QUEENSLAND COURTS

OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Phil John Richard BRENNAN**
TITLE OF COURT:	Coroners Court
JURISDICTION:	Ipswich
FILE NO(s):	2009/1238
DELIVERED ON:	05 July, 2013
DELIVERED AT:	Ipswich
HEARINGDATE(s):	15.09.10; 22.05.12; and 23.05.12
FINDINGS OF:	D.M. MacCallum, Coroner
REPRESENTATION:	
Counsel Assisting:	Snr Sgt K Carmont
Tania Richards (Mother):	Mr. S. Kissick of Counsel i/b McMillan Kelly & Thomas
Buchanan Brennan: (Father)	NLR
Dept of Communities:	Ms K Carmody of Counsel i/b Crown Law
Dept of Education:	Mr A. Ross of Counsel i/b Crown Law
Qld Health:	Mr B McMillan of Counsel and Mr Cater of Counsel both i/b Crown Law

Phil John Richard Brennan was born on 28 July, 1995 and died on 3 July, 2009 when he was 13 years of age. Master Brennan had a number of health problems including spastic cerebral palsy and epilepsy. He was reliant on assistance for daily living to the extent that his feeding was via a feed button directly into his stomach. He was unable to speak or to mobilise and was severely intellectually impaired with a functioning age of about 6 months.

Prior to death Master Brennan had been experiencing trouble breathing. On the 25 June, 2009 teachers at his school contacted his mother about his breathing and she took him to the doctor. However it seems that by the time he arrived at the doctor his breathing had returned to normal and he otherwise appeared to be fine.

On 28 June, 2009 Master Brennan went to his father's house where he was to stay for approximately a week. During the first few days his father reported that he appeared to have flu like symptoms and that he sounded 'nasally' and 'chesty' but that his symptoms appeared to worsen such that Mr Brennan became concerned and on about 2 July, 2009 he contacted the mother and they agreed the child be taken to the hospital for treatment. It was whilst the father was preparing to take him to the hospital that he (the father) was informed that the child appeared to have stopped breathing. He immediately tried to render assistance and requested that an ambulance be called. Upon the arrival of the Ambulance Service they commenced resuscitation procedures and Master Brennan was taken to the Ipswich General Hospital. Upon arrival he was put on life support but in consultation with the parents that life support was discontinued.

Throughout his life it appears that Master Brennan had a child protection history relating to allegations of neglect and hygiene issues. Concerns had been raised by his school about the maintenance of the feeding peg. Along the way home help was arranged after an earlier period of hospitalisation to assist his mother with bathing and general hygiene management of Master Brennan and to help with household cleaning.

AUTOPSY EXAMINATION

Dr Nathan Milne, a Forensic Pathologist, at Queensland Health performed Master Brennan's autopsy. He found that Phil was significantly underweight and that he also had a number of other developmental discrepancies which were consistent with his physical disabilities.

Dr Milne formed the view that Phil died as a consequence of bronchopneumonia, an infection in the lungs. The doctor was of the view that a person with limited mobility and being underweight is more likely to be predisposed to succumbing to infections such as pneumonia. He was of the

opinion that the symptoms would have been apparent at least 2 days prior to death although if I understood his evidence correctly that might be dependant upon the way in which the pneumonia developed. For example if he had developed the pneumonia from aspirating something then the early symptoms would have been more apparent. However, if he had an upper respiratory tract infection, then that could have been present for some days before the symptoms of pneumonia developed.

Dr Milne was of the opinion that a person with Master Brennan's disabilities should have been managed more proactively by his medical practitioners, in that it should have been obvious that Phil was more susceptible to pneumonia and perhaps more tests should have been performed than in a healthy child of similar age. So for example there should have been blood and/or urine tests performed and he should have been started on a course of antibiotics at a timely stage. Dr Milne did not observe any other signs on the body which alerted him to any other aspect of abuse or maltreatment. He did say however that having regard to the state of the lungs as observed by him that the pneumonia was quite developed such that perhaps Phil should have received treatment at an earlier stage.

DETECTIVE TROY SALTON

At the time of giving his evidence Det Salton was attached to the Child Protection Unit within the QPS and was also a member of the SCAN (Suspected Child Abuse and Neglect) team. SCAN is comprised of members of four core departments, QPS, Qld Health, Dept of Child Safety and Education Qld. SCAN is seen as an information sharing group so that if there are child safety concerns raised there would be a recommendation that Child Safety conduct an investigation to determine if any action needed to be taken to remove the child from what might be seen as a potentially unsafe environment. Likewise if there was a suggestion of criminal activity then QPS would launch an investigation.

Det Salton gave evidence that Master Brennan's case first came to the attention of SCAN in about January 2009 and that the case was mentioned on two occasions prior to his death. The initial referral was from Qld Health and was about hygiene concerns, particularly the alleged presence of maggots around the feeding tube. At that initial meeting it was determined that there were no grounds to initiate an investigation into any potential criminal charges.

In June, 2009 a further referral was made by Education Qld and was in relation to Master Brennan's personal hygiene. However, it seems that there was some discrepancy between the agencies, in that Child Safety informed the team that a child health nurse was attending three times per week to assist the mother and that there was also a commercial cleaning service attending weekly to help with

general house cleaning.

Overall Det Salton's evidence was in relation to the operation of the SCAN team and what could be done to improve the operation of that team. It seems that subsequent to Master Brennan's death, in about August 2012, a new system was put in place whereby the original notifier can refer a matter back to the Dept of Communities for a reassessment of determination and for that Dept to provide reasons for why the matter has proceeded or will proceed in a particular way.

In essence the detective's evidence is that SCAN is an information sharing agency rather than an agency that has directive powers.

EVIDENCE OF DET SGT TANIA PLANT

Det Plant was a relieving member of SCAN for a period of time in 2007. During that time the police had cause to investigate a report that Master Brennan had been left unattended in a car for a period of time. No charges were laid as at that time no specific offence existed and the only possible charge could have been failing to supply necessaries (CC 285/286) which could not be established on the information then available. Det Plant was unable to assist with any other matters which were more immediately relevant to the time immediately prior to Master Brennan's death.

EVIDENCE OF SNR SGT CHARYSSE POND

This officer held a position as SCAN co-ordinator for the period from October 2005 and March 2009. In that time Master Brennan's case was before the SCAN team on three (3) occasions. It seems that between the 12 June 2007 and 22 January 2008 the then Dept of Child Safety had been obtaining extensions to investigate the concerns surrounding Master Brennan's care. At the meeting on 22 January 2008 the Dept provided a report that in their assessment the home safety and the child's hygiene were at an acceptable standard. It seems as though the mother was having difficulties meeting all of Master Brennan's needs and supports were being put in place to assist her.

The officer was unable to take the matter any further.

EVIDENCE OF DET SGT DAVID GRANT HUNTER

Det Hunter was another police officer who had cause to be involved with the SCAN meetings from time to time and who was also aware of the initial Education Qld concern about the unhygienic nature of Master Brennan's feeding tube. Essentially he was not able to suggest any procedures which might assist in the better assessment of cases similar to Master Brennan, particularly having regard to children with significant disabilities.

EVIDENCE OF DET SGT DAVID JOHN TOLSCHER

Again and similar to Det Hunter's evidence Det Tolscher was not able to take the matter further. After a review of the files he was able to say that he recalled the matter being before the SCAN team meetings on 4 September 2007 and 16 October 2007 when the case was continued to enable the Dept of Child Safety to continue its investigation.

EVIDENCE OF DET SNR CONST SHANE GERRARD ROLPH

Det Rolph was the officer who investigated the incident in 2007 when Master Brennan was located apparently in a distressed state in a motor vehicle parked outside the Ipswich Hospital. From those investigations he was informed that Master Brennan could become distressed when separated from his mother even when she was in another part of the house. It seems that on the day in question his mother had left him in the car in a shaded area whilst she went into the hospital pharmacy to obtain some prescription medication. He formed the view that no offence had been committed.

EVIDENCE OF DET SGT NATHAN JOHN McINTOSH

Det McIntosh was the officer assigned the task of investigating the death of Master Brennan.

Det McIntosh interviewed both parents shortly after Master Brennan's death. He states that in his opinion both parents were co-operative and willing to help in the investigation. He obtained photos of the premises were Master Brennan had lived with his mother and had stayed with his father. These comprise part of Exhibit 44 and 45.

EVIDENCE OF BUCHANNAN THOMAS ARTHUR BRENNAN

Mr Brennan gave some graphic evidence about the difficulties experienced in caring for young Master Brennan. From time to time he would provide assistance when it all became too much for the mother.

He stated that during the time that the mother Tania Richards was feeding Phil, he (Phil) seemed to do well but when required to utilise a diet that was prescribed by other agencies he developed reflux problems and irritation around the feeding tube.

Master Brennan came to stay with his father prior to his death. At the time Mr Brennan says that it was apparent to him that Phil was unwell but says that initially he was assured that there was nothing to be concerned about. However he noticed a significant decline in Phil's health and so decided that he should ask Tania what they would need to do about this. In any event it seems that he made the decision himself to get Phil hospitalised. He commenced getting Phil's

clothes and medications together to take up to the hospital when he was informed that Phil had stopped breathing. He says that he screamed for someone to call the ambulance which was done and Phil was taken off to hospital.

EVIDENCE OF TANIA ANN RICHARDS

Ms Richards was Phil's mum and had been the principal care giver during Phil's life. Mr Brennan did provide some help when it would all get too much for her.

Ms Richards had a hard time of it as Phil was a very high needs child and required constant support and assistance. She says that she perfected a diet for Phil which took account of his various intolerances. She states that he was lactose intolerant, had an allergy to red meat and eggs tended to cause him constipation.

When she wanted to get respite care she was told that she would need to use the diet mix required by the dieticians as they found her formula was difficult for them to administer. Ms Richards says that this mix caused problems for Phil in that he seemed to be more inclined to vomit the food back up. She says that at no time was she ever informed that Phil seemed to be not thriving on her formula. She did not seek a lot of help from Dept of Communities as she had the idea that she would have to 'abandon' Phil to the Dept and by that I assume she meant that she would have to consent to him being placed into the custody of the Chief Executive, something that she did not want to do. Towards the end of Phil's life some household assistance was provided to help her in caring for Phil as well as maintaining the household. Ms Richards felt that some of the assistance was unsatisfactory in that some of the cleaners maintained they could not perform certain tasks as they were prevented from doing so by their employer's rules.

It also seems that no additional assistance was provided by way of respite during the school holidays although Ms Richards didn't really pursue it. Obviously Mr Brennan provided some help but she had no other family living locally and able to assist.

Ms Richards denied that Phil ever went to school unclean or dirty. She says that she would always make sure he was washed and clean but that sometimes accidents would happen on the way so that by the time he got there he may have been unclean. It seems that mostly Phil was transported to school by taxi.

Ms Richards agrees that in the week prior to Master Brennan's death she did send him to his father's place to stay for a few days as she needed rest and wanted to catch up on household chores. She agrees that Mr Brennan did text her to say that Phil's health seemed to be getting worse and she says that she

told him to take him to the hospital because that is what she would have done.

EVIDENCE OF ALAN CRAWFORD GRIGG

Dr Grigg gave evidence that Master Brennan was brought in to see him on 25 June 2009 about a week prior to his death. At the time of examination the doctor thought that he had an upper airway infection. He suggested conservative treatment such as Panadol and Vicks. He said that he did not think there was any problem with his chest and so did not consider any further action was required.

EVIDENCE OF STEPHANIE JANE RYDER

Ms Ryder was at the time of giving evidence, a Manager in the Child Protection Branch within the Dept of Communities and Disability Services. She had no direct knowledge of Master Brennan's file or any personal knowledge of him or his family. She was aware of a Systems and Practice Review Report that was prepared subsequent to Master Brennan's death. She agreed that the report did raise issues of concern including the delay in raising a .child protection notification, the handling of any risk assessment and the management of concerns about his hygiene and well being.

Her evidence was principally about the internal management of the section and the best practice procedures which should have operated but which quite clearly did not. I will refer to the report dated 9 December 2009 at a later point in these findings.

EVIDENCE OF MICHELLE ROSE EATHER

Ms Eather was at the time of Master Brennan's death the Regional Director of the South West region, Department of Communities (Child Safety Services). In the position, Ms Eather had responsibility for the whole of the Region including the Child Safety Service Centre which dealt with Master Brennan's file.

Her evidence was again in relation to the structure of the department and how recommendations were implemented. In a nut shell her evidence was that it's a department which had and probably still continues to have limited resources and some difficulty in managing risk assessment. She disputed that there were ever unqualified staff making assessments as this would have been against policy.

At the time of giving evidence Ms Eather had left the department and had limited recall of practices and procedures. However, it seems that whilst delays in dealing with matters could be brought to the attention of the Regional Director that seemed to depend on how the matter was first ‘screened’ at the intake centre. If it was a priority one matter then it needed to be dealt with as a matter of urgency, usually within 24 hours. However if the ‘screening’ was assessed at

a lower priority then there seemed to be little chance of it coming to the Director's attention unless it became the subject of a complaint.

EVIDENCE OF PETER JAMES DAVIS

Mr Davis was the Principal of the Ipswich Special School at the time Master Brennan was a pupil there. Master Brennan was classified as a child with very high support needs. He required the services of a physiotherapist, specialised teachers, occupational therapists, nursing and a dietician. The latter came because of concerns the school had about Master Brennan's weight. They were preparing the food supplied by his mother but because of some concerns the school called in the dietician.

Mr Davis stated that Phil was never fed food that his mother was unaware of and the school always tried to work in partnership with the parents of any of the children at the school and keep them fully appraised of the steps they were undertaking.

Mr Davis stated that the school had made notifications about Phil based on the presence of some bruising which did not seem to be explained by his disability as well as saying that concerns about hygiene had to be something more than again was attributable to his disability.

Overall, Mr Davis presented as a person who had substantial regard for the students under his care and who it seems remained concerned about these children even when they were not under his direct care.

EVIDENCE OF SHERYL JOAN LIVINGSTONE

Ms Livingstone was at the time of giving evidence a Senior Guidance Officer in the employ of the Dept of Education, Training and the Arts. Ms Livingstone was also a member of the Ipswich North SCAN Team although Master Brennan's file was in the Ipswich South/Goodna SCAN Team. She expressed concern about the assessment of his case as a Child Concern Report which meant that it was simply filed and considered that it should have been ‘upgraded’ to a notification which would have meant a more active investigation.

Ms Livingstone expressed her concerns about the SCAN process then operating and probably even with the new process. She was of the view that all persons in child safety should have specific training on the particular vulnerability of children with severe disabilities and that support for the parents and/or carers of disabled children should be enhanced. She expressed some concern about the ability of some parents of severely disabled children to understand the complex needs of those children and to engage or source the appropriate services to provide assistance.

EVIDENCE OF ALLISON FRASER

Ms Fraser was at the time of her evidence the acting Manager for the Toowoomba South Child Safety Service Centre and in March 2009 was the Team Leader for the South West Regional Intake Team. It was her team that received the notices of concern from Education Qld.

It seems that the intake team take the concerns and if they consider it requires further investigation can refer the matter to the service centre in the area in which the child resides. She made reference to the existence of a Complex Needs Panel which can adopt a multi disciplinary approach to a child with numerous needs.

Overall Ms Fraser spoke of the problems with staffing to meet the workload which faced this department.

EVIDENCE OF TERRANCE NEIL KENT

Dr Kent was Master Brennan's doctor. He says that on average his practice was seeing Master Brennan on a monthly basis over a period of about eight years. Dr Kent did not see Master Brennan on every occasion. He says that he did not observe anything which would have caused him to be concerned about Phil's safety and/or care. He last saw Phil on about 17 June 2009 when he presented with bronchitis.

EVIDENCE OF KAREN ANN CROUCH

Ms Crouch was the Acting Group Manager with Spiritus which is now called Anglicare.

She advised that Master Brennan came into the Spiritus service on 2 April 2007 and remained with their service until his death. The service provided hygiene services three (3) days per week to assist Ms Richards in bathing Phil. Also housecleaning services were provided fortnightly again to help with household chores for Ms Richards.

On about 25 March 2009 one of the service's Coordinators made a referral to improve the suitability of the housing situation. In addition a referral was also made for a physiotherapist to review the handling requirements associated with Phil's care. It seems that on 19 June 2009 a telephone call was received from Child Safety and concern was expressed about the state of the home as there was pet hair on the floors which were also cluttered with clothes and boxes. Some comment was also made about the sleeping arrangements as both Ms Richards and Master Brennan were sleeping on beds in the lounge room. Why this was of concern was never made clear. At the time of a further call on 2 July 2009 the department was advised that hygiene and domestic assistance was on

hold from 29 June 2009 to 13 July 2009 at the request of Ms Richards.

EVIDENCE OF MARGUERITE GEORGINA MASTERMAN

Ms Masterman was the Principal Program Officer within the Child Protection Programs Development Workgroup, a division of Child Safety.

She states that she was the Team Leader of the intake team at the Ipswich South Child Safety Service Centre when information was received on 21 May 2007. This was the incident in which Phil had been left unattended in the car whilst she went to get his medication from the pharmacy at the Ipswich Hospital. This information was assessed as a requiring a 10 day response priority time frame. It was not assessed as being a situation which required immediate intervention.

It was part of her duties as Team Leader to check the assessment of the officer who made the assessment. She had no recollection of Master Brennan's file and had no direct dealings with him or his family. At the time the assessment was made she had no specific knowledge of his medical conditions and/or disabilities other than what had been provided in the notification.

The above is a brief summary of the evidence given by the witnesses called during the hearing. For the record I note that affidavits were provided by a number of other persons from the various departments and organisations involved either directly or indirectly with Master Brennan but such evidence was either uncontentious or not specifically relevant to the issues.

OBSERVATIONS

This Inquest was called to consider a number of issues and to determine if any recommendations should be made.

Amongst the issues were the following:

(1) The recording, processing and management of notifications within Child Safety and the training of staff in the handling of such notifications in so far as they relate to a child with disabilities and/or vulnerability;

(2) The response time frames and follow up procedures of such notifications:

(3) Any duty of care owed by other government departments which come into contact with disabled children;

(4) Any duty of care owed by any non government organisation operating under the auspices of a government department;

(5) Whether the policy and procedures of government departments is sufficient to discharge any duty of care to a disabled/vulnerable child.

(6) What and whether any oversight procedures are or should be in place to ensure any duty of care is monitored to ensure the safety and general wellbeing of a disabled/vulnerable child.

During the hearing issues were raised about the condition of the gastrostomy feeding tube, some suggestion of malnourishment and the level of care provided by his parents, in particular his mother who was his primary care giver. As a consequence the Inquest was concerned whether the Department of Communities, in particular the Child Safety division had properly discharged it's obligations to ensure Master Brennan's safety and wellbeing.

Dr Milne the Pathologist who performed the autopsy was of the view that there was no evidence of malnutrition, no signs of physical abuse (e.g. unexplained bruising, fractures or the like) and nor was there any sign that the gastrostomy tube was infected or unhygienic.

Although Dr Milne considered Phil's weight was below the average for a child of his age, he explained that it's always difficult to determine what is appropriate for a child with such disabilities. The percentile tables are developed for 'normal' children, i.e. children with no complicating disabilities or health conditions. However, there were none of the usual signs of skin lesions and dry flaky skin which might have been expected had he been malnourished.

I also note that none of his treating medical practitioners were concerned about the state of his feeding tube or that he appeared to be malnourished. It should also be noted that the independent agency, Spiritus (as it was then known) did not raise any concerns about the feeding tube or that Phil appeared to be malnourished and they were clearly in a position to notice such a thing.

I also note that everyone who came into contact with Phil's mother, Ms Richards were of the view that despite the onerous task of caring for a child in the same condition as Phil, she presented as a loving and caring mother who was, under extremely trying and debilitating circumstances, doing her absolute best to care for him. It is clear she loved him dearly.

On the evidence before this Inquest there is no possibility that any adverse comment could be made against Ms Richards or for that matter Mr Brennan or that they were in any way culpable for his death. As Dr Milne observed the reason why people in the situation of Master Brennan can die from complications is their inability to verbalise their symptoms and that pneumonia can develop within a couple of days prior to death so that no one could reasonably have been able to determine the serious condition then developing.

In making that statement I do note that Dr Milne was also of the view that perhaps his medical practitioners should have been more proactive in treating

Phil. Neither Dr Grigg nor Dr Kent was closely questioned about this aspect so I can take this no further. Perhaps it was a situation in which the doctor thought that if the situation deteriorated then the mother would bring him back for more treatment. However, there are issues with the Child Safety division that need to be addressed. It is clear that, like all government departments it is under resourced and yet required to ensure the safety and well being of children. One can well imagine that prioritisation is paramount and that the most urgent cases go to the top of the list with everything else coming along behind.

I acknowledge that Master Brennan was not a child in care in accordance with the *Child Protection Act 1999*. Be that as it may, concerns had been raised about Master Brennan's general care and having regard to his particular vulnerabilities that should have been thoroughly investigated. To rely upon the observations of a service (Spiritus) that had no child protection responsibility (other than the most obvious ones) is unsatisfactory. It also seems that no one who was making these assessments had any real knowledge of his medical condition and needs, apart from a general knowledge of the disability.

Subsequent to Master Brennan's death a Systems and Practice Review was conducted and a report dated 9 December 2009 was delivered. That report identified areas ‘for improvement’ including the following:

(a) CSSC (Child Safety Service Centre) staff knowledge and skills, particularly in relation to information gathering and assessment, need to be continuously developed through participation in relevant training and professional development and implementation of such knowledge and skills needs to be reflected upon in forums such as formal and informal supervisions or during practice consultations;

(b) CSSC staff need to ensure that they understand and implement departmental policies and procedures, particularly in relation to pre-notification checks; and

(c) CSSC staff need to ensure that other agencies are used to their best advantage in the SCAN AMT forum by inviting other stakeholders whenever these individuals will add to the discussion.

In a long winded and somewhat jargonistic way, I interpret this as meaning that the Department accepts that better training is required, that staff be more proactive in conducting checks in a timely fashion and that resource sharing between departments should be encouraged and utilised.

I have to say that the way in which this report is presented one might wonder if staff would at the end of the day, have any clear understanding of their obligations and perhaps these reports and/or directions should be written in a

more ‘user friendly’ fashion.

It is accepted that the Child Safety division does have a duty of care to children to ensure that they are safe and secure and that their needs are being properly met. I use the term ‘duty of care’ in a general fashion and separate from any statutory obligations. However the department clearly performs a mammoth task with ever decreasing resources and mostly does so in a professional and appropriate way. As with all systems, there will be unacceptable delays and a review of priorities in a way that may cause the system to fail those it's required to care for. The department to its credit has acknowledged that and used this as an opportunity to improve its response. It’s also fair to observe that history has effectively overtaken this inquest in that the Carmody Inquiry will undoubtedly make wide ranging and sweeping recommendations for the overall for the overall improvement of the child safety system.

Education Qld has acknowledged its duty of care to Master Brennan and children with similar conditions. I can say that all the witnesses called from the special education section of Education Qld presented as immensely caring and concerned people who wanted only to help disabled children so as to give them the best life possible. The concerns raised by them were done with the best of intent although it seems their unique independent observations were not tapped into. I have to say however that the findings of Dr Milne did not support those concerns although that should not be interpreted as a criticism for lodging the information. That department has policies in place to ensure its duty of care is discharged and I can find no reason for any further actions in its regard.

With regard to Spiritus and similar non government organisations, it is clear that at least some of its personnel were aware of Ms Richards’ situation and were working with her to extend her support system. Obviously it has some duty of care to ensure that matters of concern are raised with the appropriate government department but it would seem that no one actually thought Master Brennan was at any serious risk. However organisations such as Spiritus which have a very ‘hands on’ involvement with persons in the position of Master Brennan and should be actively involved in any assessment of needs and/or protection issues.

Overall, I consider the issues for which this Inquest was established have been investigated and propose to take the matter no further by making any specific recommendations.

To Master Brennan's parents I extend my sympathies and congratulate them, particularly Ms Richards on the love, care and tireless devotion given by them to their much loved son during his life. I am sure that his absence in their lives is a continuing loss. I also apologise for the delay in delivering these findings.

FINDINGS REQUIRED BY s 45 CORONERS ACT 2000

Identity:	Phil John Richard BRENNAN
How death occurred:	Master Brennan died at Ipswich General Hospital after having experienced breathing problems at the residence of his father.
Place of death:	Ipswich General Hospital
Date of Death:	3 July 2009
Cause of Death:	Staphylococcus aureus bronchopneumonia *Due to or as a consequence of* Perinatal hypoxic-ischaemic brain injury.

The Inquest is now closed.

D.M. MacCALLUM, Coroner

IPSWICH

5 July 2013