QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INVESTIGATION

CITATION:	**Non-inquest findings into the death of T, an eight week old infant.**
TITLE OF COURT:	Coroners Court
JURISDICTION:	SOUTHPORT
DATE:	17/02/2021
FILE NO(s):	2015/3055
FINDINGS OF:	Jane Bentley, Deputy State Coroner
CATCHWORDS:	CORONERS: SIDS; co-sleeping; risk factors; parental drug use; child protection; Qld Child Death Case Review; Department of Communities; Queensland Health; information exchange

Contents

T was eight weeks old when he died. He lived with his mother, his father, and his eight year old half brother “A”.

The father was a fly in fly out worker.

The mother had three older sons who were eight (A), seventeen (B) and twenty-one years old (C) at the time of T’s death.

T was born on 11 June 2015 at Logan Hospital. He was born full term plus five days. The birth was uneventful. Tests indicated that T was born with methadone and amphetamine in his body so he was kept in hospital for five days. He suffered tachypnoea (abnormally rapid breathing) on his second day of life and was transferred to the special care nursery where he was also monitored for neonatal abstinence syndrome. He recovered and was discharged on 16 June 2015.

On 23 June 2015 a nurse from the Community Midwifery Service visited T at home and noted that he was losing weight. She advised that T should be taken to the Logan Hospital Emergency Department. When T was not taken to the hospital the Department of Child Safety (the Department) called the police who attended the residence and called Queensland Ambulance Service which took T and the mother to the hospital.

T was readmitted to hospital on 23 June 2015 due to weight loss due to poor oral intake which was attributed to tongue tie which was released surgically. His feeding improved and his weight increased. He was discharged on 1 July 2015.

After the surgery T took a long time to feed but by the time of his death he was feeding better and had been putting on weight.

A registered nurse from Children’s Health, Community Child Health Service Logan Hospital, attended at T’s home on following his discharge from hospital on 1 July. Those visits took place on 6 July, 7 July, 16 July, 24 July, 31 July and 5 August. The mother and the father were receptive to these visits and the nurses who visited had no concerns about the care T was receiving from his parents.

At the visit on 31 July 2015 T had lost 60 grams in one week and the mother advised that she had an appointment at Logan Hospital that afternoon.

On the evening of 8 August 2015 the mother and the father watched movies on television at home. T was asleep in a bassinette in the lounge room. The father went to bed at about 10.30pm. The mother fell asleep on the couch.

At about 3am on 9 August 2015 T awoke and the mother changed his nappy and then carried him to the kitchen where she made up a bottle of formula. She was talking to him while she did so and he laughed for the first time. She took him back to the couch and fed him the bottle. She recalls leaning over T feeding him the bottle and then nothing until the father woke her up.

The mother was very tired at that time. The last time she had slept was from 3am to 7am on the morning of 8 August 2020. T had been waking up frequently at night to feed.

At about 7am that morning the father woke up and went to the lounge room where he found the mother asleep on the couch with her body slumped forward over T who was in her lap. He woke her up and found T was not breathing. He immediately commenced CPR and the mother called 000.

Queensland Ambulance Service paramedics attended and continued CPR and transported T to the Logan Hospital but he could not be revived and was pronounced deceased at 8am.

Autopsy

The autopsy revealed that T had vital dimensions within the lower range of normal and his length was below average. He had no injuries. The Forensic Pathologist concluded that T died from sudden infant death syndrome category II as it was highly likely mechanical asphyxia had occurred.

I agree with that conclusion.

Sudden Infant Death Syndrome (SIDS) is a term used to describe the sudden unexpected death during sleep of an infant aged under 12 months that is not explained by circumstances surrounding death, death scene examination and a thorough post-mortem examination. The cause of SIDS is not known, but is likely multi-factorial, involving both environmental, developmental and hereditary or genetic aspects.

SIDS Category II is defined as the sudden and unexplained death of an infant under one year of age, apparently occurring during sleep, which remains unexplained after a thorough case investigation, including performance of a complete autopsy, examination of the death scene, and review of the clinical history but where age range is outside of greater than 21 days but less than 9 months, where there is a history of deaths in siblings or other infants, under the same caregiver, where mechanical asphyxia considered but not determined with certainty and/or where abnormal growth, or more marked pathological abnormalities are identified at autopsy.

Police Investigation

Police attended T's home on the day of his death and found it to be clean and tidy and containing all of the baby necessities.

The mother told police that she was a heroin addict for twelve years but had been on the methadone program and had not used heroin for eight years before T's birth (since 17 June 2007). She said that she went to the chemist every day where she received 26ml of methadone. She said that as she had been taking it for a long time it did not make her drowsy and had no adverse effect on her or her ability to care for T.

In the main bedroom of the house police found three empty bottles of methadone and two full bottles of methadone with the mother's name on them. They also found a yellow sharps container, spoons containing dry residue, one capped used syringe and empty clip seal bags. In a hand bag under the bag they found further empty clip seal bags, spoons and a capped syringe. More empty clip seal bags were strewn on the floor of the bedroom.

Police concluded that there was no evidence that the mother was criminally or grossly negligent and that she went to sleep due to extreme fatigue resulting from caring from a new born baby.

The Department of Communities, Child Safety and Disability Services (the Department)

As T was a child who was known to the Department prior to his death, the Department carried out an internal review of the circumstances surrounding his death – a "Systems and Practice Review" (SPR).

The Mother's History with the Department

The mother had a history of involvement with the Department in relation to her three older children which commenced in 2007.

Concerns about her heroin use and transient lifestyle resulted in B and C being placed with their respective fathers through Family Court orders. Two of the older children were treated for drug withdrawal following their births.

The Department were aware of allegations that the mother's drug use impacted on her ability to meet her children's needs and that she had an historical and ongoing problem with staying awake and could lapse into deep sleep where she would roll onto her infant children or not respond to their cries.

Departmental records indicated that the mother was frequently dishonest with child safety officers.

A was born with a respiratory condition which was believed to have been caused by the mother's drug use, lack of antenatal care and high risk lifestyle during pregnancy. He was treated for significant drug withdrawal symptoms for four weeks after his birth.

He was placed in foster care immediately after his birth due to these concerns. The department obtained a temporary assessment order, a court assessment order and ultimately a child protection order (CPO) granting custody of A to the Chief Executive for a period of one year from August 2007.

The mother successfully addressed the child protection concerns during the period of the CPO which resulted in the reunification of A back to her care in May 2008. At that time they resided with the maternal grandmother who provided the mother with support.

After the CPO expired in August 2008 the Department received no further concerns until July 2014 when the mother and A moved out of her mother's house. At that time the Department was notified of concerns that the mother was using drugs and unable to care for A adequately.

The mother commenced a relationship with the father in November 2013. At that time she was evicted from public housing and there were increased concerns about her drug use. Her behaviour and appearance was noted by ATODS to have declined dramatically over the previous six months. She had missed methadone doses, experienced financial problems and been arrested. She reported being 25 weeks pregnant and not receiving antenatal care.

A was confirmed as being diagnosed with Autism Spectrum Disorder at a SCAN (Suspected Child Abuse and Neglect) team meeting in December 2014.

The mother moved into the father's house. He reported he was living with his sister when he was not working away in the mines although the Department doubted the veracity of this and believed that he was living with the mother.

The Two Years Prior to T's Death

In the two years prior to T's death the Department received two notifications which resulted in Investigations and Assessments (I&A), seven Child Concern Reports (CCR) and the provision of a Support Service Case from 1 to 20 July 2015.

The I&A dated 24 December 2014

The department received a notification about the mother on 6 November 2014. It was given a five day response time and transferred to the Child Safety Service Centre (CSSC) at Logan the same day.

Despite the five day response required, the matter was not actioned until six days later, on 12 November 2014, when it was allocated to a Child Safety Officer (CSO).

Nothing was done on the file until 24 November 2014 when CSO1 obtained information from Queensland Police Service that the mother had been found in a public place under the influence of drugs. On the same day CSO1 attempted unsuccessfully to phone the mother.

On 25 November 2014 CSO1 ascertained that the mother had attended the Logan Hospital Emergency Department on 8 November 2014 when she advised that she was 16 weeks pregnant but was not booked in for maternity services. She was advised to have urgent blood tests and an ultrasound to monitor the pregnancy. She was told to speak to her GP about a referral to the Mater Hospital.

CSO1 told the SPR panel (the review team) that she had visited the family home on at least two occasions but she had not made any record in the file of these visits. She said that on the first occasion the mother was not at home and on the second occasion she had refused to engage with CSOs and told them to leave.

There was a record of a third home visit on 8 December 2014 but at that time nobody was home and they recorded that the home appeared to be unoccupied. They left a card and the mother contacted the CSSC after hours office.

The mother visited the CSSC the next day and was interviewed by CSO1 and CSO2. She said that she had been evicted earlier in her pregnancy because she was too sick to get out of bed and she asked a neighbour to pay her rent but that had not occurred. She said that following her eviction she and her son had moved in with the father with whom she had been in a relationship for about ten months.

She said she had not used illegal drugs for the past eight years and was willing to participate in random drug testing.

The mother said A was not attending school but she was home schooling him but that was not registered. She said the father was a good person who kept her on the "straight and narrow" and was a good influence on her. She agreed that departmental officers could interview the father and her son (it is unknown why the CSO required her consent). CSO1 went with the mother to Queensland Medical Laboratories and she completed a drug screen.

The family was discussed at a SCAN (Suspected Child Abuse and Neglect multidisciplinary team comprising officers of the Department, Qld Health, the Department of Education and Qld Police Service) meeting on 10 December 2014 after the case was referred by Queensland Health. QH provided the following information:

- The mother had attended Logan Hospital on 8 November 2014 requesting methadone;
- as at 25 November 2014 she was not booked in at any hospital to give birth;
- she had recommenced the methadone program on 13 November 2014 but missed doses in October 2014 and police had confiscated methadone from her in October 2014;
- she claimed she'd had pelvic bleeding but had not presented to hospital;
- she reported having blood tests but there was no record of them;
- she had been referred to CHAMP (a specialised antenatal clinic offering care and support to pregnant women who are impacted by drug addiction, DFV, homelessness and/or mental illness) at the Mater but had not attended;
- QH held concerns for A and her unborn child due to drug use, irregular compliance with her treatment plan and lack of stable accommodation.

Queensland Police Service provided information to the SCAN team that:

- In 2007 when the mother was 36 weeks pregnant she was engaged in prostitution and using heroin;
- The mother had extensive criminal history from 1997 in relation to drugs and prostitution and had been imprisoned;
- There was no DFV history for the mother and the father had no criminal history.

The Department of Education advised the SCAN team that A was enrolled at school but had not attended since June 2014.

The file was closed to SCAN that day on the basis that the I&A had commenced and the Department would verify the information provided by the mother.

On 11 December 2014 CSO1 phoned the mother's ATODS worker who advised that she had been attending appointments. There was only one known relapse when she had been cut off from methadone and was given Valium by the hospital. She used amphetamines at that time. She was due to attend the next day to provide urine screen.

CSO1 and CSO2 interviewed A and the mother at the CSSC on 15 December 2014. He did not make any concerning disclosures. The mother advised she had not been to the hospital about her pregnancy.

A safety assessment was completed that day which concluded that A was safe in the family home.

On 16 December 2014 CSO1 ascertained that the mother had not engaged with the CHAMP clinic and had still not contacted the hospital.

On 18 December 2014 the mother told CSO1 that she had visited the Logan Hospital earlier in her pregnancy and she could not have blood tests done because her veins were damaged due to previous drug use. She said she would visit her GP that day and get a referral for the CHAMP clinic.

A Family Risk Evaluation (FRE) was completed that day and the final risk level was assessed as “high” but it was decided that no intervention was required.

On 24 December 2014 CSO1 interviewed the father on the phone and he said that the mother was having weekly scans as she was having twins. He had not seen her using drugs. He intended to get work closer to home so he could help her with the babies.

The I&A was finalised and approved on 24 December 2014 with an outcome that A was not a child in need of protection.

CSO1 stated, “It is my assessment that the unborn baby will not be at risk of suffering harm post birth given limited evidence available to substantiate the allegations, in addition to limited risk factors in the home.”

The review team considered that information gathering could have been more comprehensive. The team noted that CSO1 had not confirmed that the mother was attending the hospital and/or receiving antenatal care. Her GP had not been contacted. No historical information about A’s birth had been obtained (which would have been relevant as he had been born with a respiratory condition due to the mother’s drug use and lack of antenatal care).

No information was obtained from the Department of Housing. Those records indicate that the mother was evicted due to rent arrears and neighbours reporting DFV and chairs being thrown through windows.

There was no follow up to ensure A was enrolled in and/or attending school.

The mother had been a client of ATODS Logan for only one month and no enquiries were made with ATODS Bayside which held more information about her including that her appearance had deteriorated over the previous six months and she had missed methadone doses.

The review team considered that the mother was highly like to relapse at some stage.

The review team came to the conclusion that there was sufficient information gathered during the I&A to determine an outcome but the outcome should have been that the unborn child was in need of protection.

Decision to record a CCR for information received on 14 April 2015

The Department was advised by a social worker from the Logan Hospital that:

- The mother had presented to the Logan Hospital in pain on 14 April 2015 and this was her first maternity visit;
- The mother said she was having twins but scans showed only one live foetus;
- The mother said that A was being home schooled and then said he was attending Woodridge State School;
- There was a history of DFV and financial difficulties;
- The mother was receiving large doses of methadone;
- The mother was asked to re-attend for further tests but did not;
- The mother had an appointment booked for 23 April 2015.

The Department intake officer contacted ATODS who advised that the mother's worker would not be in the office until 20 April 2015.

On 20 April 2015 ATODS advised the intake officer that:

- The mother was attending all her monthly appointments;
- A was attending Woodridge State School;
- The mother was having a caesarean section that day
- She had been providing clean urine tests;
- A looked to be well cared for;
- The father appeared to be supportive.

The intake officer recorded the information as a Child Concern Report.

When information about a child is received by the department it undergoes an initial screening process and is recorded as one of the following:

- A child concern report (CCR);
    - When allegations of harm are received that do not meet the threshold for a notification and the child is not reasonably suspected to be in need of protection;
- A notification;
    - When it is reasonably suspected that the child is in need of protection;
- Additional notified concerns (ANC) – further information in regard to an ongoing investigation.

The recording of the information as a CCR resulted in no further investigations being made.

The review panel considered that further investigations should have been conducted being:

- A phone call to the school to confirm that A was attending;
- Confirmation with the hospital as to caesarean which was inconsistent with information provided by the hospital social worker.

Decision to record a CCR for information received on 14 April 2015.

On 14 April 2015 a mandatory notifier advised the Department:

- The mother had given birth to T on 11 June 2015;
- There was little information about her prenatal care;
- She had been telling staff she was having twins but she was not;
- The father had just become aware that she was on the methadone program;
- T had been moved to the Special Care Nursery after blood tests had revealed amphetamines and methadone in his system;
- The mother was not admitting to any drug use.

The intake officer noted:

- T had not been harmed and was not at risk of future harm;
- Factors indicated that neglect may occur in the future;
- Mother has a pattern of drug abuse;
- A has not been attending school;
- Baby born drug addicted and may have sleeping and eating difficulties;
- Mother may have a diminished capacity to cope with the baby.

The officer concluded that:

> *whilst there is (sic) currently no grounds for a child protection investigation, this family may benefit from a Support Service involvement to assist at a difficult time. A referral to a Family Connect Service is recommended.*

Later that day a senior nurse from the hospital contacted the After Hours CSSC to enquire whether there was a current I&A or any concerns in relation to T being discharged from hospital. The nurse was advised that there was not but was asked to, "*observe the mother's care capacity and ascertain whether there were ongoing concerns in relation to her drug use,"* and also to report any such concerns to the Department.

The review team considered that the fact that T had been moved to the special care nursery with drug withdrawal symptoms and amphetamine and methadone in his blood was evidence that he had experienced significant physical harm and that the mother would be unlikely to meet his daily needs without a high level of support. The information should have been recorded as a notification requiring an I&A.

Decision to record a CCR for information received on 16 June 2015

On 16 June 2015 the Department was advised by hospital staff that T was still in hospital for monitoring for drug withdrawal and was likely to remain there for five to six days.

The information was recorded as a CCR on the basis that the children had not been significantly harmed or were at risk of harm and there is nothing to suggest the mother was unable to meet their needs.

The family was referred to Intensive Family Support (IFS) Service as it was considered they were at risk of re-entering the child protection system and T was particularly vulnerable due to his age.

The review team considered that T had experienced significant physical harm and, taking into account the history, a notification requiring an I&A should have been recorded.

The referral to the IFS was not progressed (by CSO5) until 9 July 2015.

Decision to record an outcome of unsubstantiated for I&A dated 30 June 2015

On 22 June 2015 the Department was notified that the parents had been asked on 20, 21 and 22 June 2015 to take T to the Logan Hospital for medical follow up due to weight loss but they had not done so.

The information was recorded as a notification with a 24 hour response time. It was allocated to CSO3 on 23 June 2015 and the I&A was commenced that day.

On 23 June 2015 the Department received two further notifications which were recorded as ANCs in relation to the mother and the father failing to take T to hospital on 20, 21 and 22 June 2015.

CSO3 and CSO4 went to the Logan hospital that day. They saw T and interviewed the parents and the Child Protection Liaison Officer (CPLO).

The CPLO told them that the mother had threatened to leave the hospital with T, that she appeared to be withdrawing and had been rough with the baby.

The mother told the CSOs that she'd had trouble getting her methadone due to hospital workers believing she was injecting methadone. She said she wasn't and she had only used amphetamine once in November because she had been cut off from her methadone. She said that she provided random drug tests to ATODS. She denied that T was born with amphetamines in his system and also denied that he was withdrawing. She said she not used amphetamines during her pregnancy.

On the same day the father told the CSOs that the mother was delusional and believed she was involved in a probate case with a supreme court judge. He said he didn't think she was fit to look after T and she had tried to take him from the house and he had not known where he was last night. He said she was a drug user and a compulsive liar and he didn't want to be attached to her. He said he did not live with her. He had been unaware that T was withdrawing from amphetamine when he was born. He believed the mother needed a mental health assessment.

Both parents denied that they were aware of the need to take T to the hospital due to weight loss.

On 25 June 2014 the Department was advised by hospital staff that the mother was:

> *actively withdrawing from opioids, hysterical, throwing neonate around in room. Neonate failure to thrive … imminent danger to child if mother were to take patient home*

The Department was advised that T was due for discharge over the weekend or on Monday 29 June 2015 and he would require "extensive feeding support due to a significant tongue tie" and he also had an uncoordinated suck and would require close supervision and monitoring.

On 26 June 2015 the mother told CSO3 that she had completed a urine screen but QML advised that she had not. The mother went with CSO3 to QML and provided a sample.

The father told CSO3 that they were working on their relationship and if T was discharged he would provide support but not live with them.

Later that day the CPLO told CSO3 that they had concerns for the mother as she had fallen asleep on the kitchen floor at the hospital and she was "out to it." She had been making ten cups of coffee and then "crashing". The father was stressed and had been unaware that the mother had hepatitis C.

On 30 June 2015 the mother's drug test was found to be positive for methadone, amphetamine and methamphetamine.

CSO3 was told that T would be discharged that day. She spoke to the mother who denied drug use but then admitted it when advised of the drug screen results.

CSO3 was advised that nursing staff had seen blankets over T's face on two occasions while the parents were present and the mother had been found asleep on top of him while he was lying in a large cot. Nursing staff saw the mother standing up leaning on the cot and snoring. She was woken by staff. They later found her asleep on the floor in the parents' room. She said she was picking up her phone from the floor and fell asleep. They found T in her bed on two occasions and returned him to his cot both times. The mother was seen to be

standing up holding T with one hand and her phone in the other and she appeared to be asleep.

CSO3 was told that on 27 June 2015 the mother had been sleepy and smelt of alcohol.

On 30 June 2015 QH informed the Department that a recommendation had been made at a clinical meeting that the matter be referred to the SCAN team.

On 30 June 2015 a Safety Assessment was completed and approved and found that T was "safe" in the family home. The FRE was completed on 30 June 2015 with an outcome of "high risk."

The outcome of the I&A was recorded as unsubstantiated and T was found to be not in need of protection. A decision was made to open a Support Service Case.

The Support Service Case was commenced with the family on 1 July 2015.

On 6 July 2015 QH submitted a referral to the SCAN team. The SCAN team co-ordinator (an officer of the Department) refused to accept the referral on the basis that the I&A had been completed.

On 9 July 2015 QH resubmitted a referral to the SCAN team. The SCAN team co-ordinator did not respond that that referral at all.

The review team considered that:

- The case should have been referred to SCAN to allow a multi team approach and the sharing of information;
- Further information should have been obtained about concerns about mother falling asleep;
- Mother's sleeping issues were indicative of significant drug use;
- Mother was repeatedly asked not to co-sleep with baby but continued to do so.

The review team obtained information from a paediatrician who advised that T looked unwell and scrawny when brought in and it was unlikely that the tongue tie was the cause and it was more likely that he had not been fed adequately. It was likely that the mother had under-reported his symptoms of drug withdrawal as she had a good knowledge of scoring in relation to neo-abstinence syndrome as she'd had similar experiences with her older children.

The review team noted that the above information would have been made available to CSOs if the matter had been discussed at SCAN.

The review team noted that the presence of the father was considered a protective factor even though he had advised that he was leaving for work and that he was not living with the mother. Further, the CSO had identified that the maternal grandmother would be supportive to the mother but had not spoken to the grandmother to corroborate this.

The fact that T was born with amphetamines and methamphetamines and the mother's positive drug test for that substance indicated she was using drugs. The review team considered that CSOs should have obtained further information from ATODS re the mother's drug use and treatment and consider that information taking into account that T was an infant and particularly vulnerable given his special feeding requirements.

CSO3 told the review team that she and CSO4 had observed that the father was living in the house when they made two unannounced home visits. Neither of those visits to the house had been recorded in the I&A.

CSO3 acknowledged that she should have made accurate records but said, “this was a learning for her.”

The review team concluded that the I&A should have had the outcome that T was a child in need of protection and agreed with the FRE outcome of “high” risk.

The Safety Assessment was completed at the end of the I&A even though the I&A only took five days. CSO3 and CSO4 stated that the focus of the assessment was only on the notified concern of weight loss.

The review team considered that the safety assessment was inadequate and did not rely on a holistic view of all of the circumstances known to the Department and a safety plan should have been developed for T which addressed the medical and monitoring needs of T as advised by Qld Health and include details of who would be involved (e.g. the Department, family) and the frequency of their involvement.

TL1, CSO3 and CSO4 disagreed with the review team’s conclusion and stated that they would not have changed the outcome of the I&A because, whilst there were a number of risks identified, there were also a number of strengths identified which were:

- The parents agreed to a support service case;
- The father was aware of the mother’s drug use and could monitor it (although he would be away for work regularly);
- T was seen to be sleeping in his own cot (although that visit not recorded by either);
- Positive observations of mother in home (not recorded by them);
- ATODS had no concerns for mother and half brother (not up to date information as they had not engaged ATODS in this I&A);
- Half brother was attending Redlands Special School (they did not verify this information);
- The maternal grandmother was supportive (they had not spoken to the maternal grandmother to verify this);
- The previous I&A was unsubstantiated.

Decision to Open a Support Service Case, Ongoing Intervention Provided and Decision to Close Support Service Case on 29 July 2015

The second I&A was finalised on 30 June 2015 with an outcome that T was found not to be a child in need of protection but the family required support.

The review team disagreed with that conclusion and considered that T was a child in need of protection and should have been subject to an Intervention with Parental Agreement (IPA).

Ongoing intervention was provided during the Support Service Case between 1 July 2015 until it was closed by the Department on 20 July 2015.

During the period a support plan was developed with the parents aimed at addressing the mother’s drug use, medical follow up for T and safe sleeping practices. The family was linked to IFS. A review was to occur on 3 August 2015.

At a home visit on 2 July 2015 T was seen to be sleeping in his cot, the mother presented well and the father was home and had been asleep. The parents advised that T was feeding well and they were agreeable to the IFS referral.

There was a phone conversation with the mother on 3 July 2015 and she advised all was going well with T. A home visit was scheduled for 6 July 2015 and T was to be weighed on 7 July 2015. The IFS advised that a referral would be completed by an intake worker the following week.

On 6 July 2015 the mother appeared tired but not under the influence of drugs. The father told the CSO that he had not heard back from the mines but when he did he expected to go away immediately to start work.

On 9 July 2015 CSO5 completed a referral to Family and Child Connect (FCC).

On 10 and 13 July 2015 CSO3 attempted unsuccessfully to contact the mother and the father.

At a home visit on 15 July 2015 the mother was at home with A and T. She said that the father had gone to work in the mines and would be working one month and then be home for two months.

On 20 July 2015 CSO3 was contacted by an FCC worker who advised that the family had been visited on 15 July 2015 and that the mother wanted to work with the agency and the family would be referred to an Intensive Family Support Service (IFS).

The case was allocated to an IFS support worker on 6 August 2015. Upon reading the referral information the support worker was concerned about the mother's drug use, that T had tested positive for amphetamines and that the father was not a consistent presence in the house. The support worker referred the case back to FCC on 7 August 2015 seeking further information about these issues. The FCC worker contacted CSSC to speak to CSO3 that day but was told CSO3 was on leave.

Qld Health advised the review team that the mother had missed two child health appointments on 24 July and 4 August and did not attend an appointment at the Logan Hospital on 31 July 2015. Child Health visited the family on 31 July 2015 and T's weight had decreased by 60 grams. They visited again on 5 August and his weight had increased 140 grams (less than the desired increase). This information was not obtained or considered prior to the Support Service Case being closed.

The review team considered that QH and ATODS should have been involved in the support plan for the family.

The Support Service Case was closed by the Department on 20 July 2015. The decision was made without compliance with the procedural requirements for closing which included review of the support plan, completion of a safety assessment, clarifying the roles of the other agencies and completion of a family risk evaluation.

TL1 and CSO4 acknowledged that the requirements had not been fulfilled and stated, "they have identified the importance of strengthening their knowledge of case management requirements."

Decision to Record a CCR for information received on 24 July 2015

On 24 July 2015 QH advised the Department that:

- The mother had not taken T to multiple medical appointments;
- T had lost weight;
- The concerns that had been raised during T's hospital admission (already referred to above);
- The mother did not attend the Paediatric Outpatients' Department;
- The Consultant Paediatrician was concerned about the lack of follow up;
- Whilst T had gained weight on 16 July 2015 the gain was 110 grams below the average weight gain expected for a child of his age;
- The mother was struggling to get to the pharmacy to get her methadone dose which would impact directly on her capacity to care for T;
- On 14 July 2015 she had disclosed to ATODS that she was irritable and having difficulty sleeping.

TL1 was consulted about the concerns and made the decision to record the information as a CCR as it was not new information and the Department had recent contact with the mother.

The review team considered that the information indicated a significant risk for T given his young age and medical needs and his health could deteriorate very quickly. The team concluded that the information should have been recorded as a Notification.

Overall Findings

The review team identified the following concerns:

- The investigation lacked a detailed information gathering process and access to expert advice. Expert advice was needed in relation to the mother's drug use.
- Information provided by the parents that formed part of the assessment was not validated from other sources.
- There were allegations of domestic and family violence that were not fully explored.
- The role of the father was not fully explored or assessed. Assumptions were made about his ability to protect T and weight was placed on him as a protective factor without sound information to base this on.
- The mother's significant history of drug use and tendency to fall asleep in unusual circumstances indicated a very high risk if co-sleeping occurred. There should have been significant education and reinforcement of safe sleeping practices with both parents.
- In considering substance misuse there was an over-reliance on forensic evidence (drug testing) which needed to be considered more holistically within the broader context of other information known about the family and family functioning.
- Stronger working relationships between the Department and QH would have strengthened the understanding of the risks and increased clarity about the roles of each agency. There could have been much greater collaboration in meeting the needs of T.
- Assessment and decision making in relation to unborn children is complex work and requires robust oversight, such as the use of SCAN team discussion, practice panels and a critical friend.
- Robust safety planning requires a broad range of stakeholders including the involvement of extended families and service providers. In this case the extended family could have been engaged given the significant role the maternal grandmother had played in the past.

- A full and deliberate analysis was needed to make sense of multiple concerns and contacts with this family and the impact of cumulative harm on the children. Undue weight was given to previous assessment outcomes.
- The understanding of static risk factors in Structured Decision Making tools needs to be further developed.
- Referral pathways to the secondary service system should enable seamless access to services for families. It was noted that direct referral could have been made to IFS rather than through FCC.

The review panel considered there were a number of missed opportunities where action could have been taken to increase the safety for the T.

The review panel made the following recommendations:

- The Region will work with the Regional Intake Service and CSSC staff to reflect on the learnings from the review and consider implications for future practice.
- Practice Leadership Unit will facilitate a workshop with key RIS staff across the state to reflect on learnings from this and other reviews.

Queensland Child Death Case Review

The Child Death Case Review Panel (CDCRP) reviewed the Department's Systems and Practice Review and delivered a scathing report.

The CDCRP was "alarmed at the poor and completely inadequate response by the Department to the very serious child protection issues" in T's case.

The CDCRP noted:

- The Department were unable to identify the significant level of risk to T even though professional notifiers advised of them on a continual basis;
- It was reasonably foreseeable that T could die in the mother's care but the Department took no action to remove him;
- The notifications received by the Department about B and C included concerns that the mother fell asleep on them as babies, co-sleeping and that she dropped one of them whilst drug affected.

The CDRCP found:

- The practice in this case was substandard, T was unsafe and an application for at least a Court Assessment Order should have been made;
- There were numerous serious risk indicators but they were not assessed in totality during the process and so there was a lack of consideration of the accumulation of the risk factors;
- The mother's history indicated a high level or risk for T;
- Both CSOs and TLs clearly demonstrated a lack of knowledge of the impacts of drug usage and long term drug dependency on a person's ability to parent safety and did not assess this factor;
- The support goal of the mother abstaining from drug use as set out on 1 July 2015 was naïve as the mother had been using drugs for nearly twenty years;
- There was clear evidence that the mother was using amphetamines – T tested positive for the drug at birth and her urine screed on 30 June 2015 was positive for

amphetamine, methamphetamine and methadone – but it was accepted that she would "work with the Department voluntarily to ensure T could remain with her at home". There was no assessment of her genuine willingness or her parenting capacity;

- CSO3 visited the mother and stated she appeared tired but not under the influence but she did not have the specialised knowledge to make that assessment. QH provided information that the mother was under the influence of drugs around the time of T's birth;
- CSO3 considered it a protective factor that "no drugs/implements were observed" but she did not search the home so her observations were of no probative value;
- There was no assessment of the mother's ability to parent safely whilst she was on a large dose of methadone as reported by a professional notifier.

In relation to the above findings the CDRCP recommended that the Department provide training to CSO and TLs in relation to the assessment of information related to drug use and how to gather reliable information in the investigation and assessment of these issues.

The CDRCP found that the lack of weight placed on information provided by professional notifiers was "deeply concerning."

Information from professionals with expertise and specialised knowledge should be given significant weight as the Departmental officers do not have such expertise.

The CDRCP recommended that the Department review the training provided with respect to the assessment of information provided by the different categories of notifiers and in particular, what weight should attach to information provided by professional notifiers.

The CDCRP found that the Department relied on protective factors which were not in fact genuine e.g. that the grandmother would support the mother when it was also noted that they were estranged; that the mother was linked with CHAMP when in fact she had not attended the hospital; that the father would be supportive when it was known that he would be away for work. Further there was no investigations made to resolve contradictory information.

The CDRCP was critical of the review team's findings and conclusions and considered that a number of them were not accurate.

The CDRCP was concerned about the practice of insufficient note taking in the case and was of the view that the importance of timely and accurate record keeping must be reinforced with CSOs. The poor record keeping resulted in new information being lost amongst existing information and treated as thought it had previously been responded to when it had not.

The matter should have been referred to SCAN after T's birth and when he was admitted to hospital. The refusal by the Department co-ordinator to accept the SCAN team referral from QH demonstrated a lack of understanding of the issues and was an "extremely poor decision."

The CDCRP was:

> *alarmed at the disregard by both the Child Safety Officer, Team Leader and Regional Intake Service of information provided by Logan Hospital, including information from doctors, the Child Protection Liaison Officer and the nurses who had observed the*

mother when [T] was admitted on 22 June 2015. There was a wealth of information that raised serious concerns that was ignored.

The CDRCP concluded that an application for a CPO should have been made during that admission and had the Department responded to the medical information as it should have T would not have been returned to his mother's care.

The CDRCP stated:

> *The Panel are very concerned that the case management of this matter appears to indicate a working relationship between Logan Hospital and the Department that is so flawed that children may be placed in situations where there is an unacceptable risk of harm.*
>
> *In this case, whilst receiving and recording information from Logan Hospital assessments and decisions were made without adequate or any reference to the information being provided by these professionals.*

The CDRCP recommended that the Department arrange a review-reflection process with Logan Hospital to share the learnings from this case and identify processes for future engagement.

The CDRCP noted that the comments of Departmental staff interviewed for the SPR indicate a lack of acknowledgement of the degree of the shortcomings in their practise and that a thorough and proper assessment based on reliable facts would have resulted in a different outcome for T and recommended that those officers received comprehensive professional development in regard to assessment and recording of information and investigation and assessment skills. The CDRCP recommended that a plan for the professional development of CSO1, CSO3, CSO4 and TL1 be created to address the issues with their practice that have been identified in the reports.

The CDRCP was "deeply concerned with the response from TL1 which indicated that further information could have been gathered however, 'this unfortunately would not have changed the overall tragic outcome for [T]." The CDRCP considered this response demonstrated poor insight and little regard for the learnings of the review.

The CDRCP concluded that if those particular staff did not change their unsafe practices and implement learnings from this matter into their current conduct of casework their work may result in "children being placed at an unacceptable risk of future harm."

The CDRCP concluded:

> *The assessment of information received by the Department in this case was entirely inadequate. There were many missed opportunities to gather information that was relevant and readily available. The Panel is of the view that if the matter had been properly managed, a decision would have been made that [T] was unsafe in the mother's care and the child would have been removed from her care by agreement or with court intervention. This would have changed the outcome for [T].*

Response from the Department

The Department has advised that the concerns raised by the CDRCP have been addressed. CSO1, CSO3, CSO4 and TL1 are no longer employed by the Department.

A position has been created – the Health Liaison Officer – based at the Logan Hospital to facilitate communication between the hospital and Logan Central CSSC.

Conclusion

I find that T died from SIDS category II against a background of likely mechanical asphyxia due to the mother falling asleep and slumping forward over him.

I find that the Department's assessment of T as being a child not in need of protection was incorrect. That decision was largely the outcome of the Department ignoring important information provided by medical professions in relation to the risk that the mother's drug use posed to T's safety. Doctors and nurses warned the Department that the mother was using drugs and had fallen asleep on top of T but the Department did not adequately assess that information. Had that information been given the significant weight it deserved, it is highly likely that T would have been removed from his mother's care prior to his death.

I publish these findings in order to highlight the risk factors for SIDS including co-sleeping and the use of drugs.

Findings required by s.45

Identity of the deceased –	T, an eight week old infant.
How he died –	T died from sudden infant death syndrome, category II in circumstances of accidental asphyxiation.
Place of death –	Logan Hospital QLD AUSTRALIA
Date of death–	9 August 2015
Cause of death –	1(a) Sudden infant death syndrome

I close the investigation.

Jane Bentley
Deputy State Coroner
CORONERS COURT OF QUEENSLAND