties carelessly, incompetently or inefficiently or whether disciplinary action should be referred or warranted. I am not aware as to the outcome of that recommendation however I agree with the submission of Counsel who appeared for QLD DOCS that there was no evidence to suggest any employee had done any act or made any omission that amounted to official misconduct or that there should be a referral to any disciplinary body.

104. I do not consider there are any issues arising from the actions of the mental health authorities which would warrant particular comment or require recommendations. The QHMHS appeared to provide very appropriate, and at times, staff resource intensive service to which H was not particularly receptive. The decision to discharge her from the service whilst at the same time setting up an alternative care program with a GP was appropriate

How did the burns and/or trauma occur?

105. About 6 weeks prior to C's death he was a passenger in a taxi which was involved in a minor accident. He did not appear to sustain any injuries and neither did anyone else who was in the taxi. In the week or so prior to C's death, his parents recall there were a few incidents where C fell over and the like. These included him falling over in the hall way at home and sustaining a blood nose, falling off a table in the lounge room, having D kick him and having D jump off a couch and landing on C's head and back. C did not appear to sustain any serious injuries from these various incidents. In the days leading up to him suffering the burns, C was apparently eating normally, had normal bowel movements and was behaving as he always did.

106. D was nearly 3 years old. D's behaviour was difficult for his parents to control and it would seem likely he suffered from a form of Attention Deficit Hyperactivity Disorder. H stated D has now been diagnosed with this condition and is taking medication. There is ample evidence from other reports of his difficult behaviour at times. His mother described D's behaviour towards C as "nasty" and that he would hit and kick C. H told police in an early interview of an incident a week before where D had jumped from a couch and landed between C's head and back. S gave evidence he suspected D had hit C with the bed slats from the bedroom they occupied which had clearly been pulled apart, presumably by D. S also indicated C had a black eye caused by D. S told police D could turn taps on and off. He attempted to resile from that position when he gave evidence.

107. The significance of this evidence (most of which H now says she cannot remember saying to police) is twofold. Firstly, it has significance as to the level of supervision provided to the children. Secondly, it has some significance when looking at whether there is some other

explanation for an incident of trauma which could possibly explain C's internal injuries identified later.

108. The burns occurred on 30 October 2005. The events of the morning are not certain although it would seem H may not have risen until late in the morning around 11. It is apparent C had lunch, which included spaghetti. D may have thrown some of it around according to S but whatever is the case C was left with spaghetti on his clothes. Following this H took C to have a bath to clean off the remnants of his lunch. S remained in the lounge room. D followed H and C into the bathroom. A short time later S went to the toilet which was next to the bathroom and saw C in the bath, sitting up and splashing about.

109. S returned to the lounge room and a short time later commenced watching the movie, "Herbie". The Channel Seven records show the movie started at 2.40pm.[14] S recalls after the movie started H came to the lounge room and asked S if he was taping the movie for the kids. H has given conflicting versions as to whether she left C in the bath prior to going into the lounge room. Initially she denied this but later admitted it. S and H talked in the lounge room for a short period of time. S remembers H going into the kitchen and he thought she was getting a drink of water. H denies she got a drink of water. It was not clear from their statements to QPS just how long all this took (i.e. how long C was unsupervised) with time estimates varying from a few minutes up to 15 minutes.

110. H and S told QPS they both recall hearing a banging and moaning noise. S went down the hallway to investigate and when he got to the bathroom, he found C flopping around the bath with steam coming off the water. C's feet were closest to the bath taps and he was facing downwards. His arms were trying to hold his body up but they kept on giving way. His legs and stomach were submerged in the water. The hot water tap was running and D was leaning over the bath playing with them. S told the QPS whilst he could not recall whether D's hand was on top or underneath the tap he did however recall there was nothing obstructing the water from flowing.

111. S called out to H to get an ambulance. He pulled C out of the bath. C was not screaming or crying. He was just saying "daddy, daddy". S turned off the hot water, turned on the cold water and pulled out the plug in the bath. S told QPS when he put his hand in the water it was stinging from the heat.

112. Once the water cooled down, S placed C back in the bath with the cold water running and the plug out. He used his hands to direct the cold water over C. He then ran to his bedroom, took the doona off his bed, ran back into the bathroom and splashed it with water. He then picked C up out of the bath and placed him in the doona. S carried C out into

[14] Exhibit C21

the lounge room and placed him on the floor so he could wrap the doona around him properly. S left him on the floor while he went to the fridge to get a cold water bottle but there were none there. When he got back into the lounge room, C appeared to have rolled off the doona onto the floor. He picked him up, wrapped the doona around him again and took him outside.

113. H told the QPS during the course of the video re-enactment that once it was apparent C was burnt, she went to the door leading onto the verandah, realised it was locked, retrieved the key off the top of the television, unlocked the door and ran out of the house yelling for an ambulance to be called.[15]

114. The ambulance records confirm triple O was called at 3.08pm and the ambulance arrived at 3.12pm. Ms B was the next door neighbour. She recalled hearing H yelling out for an ambulance to be called. H arrived at her door within seconds and immediately called the ambulance. Ms B estimated the time between hearing H yelling out and the ambulance being called, to have been a matter of seconds rather than minutes.[16]

115. C was transported to the Toowoomba Hospital and then, because of the severity of his condition, was flown by helicopter to the Royal Children's Hospital ("RCH"). He arrived there at about 6.30pm. C's condition progressively deteriorated over the following day and there were concerns his deterioration was not in keeping with a typical burns patient.

116. A comprehensive investigation was undertaken by the QPS Child Protection Investigation Unit at Toowoomba under the lead of Detective Sergeant Darren Lees. The QPS were advised of the incident at about 3.15pm and attended the home at about 5.00pm. The father S was present and told police of his involvement with the NSW WPP. A crime scene warrant was obtained.

117. The version of events provided to police by S was that the children had eaten spaghetti and sausages for lunch and had become filthy from eating spaghetti. H decided to take C for a bath. D followed and sometime later S went to the toilet and could see C was in the bath splashing around with H. D was also in the bathroom. S told police there was a movie called Herbie on television and he was taping it. A short time later H came out of the bathroom and discussed the taping of the show and went to the kitchen to get a drink of water. S told police he heard the sound of hot water running through the pipes of the house as they made a distinctive noise. He then heard a scream and he ran to the bathroom area.

[15] Exhibit D6 p 12
[16] T10-4

118. When police later spoke to H at the RCH she provided a version of events which was inconsistent in that she told them she could not recall how C got to the bathroom and into the bath.

119. Subsequently both parents were interviewed a number of times as to their versions of what occurred. It became apparent there were several inconsistencies in their stories especially in the version supplied by H. S's version remained reasonably constant but H's version changed a number of times and it was not until the last interview on 6 November 2005 she finally admitted to police she had left C in the bath with the plug in and approximately 10cm of water in it.

120. Prior to making these admissions to the police on 6 November 2005, there were seven separate occasions where H had provided versions as to the circumstances in which C came to be burnt. On each such occasion she sought to lay the blame on D, her three year old son. Some examples of the versions provided included:

a D had put the plug into the bath and C fell in;[17]
b H did not realise D and C had gone into the bathroom and D must have placed the plug into the bath;[18]
c H did not know whether the plug fell in or whether D placed it in;[19]
d D lifted C into the bath. She did not know whether the plug was in the hole or it had fallen in;[20]
e C was crawling around the floor and must have fallen into the bath and D put the plug in;[21]
f There was no water in the bath and somehow the plug fell into the plug hole or D dropped it off the side;[22]
g C was playing in the lounge room and it wasn't until later H discovered he had made his way into the bath room. C had hopped into the bath, the plug had somehow fallen off the bath and D turned the tap on;[23]
h After bathing C, H pulled the plug out;[24]
i H pulled the plug of the bath before getting C out and putting a nappy on him. She did not leave C in the bath.[25]

121. During the course of the investigation, QPS used covert information gathering techniques in an attempt to obtain information about the injuries sustained by C. There were no admissions made during the time those techniques were deployed by either parent of having committed any deliberate act upon C.

[17] Annexure to Exhibit C9.1
[18] Exhibit C9.1
[19] Exhibit C17.2
[20] Exhibit C40.2
[21] Exhibit C33
[22] Exhibit D1
[23] Exhibit D1 p 13
[24] Exhibit D1 pp 24 – 25
[25] Exhibit D3 pp 84 – 96

122. After both parents were interviewed for the last occasion in late December 2005 it was concluded there was insufficient evidence to charge either or both parents for offences leading to the death of their son however they were charged with grievous bodily harm, negligent acts causing harm and three offences of cruelty to children. Subsequently the charge of grievous bodily harm was not proceeded with by the Crown and H and S pleaded guilty to the other charges and were given a good behaviour bond.

123. When H gave evidence she continued in her attempts to distance herself from having any responsibility for the tragic circumstances in which C came to be burnt. The tenor of her evidence was to the effect she could no longer recall the events of the day C was burnt and the days subsequent to this when she was repeatedly interviewed by police. She sought to assert one explanation for this was she had ceased taking her medication on the day C was burnt.

124. H gave the very distinct impression of being an untruthful witness. She was histrionic during most of her evidence. She was unhelpful and had to be drawn almost screaming by Counsel Assisting to provide a version of events. Her efforts to continue to distance herself from responsibility and blame her 3 year old son were extraordinary and indicative of her character.

125. It is difficult to be certain how long C was left in the bath in the absence of parental supervision. It is without any real doubt it was longer than the few minutes both parents would have the court believe. S provided inconsistent versions to investigating officers regarding the timing of events after he returned from the bathroom. There is sufficient evidence to suggest S sat back down in the lounge room shortly before or shortly after the movie "Herbie goes to Monte Carlo" commenced on the television. S told the QPS on two separate occasions that H returned to the lounge room a couple of minutes later.[26]

126. It is likely it was a few minutes prior to 3.08pm that S and H heard the banging from the bathroom which caused S to go and ascertain its source. Even if it is to be assumed H did not go from the bathroom to the lounge room until about 2.50pm, it can be concluded C and D remained unsupervised in the bathroom for at least ten minutes and most likely up to 15 minutes. The bath had the plug in and there was probably a number of centimetres of water in the bath already. It is most likely D turned the hot water tap on and this caused the burns. In any event the children were left unsupervised.

127. The hot water tap was tested following C's death. The temperature was found to be 65° C. At this temperature, Dr Harvey considered C would only have to have been immersed in the water for approximately

[26] Exhibit D2 p 6 and exhibit D5 p 16

one second. However, the calculation is complicated by the fact H had left C in approximately 10cm of lukewarm water up to fifteen minutes prior to C sustaining the burns. Dr Harvey explained this scenario was likely to lengthen the time C was immersed in the hot water but could not provide an estimate as to how much longer.[27] There was evidence from S a kettle was also left in the bathroom. Dr Harvey considered it was more likely the burns were caused by C being immersed in the water rather than D having poured a kettle of boiling water over him. The distribution of the burns supports this conclusion.[28]

What is the cause of C's death?

128. The severity of the burns was such that C was airlifted to the Royal Childrens Hospital (RCH). C's condition progressively deteriorated over the following day and there were concerns his deterioration was not in keeping with a typical burns patient.

129. It was decided to take him to surgery because of concerns with abdominal distension. He was taken to the operating theatre at around lunchtime on 1 November. It was discovered C's entire abdomen was gangrenous or dead which related to impaired blood supply (ischaemia). Tears to the mesentery (fat around the small bowel) were also found as was a perforation to the stomach. The clinicians considered such injuries are usually only seen in cases of serious trauma and not from burns. The medical team decided his condition was irreversible and he died later that day. There was a concern raised late in the coronial investigation by H and S that the internal injuries were caused during the operation (by the insertion of a pigtail catheter) and of a possible delay in diagnosing the internal injuries.

130. An autopsy examination confirmed the clinical findings but stated there had been rare reports of internal injuries such as found here occurring in severe burns cases.[29] The pathologist, Dr Milne opined he could not rule out some form of trauma may have been inflicted upon C. He also stated he could not exclude that the tearing of the mesentery and damage to the stomach wall may have been caused when medical staff were placing the drain prior to surgery. The cause of death on the autopsy report was opined to be due to complications from burns. With the benefit of further information provided just before the inquest Dr Milne had come to a different conclusion.

131. A number of other medical opinions were sought by investigating police and statements were tendered to the inquest. A summary of their evidence follows.

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[27] T10-66
[28] T10-72
[29] Case Report A4.12 "*Severe gastrointestinal haemorrhage and ischaemic necrosis of the samml bowel of a child with 70% full thickness burns"*

132. Dr Choo[30] was the consultant paediatric surgeon who saw C when he arrived in hospital. He stated the abdominal injuries were caused by severe blunt force as evidenced by:

a. the existence of petechia;
b. the fact the mesentery was torn;
c. C did not exhibit the degree of shock required as a result of the burns for the blood flow to the gut to be affected to cause it to die; and
d. there is not necessarily evidence of bruising where there is a blunt force to the abdomen. Further, bruising can be masked by burns.

133. Dr Coulthard[31] is a paediatric intensive care physician who was part of the treating team. He:

a. conceded that in hindsight petechia were a clue to abdominal injuries;
b. had never seen the type of internal injuries C suffered and he was of the opinion external force would have been required to cause them;
c. found no external marks on C that would suggest he was struck by a weapon such as a bed slat. In any event the extensive internal injuries were unlikely to have been caused by such an instrument;
d. observed there was a small bruise on his left temporal region:
e. did not know whether the internal injuries were suffered before or after C was burnt; and
f. recalled H asking him an unusual question along the lines ”is he all right on the inside”. It was unusual given the obvious injuries were the external injuries.

134. Dr Mott[32] was a surgical registrar involved in the treatment. He said:

a. he had never seen any injuries as extensive as C’s internal injuries;
b. the abdominal injuries would have had to have been caused by some form of extreme shearing or crushing injury and would have occurred about 48 hours earlier or slightly longer. He did not notice any injuries consistent with being hit by a wooden bed slat; and
c. he had seen much less mesentery tears as a result of deceleration in motor vehicle accidents and motorcycle crashes.

135. Dr Borzi[33] was the paediatric surgeon who was asked by Dr Choo to provide a second opinion in relation to C’s gut. He stated:

[30] Exhibit C10
[31] Exhibit C14
[32] Exhibit C46
[33] Exhibit J4

a. the infarction thrombus dummied into the large bowel would possibly implicate a generalised process effecting all major vessels to the intestine, rather than an isolated event to one vessel;
b. if the injuries were caused by trauma, one would have thought the trauma would have had to involve all three vessels. Having said this, it was possible the trauma only damaged one of the vessels which in turn caused ischaemia to that part of the intestine causing a generalised sepsis and the sepsis in turn caused the wide distribution of infarction;
c. more generalised causes for such extensive ischaemia would be:
    (i) abdominal compartment syndrome (unusual and rare complication in children);
    (ii) thrombosis of the aorta; and
    (iii) generalised sepsis with disseminated intravascular coagulation
d. Dr Milne's articles reinforce all the factors which come into play in the presence of a severe burn which can affect profusionial blood supply to the gut, however, these effects are at a microscopic level and do not fully explain the extent of injury and the presence of mesenteric tearing as demonstrated on the clinical photographs;
e. the clinical intraoperative photos appear to show bruising on the right: around the duodenal jejunal junction along the inferior aspect of the base of the defect in the transverse meso-colon. If this is true bruising and that preceded the emergency laparotomy then it is likely to be caused by trauma related to intra-vascular coagulation sepsis and producing a spontaneous bruising;
f. it is possible C's abdominal injury is a combination of trauma and abdominal compartment syndrome caused by the burns; and
g. whatever has caused the ischaemia and necrosis is likely to have occurred more than 24 hours prior to the operation.

136. Professor Kimble[34] is the Director of Paediatric Burns and Trauma of the University of Queensland, Royal Children's Hospital. He was also part of the treating team. He stated:

a. he had seen this type of searing injury to the mesentery previously and it takes a great deal of violence to cause this injury (any accident where there is a high velocity and then a sudden deceleration);
b. the multiple tears and haematoma, as well as blood in the tissues is usually associated with being thrown from a motor vehicle or being dropped from a height;

[34] Exhibit J7

c. the initial trauma to the abdomen could have occurred three days prior to the operation but it is likely to have occurred within one day prior to C arriving at hospital. It is not possible to survive this type of injury for more than 48 to 72 hours;
d. from the point at which C arrived at hospital he had a non-survivable injury to his abdomen; and
e. mesenteric tears could only have been caused by trauma and not abdominal compartment syndrome. The mesenteric injury may ultimately have caused a compartment syndrome.

137. Dr Leditschke[35] is a paediatric surgeon who was also consulted. He stated:

a. mesenteric tears are caused by significant blunt trauma to the abdomen and for this reason the injury to C's gut was unlikely to be related to the tears;
b. the gut death probably occurred 12 to 24 hours earlier; and
c. Dr Milne's articles do not explain the presence of the mesenteric tears.

138. Dr Rudd[36] is the Director of the Adult Burns Unit at Royal Brisbane Hospital. He stated:

a. the clinical photos showed patchy gangrene and infarction which is most likely to have been caused by non-occlusive ischaemia as opposed to occlusive ischaemia. This means it is less likely that C was suffering from a thrombosis. Non occlusive ischaemia might be caused by blunt external injury or a reduced blood pressure because of the burns;
b. mesenteric tears can cause ischaemia. It is possible the segment of gut affected by part of a mesenteric that was torn, died, which in turn caused bacterial growth, which invaded the bowel wall and got into the blood supply, causing septicaemia, producing a low blood flow and resulting in the rest of the gut infarcting. If this is the way the gut died, 48 hours would be a sufficient time for this to occur; and
c. it is impossible now to say whether the injuries were likely to have been caused by burns, trauma or both. However, the mesenteric tears could only have been caused by some external blunt trauma such as colliding with the handlebars when thrown off a bike or being an unrestrained passenger in a motor vehicle and colliding with the steering wheel.

139. At autopsy, Dr Milne made the following significant findings:

a. a three gram acute subdural haemorrhage overlying the left anterior superior frontal lobe;

[35] Exhibit J6
[36] Exhibit J9

b. burns to approximately 59% of C's body, including much of his forearms, chest and buttocks; and
c. multiple lacerations to the mesentery.

140. It was Dr Milne's opinion that whilst the subdural haemorrhage was significant, it was unlikely to be the cause of C's death. There were two reasons for this, namely the relatively small volume of fluid and the otherwise normal appearance of the brain. Dr Milne thought the haemorrhage had probably been present for less than a week, but was unable to give a more definitive estimate.[37] During the course of the investigation by police into the circumstances surrounding C's death, H and S provided information regarding a number of occasions in the week prior to C's death when he had fallen or D had jumped on him. Dr Milne was satisfied none of these incidents would explain the presence of the subdural haemorrhage. He also gave evidence it was very unlikely C sustained the injury in the bath prior to being burnt, or as a consequence of any medical treatment he received following the burns.[38]

141. In his autopsy report, Dr Milne identified the cause of death to be complications of the burns. However in his evidence he revised his opinion and concluded the cause of death is undetermined.[39] Dr Milne was of the opinion the mesenteric tears were definitely not related to the burns. The reason for this is they are a traumatic injury and even if burns had caused some of the ischaemic damage to the bowel, it would not cause tears to the mesentery. Dr Milne was also satisfied, after reading Dr Choo's latest evidence about the insertion of the pigtail catheter, that this provided no explanation for the mesenteric tears. He did not think a three year old child could cause such injuries. He did think C would have been having significant abdominal pain and exhibiting symptoms of not being well.

142. Dr John Harvey is a paediatric surgeon and paediatric burns surgeon, a past Director of the Burns Unit at Westmead Hospital, New South Wales and a past President of the Australian New Zealand Burns Association. He was briefed by the Coroner to conduct an independent review and prepare a report. He agreed with Dr Milne that the medical and post-mortem findings were very difficult to interpret.

143. Dr Harvey considered that the majority of C's gastrointestinal tract was found to be ischaemic. Whilst both mesenteric tears and burns can cause ischaemia, Dr Milne thought the nature and extent of the ischaemia found in this case could not be explained by the burns process alone or alternatively by the tears to the mesentery alone.[40]

[37] T10-9
[38] T10-12 to 13 and T10-31to 32
[39] T10-27
[40] T10-17

144. Dr Harvey disagreed with this and opined it would have been possible for the burns to have caused the ischaemia. However, he thought the presence of the mesenteric tears meant the totality of the ischaemia could not be confidentially explained by the burns.[41] Despite this difference in opinion, both doctors concluded the ischaemia was most likely caused by a combination of the mesenteric tears and the burns.[42] It is not possible to disentangle the consequences of the burns from the consequences of the mesenteric tears.[43] Having said this, Dr Harvey gave evidence that in the absence of the mesenteric tears, there was an 80% chance C could have survived the burns. Conversely, he thought in the absence of the burns, the expectation would have been C would have survived the mesenteric tears.[44]

145. There is no dispute on the totality of the extensive expert medical evidence that the mesenteric tears were a consequence of a traumatic blunt force injury and are in no way causally related to the burns.[45] Dr Harvey was satisfied they were sustained prior to C being burnt and probably within the previous 12 hours.[46] He thought there may well have been no obvious clinical signs when medically examined following the burns.[47] He would however have expected C to have been in significant pain and perhaps vomiting.[48] He thought C would have been unable to have eaten the spaghetti he ate prior to having the bath, although placed a caveat on this by saying it was hard to be sure.[49]

146. On the basis of the current evidence, the cause of the mesenteric tears cannot be definitively determined. Both doctors were satisfied the tears cannot be explained by the insertion of the pigtail catheter following C sustaining the burns.[50] Dr Milne was unable to find any evidence of an anatomical abnormality on autopsy that would have predisposed C to such tears.[51] The doctors thought D would not have been able to cause such a serious injury to his younger brother.[52] Both doctors considered none of the incidents which H and S relayed to the police would have been sufficient to have caused the mesenteric tears.[53]

147. H and S were able to offer no other potential explanations for the mesenteric tears although it is evident they both had a propensity to leaving the children unsupervised. Certainly there was an injury which

[41] T10-57
[42] T10-23, T10-25, T10-54 to 56, T10-63
[43] T10-27
[44] T10-63 to 64
[45] T10-19
[46] T10-60
[47] T10-57, T10-75
[48] T10-58
[49] T10-74
[50] T10-18 to 19, T10-59
[51] T10-47
[52] T10-20 to 21, T10-61
[53] T10-60

caused the subdural haemorrhage which may have been the result of falling or injuries caused by D. It may well be S and H's inattentiveness towards their children meant the occurrence of the incidents sufficient to cause the mesenteric tears and the subdural haemorrhage and the signs of those injuries, which would ordinarily be evident, went unnoticed by them.

148. After considering all of the evidence, my finding is the cause of death was due to a complication of burns caused by scalding in the bath, and also due to an injury to the mesenteric artery caused by trauma the form of which is unknown.

Burns and Scalds to Children

149. The Queensland Injury Surveillance Unit (QISU) collects and analyses data from Emergency Department injury presentations in participating hospitals. It has published a number of Injury Bulletins on the subject.[54] An uncontroversial conclusion and recommendation that arises from its research was that adult supervision was essential when children under 5 are in the bathroom and they should never be left alone even for a short time.[55]

150. QISU also noted the bathroom is a common location for injury in this age group. The bathroom contains a wide range of potential hazards for young children, including the risk of immersion in the bath, burns from hot tap water and falls as a result of wet slippery surfaces. Burns to children in the bathroom are almost exclusively as a result of hot tap water burns.

151. QISU noted whilst parental supervision is important in scald and burns prevention, educational campaigns raising awareness and encouraging behavioural and environmental modifications seem to have had little impact in Queensland.

152. It noted changes had been made to the Australian Standards for all new hot water installations in 1997[56] which meant a tempering valve or thermostat mixing valve is required to reduce the temperature of hot water delivered at the bathroom to 50°C (45°C in child care and care facilities). Hot water is required to be stored at a temperature in excess of 60°C to prevent the incubation of bacteria particularly Legionella. A tempering valve mixes cold water with the hot water to keep the outgoing water temperature fixed at 50°C.

153. QISU had some concerns this temperature reduction was not required for other hot water outlets in the house and the standard is not retrospective. The Standard applies to new installations, alterations,

[54] Bulletin 89 December 2005 "Burns and Scalds in Queensland Toddlers" and Bulletin 91 May 2006 "Bathroom Injuries in Queensland".
[55] Bulletin 91
[56] AS4032[1] 2-2005 and AS 3500[1] 4.1 1997. Copies of these standards have been obtained by the Office of State Coroner and form part of the record for these proceedings.

additions and repairs to existing installations only. QISU noted there was evidence to suggest that despite a public awareness campaign, domestic hot water temperatures in Queensland remain higher than 50°C.

154. Dr Harvey stated the Australian and New Zealand Burns Association has been campaigning for a long time for legislation to be expanded to include valves being fitted to hot water inlets to all bathrooms for all houses at the point-of-sale. He reiterated this is a very serious issue and if when D turned on the hot water tap with the delivery of hot water at 45°C, it was very unlikely C would have been burnt.

155. This is emphatically illustrated in Appendix E to AS 4032 which notes the safe contact time to avoid third degree burns at 50°C is 5 minutes, at 60°C for an adult is 5 seconds and for a child is 1 second, and at 70°C for an adult is 1 second and a child is 0.5 of a second.

156. In is part of the public record that in recent years in Queensland there has been productive safety legislation introduced which mandates retrospective changes to smoke alarms, electrical safety switches and swimming pool fencing at point of sale and rental of houses. The swimming pool legislation is particularly rigorous, and there seems to be no good reason why the position of domestic hot water should not be considered as a safety issue in a similar manner.

157. Indeed there has been some recognition of this by the Queensland Government. Since January 2010, when a house or other residential unit is offered or marketed for sale a sustainability declaration must be completed to the best of the seller's ability and knowledge. The declaration identifies sustainability features of a home in three key areas including energy; water and access; safety and other features. In relation to the safety issues there is specific reference to smoke alarms and smoke detectors, electrical safety switches and swimming pool fencing. In relation to those three items homeowners must have them installed and be compliant with current regulations.

158. Hot water tempering valves are also referred to in the "Guide to Sustainability Declaration"[57] noting any hot water systems installed after 30 April 1998 are required to have a tempering valve fitted so the hot water is delivered to hot water outlets at a maximum 50°C to prevent scalding. However, completion of this component of the Declaration is optional. The Sustainability Declaration does not cover rental properties.

159. Given there will be economic and practical implications and as this issue was not raised specifically with the relevant government department during the course of the inquest, my recommendation will be that the Department of Infrastructure and Planning investigate and

[57] See website for Department of Local Government and Planning

considers retrospective mandating of the Australian Standards in respect to hot water tempering valves at point of sale and lease in a manner similar to that now adopted for smoke alarms, electrical safety switches and swimming pool fences.

160. In this case the evidence suggests the family was residing in Department of Housing premises. At the very least, and despite the possible financial impost, the State government should be setting an example by applying the Australian Standard to all of its housing stock. Given the standard has been in effect since 30 April 1998 and applies new installations and to any repairs to existing installations, one would surmise in the last decade or more most of its housing stock would have had repairs or new installations to its hot water systems and most of its stock already complies.

Findings required by s45

161. I am required to find, as far as is possible, the medical cause of death, who the deceased person was and when, where and how that person came by his/her death. As a result of considering all of the material contained in the exhibits, I am able to make the following findings:

- Identity of the deceased – A child C born on 6 June 2004
- How the person died - C died as a result of a combination of complications from burns to his body which occurred as a result of having been scalded in a bath of hot water on 30 October 2005, and as a result of tears to his mesenteric artery as a result of trauma. The precise nature of the trauma is unknown. Both the incident which caused the burns and the incident of trauma which caused the tears to his mesenteric artery occurred because he was left unsupervised by his parents.
- Place of death – Royal Children's Hospital, Brisbane
- Date of death – 1 November 2005
- Cause of death – Complication of burns and trauma to the mesenteric artery

Concerns, comments and recommendations

162. Section 46, insofar as it is relevant to this matter, provides that a coroner may comment on anything connected with a death that relates to public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in the future.

163. The issues raised by the circumstances of this case which warrant consideration from that perspective relate to the issues concerning exchange of information whilst families are subject to witness protection and in relation to the installation of hot water tempering valves.

164. **Recommendation 1** – The cross jurisdictional issues raised by this case be considered by the Witness Protection Program National Meeting so common ground amongst all witness protection programs can be reached as to how an exchange of information between relevant agencies in relation to child protection concerns can best be delivered.

165. **Recommendation 2** – The Queensland Government ensure all Queensland Housing stock it has responsibility for comply with AS 4032[1] 2-2005 and AS 3500[1] 4.1 1997 such that hot water tempering valves are installed in all premises notwithstanding that the hot water systems were installed prior to 30 April 1998.

166. **Recommendation 3** – The Department of Infrastructure and Planning investigate and considers retrospective mandating of the Australian Standards in respect to hot water tempering valves at point of sale and lease in a manner similar to that now adopted for smoke alarms, electrical safety switches and swimming pool fences.

167. Given that the State Government has not been specifically asked to comment on recommendations 2 and 3, the appropriate Department will be given an opportunity to comment and report back to the Coroner in relation to those recommendations.

I close the Inquest subject to the above.

John Lock
Brisbane Coroner
24 June 2011