JURISDICTION	**:**	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	**:**	CORONERS ACT 1996
CORONER	**:**	Rosalinda Vincenza Clorinda Fogliani, State Coroner
HEARD	**:**	9-11 SEPTEMBER 2019
DELIVERED	**:**	23 SEPTEMBER 2020
FILE NO/S	**:**	CORC 112 of 2016
DECEASED	**:**	PT

Catchwords:

Nil

Legislation:

Nil

Counsel Appearing:

Mr T Bishop assisted the State Coroner.

Ms N Eagling, with Mr E Cade (State Solicitor's Office) appeared on behalf of the Department of Communities and the Child and Adolescent Health Service.

Ms M Naylor (Tottle Partners) appeared on behalf of Dr John Spencer and Dr Richard Martin.

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

I, Rosalinda Vincenza Clorinda FOGLIANI, State Coroner, having investigated the death of ***PT (Subject to a Suppression Order)*** *with an inquest held at the Perth Coroner's Court, Court 85, CLC Building, 501 Hay Street, Perth on 9-11 September 2019, find that the identity of the deceased person was* ***PT*** *and that death occurred on 27 January 2016 at St John of God Hospital Midland, as a result of aspiration of vomit, with microscopic early pneumonia, in a child with a history of cerebral palsy and epilepsy in the following circumstances:*

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Warning: The contents of this finding may be particularly distressing to readers because the contents refer to inflicted injuries suffered by a very young infant.

SUPPRESSION ORDER

Suppression of the deceased child's name from publication and any evidence likely to lead to the child's identification. The deceased child is to be referred to as PT.

INTRODUCTION

1. This is my finding upon inquest, in relation to the tragic death of a young child who had been removed from her parents by Order of a Court, upon application by the Department for Child Protection (DCP, now known as the Department of Communities). Under this arrangement, the child was placed into the care of foster carers when she was two and a half months old. The child had been removed from her parents because she sustained a life threatening traumatic head injury while in the custody and care of her parents.

2. The child had been in the custody and care of her parents between the time of her birth on 11 January 2011, including up to the time of her hospitalisation commencing on 1 March 2011. Her injury, shortly before her hospitalisation, was likely non-accidental.

3. As a result of her injury the child became profoundly disabled and required a high degree of care. She remained a non-verbal quadriplegic with cerebral palsy, she suffered from seizure disorder, she was visually impaired, and she needed to be fed by means of a percutaneous endoscopic gastrostomy (PEG) tube. She died at St John of God Hospital Midland on 27 January 2016, when she was five years old.

4. For legal reasons, the child's name and any information likely to identify her is suppressed, and she is referred to in this finding as PT.

5. PT's death was a reportable death within the meaning of s 3 of the *Coroners Act 1996* (WA) (Coroners Act) because she was a "*person held in care*" by reason of being subject to a Protection Order under the *Children and Community Services Act 2004* (WA).

6. Under s 19(1) of the Coroners Act, I have jurisdiction to investigate PT's death. The holding of an inquest, as part of the investigation into her death, is mandated by reason of s 22(1)(a) of the Coroners Act because immediately before her death PT was under the care and protection of the Chief Executive Officer of the Department of Communities.

7. I held an inquest into PT's death and heard evidence from eight witnesses between 9 and 11 September 2019. During the inquest I received the following number of exhibits into evidence:

   a) Exhibit 1, containing 30 tabs;
   b) Exhibit 2, containing 24 tabs;
   c) Exhibit 3, containing electronic medical files from the Child Protection Unit of Princess Margaret Hospital;
   d) Exhibit 4, containing seven tabs;
   e) Exhibit 5, containing four tabs; and
   f) Exhibits 6 to 10.

8. After the inquest, between 17 and 19 September 2019, I received the following number of exhibits into evidence:

   a) Exhibit 11, containing five tabs;
   b) Exhibit 12, containing five tabs; and
   c) Exhibit 13, containing four tabs.

9. My primary function has been to investigate PT's death. It is a fact-finding function. Pursuant to s 25(1)(b) and (c) of the Coroners Act, I must find if possible, how PT's death occurred and the cause of her death.

10. Pursuant to s 25(2) of the Coroners Act, in this finding I may comment on any matters connected with PT's death, including public health or safety or the administration of justice. This is the ancillary function.

11. Pursuant to s 25(3) of the Coroners Act, as PT was a person held in care, in this finding I must comment on the quality of the supervision, treatment and care of PT while in that care. This obligation reflects the community's concern about the treatment of children who are removed from their parents.

12. Section 25(5) of the Coroners Act prohibits me from framing a finding or comment in such a way as to appear to determine any question of civil liability or to suggest that any person is guilty of an offence. It is not my role to assess the evidence for civil or criminal liability, and I am not bound by the rules of evidence.

13. Pursuant to s 44(2) of the Coroners Act, before I make any finding adverse to the interests of an interested person, that person must be given the opportunity to present submissions against the making of such a finding. At the end of the inquest on 11 September 2019, and by correspondence dated 18 September 2019, submissions were made to me concerning potential adverse comments, and I have taken those submissions into account in formulating my comments.

14. Where I have made any adverse comment in this finding, it is to be clearly understood that none of the conduct referred to caused or contributed to PT's death.

15. In making my findings I have applied the standard of proof as set out in *Briginshaw v Briginshaw* (1938) 60 CLR 336 per Dixon J at 361 - 362 which requires a consideration of the nature and gravity of the conduct when deciding whether a matter has been proved on the balance of probabilities.

16. My findings appear below.

EVENTS LEADING UP TO INITIAL INJURY

17. The child PT was born at term, with no complications or health issues, on 11 January 2011 and she was discharged home into the care of her parents on the day after her birth.

First medical review

18. On 15 February 2011, when PT was five weeks of age, she was taken by her mother to be reviewed by the Community Health Nurse. PT was observed by the Community Health Nurse to have bruises on the left side of her cheek and chin and a small scratch on her nose and forehead. PT's mother reported that it seemed like she was in pain, but she was settled in the clinic. PT's mother also told the nurse that PT had been punching herself because she was constipated. The Community Health Nurse advised PT's mother to take the child to see a GP.[1]

19. As a consequence, PT's mother took her to be reviewed by GP Dr John Spencer (Dr Spencer) on the same day (15 February 2011). The history obtained by Dr Spencer was that PT was grizzly and upset, especially later in the day/early evening. Dr Spencer noted that PT had gained weight and he observed no abnormalities on examination.[2]

20. Dr Spencer did not make a note of any bruising on PT at that consult. At the inquest Dr Spencer testified that if he had noted bruising on PT on that date, he would have written it down. The Community Health Nurse did not directly inform Dr Spencer of the bruising, nor did PT's mother tell him that the Community Health Nurse had recommended the referral to him, because of the bruising.[3]

21. Dr Spencer's clinical assessment was that PT had typical signs of infantile colic, and at the inquest he described it as a "*common presentation*" in respect of an infant. He ordered blood and urine tests to exclude infection or other significant illness. The consultation was for approximately 16 minutes. Dr Spencer had known PT's grandmother since the early or mid-1990's, he recalled the mother as a child, and he was her GP and obstetrician during her pregnancy with PT. He had a good relationship with PT's mother and grandmother, leading him to trust them.[4]

[1] Exhibit 2, tab 20.
[2] ts 18 to 19; ts 32 to 33.
[3] Ibid.
[4] ts 15 to 17.

22. PT's blood tests became available to Dr Spencer on 18 February 2011 and they revealed thrombocytosis, namely raised platelets at 1156 x 10^9/L (platelets being blood cells that help form clots to stop bleeding). The test results contained the haematologist's comment: "*The thrombocytosis is interpreted as reactive*." This meant the raised platelets were reacting to something, such as trauma or infection (though that was not specified, and could not have been specified in that context).[5]

23. At the material time Dr Spencer did not apprehend that platelets may be raised as a response to trauma. He took the precaution of discussing PT's blood test results with a paediatrician, to seek his opinion, and he was advised to repeat the test in a week or so. Dr Spencer acted on this advice and made arrangements to repeat PT's blood test.[6]

24. At this juncture, if it had been more generally understood that a bruise on a non-ambulant infant is a red flag, warranting prompt specialist investigation, and if it had been more specifically understood that that a raised platelet count may be a response to trauma, the matter would likely have taken a very different course, leading to a thorough investigation of the circumstances giving rise to the bruising on PT. It is to be borne in mind, however, that at this juncture, Dr Spencer had not sighted a bruise on PT.

Second medical review

25. On 24 February 2011, when PT was six weeks of age, she was again taken by her mother to be reviewed by the Community Health Nurse. The results of initial blood tests showing an increased platelet count were documented. The Community Health Nurse observed that PT had bruising on the left side of her check and right upper forehead, each approximately the size of a 50 cent piece. PT's demeanour was quiet. Her mother appeared slightly defensive when questioned by the Community Health Nurse about the bruising, and again appears to have reported that PT had punched herself in the face while constipated.[7]

[5] ts 273 to 277.
[6] ts 20 to 21.
[7] Exhibit 1, tab 20.

26. As a consequence, the Community Health Nurse referred the matter of PT's injuries to the DCP, by telephone contact with the DCP Senior Field Worker. This was the first time PT came to the attention of the DCP. The Community Health Nurse sounded worried. The Regional Office of the DCP immediately opened an Interaction Process on suspicions of possible abuse because it was understood by them that a baby of approximately six weeks of age is not able to punch or hit themselves so as to create a bruise. The Senior Field Worker assessed the bruise as being an indicator of potential physical abuse and a risk to PT's safety.[8]

27. That same day in the afternoon (24 February 2011) a priority 1 home visit was conducted by two DCP staff members, one of them being the Senior Field Worker, for the purpose of assessing PT's bruising. On the second attempt to make contact, the mother of PT, and later her father, were at home. The Senior Field Worker observed a dark visible bruise on PT's left cheek. No other visible injuries or bruises were seen elsewhere.[9]

28. The Senior Field Worker was concerned about the bruise on PT's face. Self-evidently, she understood that a six week old baby cannot inflict those bruises on her own face. The mother's explanation was that she was informed it was due to PT's blood condition. The Senior Field Worker wanted confirmation and asked the mother to take PT to the Regional Hospital, but the mother declined due to previous interactions with that care provider. The mother did agree to take PT to her GP, for a medical assessment of the bruising.[10]

29. In the Senior Field Worker's presence, PT's mother had a telephone conversation with her GP, Dr Spencer. PT's mother relayed back to the DCP Senior Field Worker that Dr Spencer would not be discussing PT's case directly with the Senior Field Worker, that PT's bruising was due to her high platelet count, and that Dr Spencer would be seeing PT the following morning. At the inquest, Dr Spencer did not recall PT's mother telephoning him on 24 February 2011, in the presence of DCP, and asking him to speak with DCP.[11]

[8] Exhibit 4, tab 1; ts 40 to 41.
[9] ts 40 to 43.
[10] ts 40 to 43; ts 291.
[11] ts 33 to 34; ts 44 to 45.

30. The DCP Senior Field Worker did recall that telephone conversation occurring, but obviously only heard PT's mother speaking on the telephone. At the inquest the DCP Senior Field Worker explained that if she had had the opportunity to speak directly with Dr Spencer during that telephone call, she would have explained why DCP attended PT's home, and what she had seen on PT's face. She would have asked him to examine PT to ascertain if there were other injuries, including internal injuries.[12]

31. After the home visit, the DCP Senior Field Worker contacted the Community Health Nurse, to inform her of the upcoming GP appointment and confer about the nurse's discussions with PT's mother. The home visit also enabled the DCP Senior Field Worker to gain an impression of PT's home environment. From that home visit, she observed that PT had a good rapport with her mother, who showed affection towards her, and that the home environment appeared suitable.[13]

32. As arranged, the following morning (25 February 2011), PT was reviewed by Dr Spencer, having been taken there by her mother, with her grandmother in attendance. This consultation was for approximately 17 minutes. DCP officers did not directly contact Dr Spencer about this consult. However, due to their preceding interactions with PT's family, the DCP was under the impression that Dr Spencer knew he was reviewing PT at their behest.[14]

33. At the inquest, Dr Spencer explained that he did not understand this consult to be an examination of PT on behalf of DCP. Dr Spencer thought that PT's mother and grandmother came in because the mother felt accused by DCP of hurting her child, and they wanted help regarding that accusation. He recalled them being upset. It is clear, however, that Dr Spencer knew that DCP had some concern about PT, and that it related to her bruising.[15]

[12] ts 44 to 45.; ts 51.
[13] Exhibit 2, tab 19; ts 52.
[14] ts 22 to 23.
[15] Ibid.

34. Dr Spencer described the demeanour of the mother and grandmother during this consult as caring and loving towards PT. When he was told that PT's mother had been reported to DCP because of bruising on her face, he did not believe that the mother could be hurting the child.[16]

35. During his examination of PT, Dr Spencer noted that she was gaining weight, smiling and her constipation appeared to have resolved. On this occasion Dr Spencer did note that PT had a small scratch with an underlying bruise on the left side of her cheek and a small resolving bruise on the right side of her nose. At the time he felt these injuries were self-inflicted by PT's fingernails. No other marks were seen. Dr Spencer thought there was a link between PT's high platelet count and her bruising. However, he proceeded to repeat the blood test for PT, in accordance with the paediatrician's earlier advice, and placed an order for that to occur.[17]

36. At the request of PT's mother, Dr Spencer wrote an open letter dated 25 February 2011, essentially in support of her parenting, to assist her with her concerns that she had been wrongly accused by DCP of harming PT. Dr Spencer was aware that the mother's intention was to show it to DCP if she needed to. Dr Spencer's letter contained the following comments:

> *"This child currently has a haematological disorder that predisposes to bruising. I can find no evidence for non-accidental injury & have no suspicions that this is occurring. I do not think DCP should be involved any further with this child but will report any significant changes should they occur."*[18]

37. It is clear from this letter that Dr Spencer linked PT's high platelet count to her bruising, and it is also clear on the face of the letter that he was aware DCP had an involvement in the matter, and that he held the view that they should not be involved.

38. As outlined earlier, at this stage Dr Spencer was not aware that a high platelet count could be a response to trauma, and he had not appreciated the import of the haematologist's comment on PT's blood tests to the

[16] Exhibit 1, tabs 10 and 11; ts 32; ts 191; ts 292.
[17] ts 16; ts 22 to 23; ts 29 to 30.
[18] Exhibit 1, tab 10; ts 24; ts 34.

effect that the raised platelets were interpreted as reactive. Dr Spencer thought it may have been a bone marrow issue where platelet count was high and bruising could occur. At the inquest he referred to this condition as "*essential thrombocythemia*" and having subsequently researched this, he is now aware that it usually requires specialised haematological treatment.[19]

39. At the inquest Dr Spencer explained that he felt he lost his objectivity with this presentation. In balancing the matters of looking after PT's interests, and writing the letter to help the mother, he conceded that balance was not right. He was focussed on the mother's plight, having known the mother and grandmother for quite some time and trusting them.[20]

40. Dr Spencer testified that with the benefit of hindsight, he would now note any bruising upon a child less than six months old, and is now fully aware of the causes of a high platelet count. At the material time, he did not realise the significance of bruising on young children's faces. When his attention was drawn to his open letter dated 25 February 2011, he stated that he would not write such a letter again.[21]

41. PT's mother took Dr Spencer's letter to the offices of the DCP the same day (25 February 2011). At the inquest the DCP Senior Field Worker explained that she saw this letter the following week when she returned to work, and it made her think that the child had a blood disorder, and relieved a little bit of that fear she held, that someone had hurt PT.[22]

42. With the benefit of hindsight, Dr Spencer considered that if an infant child now presented to him with bruising on the face of the nature he saw with PT, he would investigate the child a lot more thoroughly, arrange for a skeletal survey such as x-rays, and if he was concerned about physical abuse, he would likely call PMH and seek advice and direction, stating: "*….with the wisdom of hindsight I wouldn't miss signs of physical abuse*."[23]

[19] ts 24; ts 29; ts 274 to 277.
[20] ts 22 to 25; ts 28.
[21] ts 26; ts 35 to 36.
[22] ts 44.
[23] Ibid.

43. On 28 February 2011, a few days after Dr Spencer saw PT for the second time, PT's repeat blood tests became available to him. They showed that her platelets were still high, but had fallen from 1156 to 814 x 10^9/L. Haemoglobin, while still in normal range had fallen from 131 to 102 g/L. At the inquest Dr Spencer explained that he saw this result as showing that PT's platelet count was recovering to normal (though it was still double the normal range). It made him think that PT's initial high platelet count was probably reactive to something that had stopped occurring. He did not consult the paediatrician on the matter of PT's repeat blood tests, nor did he hold any further concerns for PT.[24]

44. At the inquest Dr Spencer expressed his sorrow at what later happened, in the context of PT's subsequent and life-threatening injuries.[25]

Comments on the medical reviews

45. I heard evidence from specialist doctors involved in PT's care after her hospitalisation, and evidence from an independent expert, that related to PT's care and treatment by the GP Dr Spencer, prior to her hospitalisation.

46. Dr Geraldine Goh (Dr Goh), the paediatrician from the Child Protection Unit at PMH who reported on PT's subsequent and traumatic injuries, gave evidence at the inquest to the effect that it is "*highly unlikely, nearly impossible*" for a baby to cause herself bruising, such as was seen by Dr Spencer on PT's face on 25 February 2011. Dr Goh referred to such bruises as "*sentinel injuries*" that can have serious consequences for a young baby.[26]

47. Independent expert Dr S P Nair, Senior Consultant Paediatrician with experience in forensic paediatrics and child protection work, was asked to review PT's blood tests, as part of an opinion that included a review of the GP involvement in PT's case. In his report to the coroner, Dr Nair focussed on the fall in PT's haemoglobin, and its implications:

[24] ts 30.
[25] ts 36.
[26] ts 67; ts 71.

> "*When the blood tests were repeated a week later the platelet count was falling, but even more concerning is that the Haemoglobin level had fallen from 131 to 102 g/dl, in just one week. This would certainly imply that there had to be blood loss somewhere in the deceased's body, however because of the preoccupation with the platelet count, the significant fall in the haemoglobin count within one week had gone completely unnoticed. It is most likely therefore that the elevated platelet count was a reactive response to blood loss haemorrhage within the body of the deceased in the preceding one to two weeks*."[27]

48. At the inquest Dr Spencer confirmed that his focus was indeed on the platelet count, that was still outside the normal range (though dropping), but because the haemoglobin count was within the normal range, he did not specifically look at it, to ascertain that it had dropped. He posited that a fluctuating haemoglobin level is sometimes caused by fluctuations in hydration.[28]

49. Dr Nair explained that PT's initial high platelet count was very elevated and extremely rare, and he has never seen such a level in over 20 years of specialist practice. Having regard to what became known of PT's injuries, at the inquest he opined as follows:

> "*….that elevated platelet count was a response to trauma, so clearly the trauma that she had suffered in the preceding days or one or two weeks prior to that. Clearly the fall in that haemoglobin level would have reflected the blood that they saw in the subdural spaces, that massive amount of blood on the catastrophic presentation. That will have, you know – somewhere – she had a – she had a few subdurals, and that would have reflected the blood loss there because that's clearly where there was some blood loss*."[29]

50. It transpired that PMH had later confirmed to DCP (consistent with Dr Nair's advice), that the raised platelet levels meant that there was trauma to PT.[30]

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[27] Exhibit 1, tab 8.
[28] ts 38.
[29] ts 255; ts 258.
[30] ts 45 to 46.

51. In Dr Goh's considerable experience, a platelet count as high as PT's would trigger a consult to a neonatologist or a haematologist. Balancing this, it is to be borne in mind that on the matter of the high platelet count, Dr Spencer did consult a paediatrician, and he testified that the advice he received was to repeat PT's blood test in one or two weeks.[31]

52. Regarding the accessibility of specialist doctors for advice, Dr Goh explained that at the material time in 2011, and up to the present, the Child Protection Unit at PMH had (and continues to have) an on call consultant available for telephone consultation generally during working hours, for medical practitioners having child protection concerns (after hours calls are re-directed to the Emergency Department).[32]

53. Dr Goh's evidence was that, if hypothetically, they had received a call about the bruise seen on PT's face, the advice to the GP would have been to refer the child to the local hospital, a paediatrician if available, undertake a skeletal survey and if there were concerns around lethargy or any neurological symptoms, they would be advising a CT head scan. If the Regional Hospital was not equipped, they would advise transfer to Perth provided the child is stable.[33]

54. It is of relevance to note that Dr Spencer had not been directly contacted by DCP or Community Health Nurse, and he did not know the extent of the grounds for suspecting abuse in relation to PT. His medical notes reflect that he was aware that the bruising on PT's face had been referred to DCP. It is also clear, from the terms of Dr Spencer's own letter, that he knew that non-accidental injury to PT was suspected by DCP.[34]

55. It is not clear to me that Dr Spencer understood the extent to which DCP was to rely upon his letter, but it does appear on the face of his letter, that his aim was to seek to persuade: "*I do not think DCP should be involved*

[31] ts 80; ts 89.
[32] ts 70 to 71, ts 110.
[33] ts 72.
[34] Exhibit 1, tabs 10 and 11; ts 32; ts 191; ts 292.

any further with this child but will report any significant changes should they occur."[35]

56. Dr Spencer's evidence was that DCP did not ever ask him to do a medical assessment of PT on 25 February 2011, and that he had not ever been asked by DCP to do a medical assessment of a child in a case of suspected abuse. He felt that if another health professional had approached him directly and explained their concern, it would have made a big difference to him.[36]

57. At the inquest DCP Senior Field Worker agreed that with the benefit of hindsight, DCP ought to have talked directly to Dr Spencer and that he ought to have been informed that the Community Health Nurse had expressed concerns to DCP about PT. The DCP Senior Field Worker's evidence was that it was not, in 2011, a requirement for DCP to talk (or contact) Dr Spencer. Nor, to her knowledge, was there a practice of DCP officers speaking with GP's in a case such as this.[37]

58. At the inquest Dr Goh agreed that if DCP was in possession of information that a Child Health Nurse had safety concerns about a child, that information ought to be shared with the doctor (such as Dr Spencer). Further, that there ought to be open discussions about the concerns, and she agreed that it ought to be made explicit to the examining doctor that DCP will rely on their report.[38]

59. This perspective was supported by the Team Leader of the Child Protection Unit at PMH, whose expectation was that the DCP would phone the GP if they have directed the child be taken to the doctor, and would check back with the GP within a day or two if they do not hear back.[39]

60. It was also supported at a general level by Dr Karen Langdon, Consultant Paediatrician in Paediatric Rehabilitation Medicine, who on a review of

[35] Ibid.
[36] ts 34; ts 37.
[37] ts 43 to 44; ts 55 to 56.
[38] ts 82; ts 121; ts 130.
[39] ts 131.

the clinical records, noted that: "….*there were other people being asked for other opinions, where there was a definite function that they didn't know they were fulfilling*."[40]

61. In practice, Dr Spencer's letter of 25 February 2011 did not unequivocally delay the DCP investigation. On the afternoon of the meeting arranged between DCP Senior Field Worker and the Team Leader to discuss the next step to be taken by DCP, very sadly police made contact with them to advise PT was in hospital (having by then sustained her serious and life-threatening injuries). It is clear DCP were still exercising a function and looking into the matter, notwithstanding Dr Spencer's letter.[41]

62. There may have been an element of delay to the DCP investigation caused by Dr Spencer's letter, because the DCP Senior Field Worker had expected the DCP Team Leader to contact Dr Spencer to see that PT had been taken there, and talk to him about the outcome. However, it was noted that PT's mother had quite promptly attended DCP's offices with Dr Spencer's letter on 25 February 2011, and this appears to have either partially allayed DCP's concerns, and/or caused the matter to be de-prioritised. It is to be borne in mind that Dr Spencer's letter specifically contained a purported diagnosis, namely he referred to PT having a "*haematological disorder that predisposes to bruising*." It is understandable that this could operate to allay some concern.[42]

63. In Dr Nair's opinion, on this point Dr Spencer was commenting well outside his area of expertise, and that he formed a conclusion that the high platelets were due to a haematological disorder with no basis for that, no further investigations, and no discussions with a specialist or a sub-specialist to support that. Dr Nair did, however, agree that a GP in a regional area that is consulted on such a matter is in an invidious position, that it would be a difficult assessment to make, and it was borne in mind that Dr Spencer did consult the visiting paediatrician, who advised him to repeat PT's blood tests.[43]

[40] ts 98.
[41] ts 45.
[42] ts 51.
[43] ts 260; ts 264.

64. I have considered Dr Spencer's letter dated 25 February 2011, and taken account of the information before me, and his submissions through his counsel. It was relevantly submitted to me by Dr Spencer that:

a) he had not been fully informed of the reasons for the referral to see PT by the Community Health Nurse or DCP, nor did he receive formal instructions to assess PT;

b) he had not received any education about the implications of a bruise on the face of a non-ambulant child;

c) he had no prior clinical experience in assessing or recognising signs of child abuse;

d) his knowledge of PT's grandmother and mother were confounding factors in the consultations in February 2011, he did not believe the mother was responsible for the abuse and she appeared appropriately protective;

e) he was not aware that his letter of 25 February 2011 would be relied upon by DCP for a child safety assessment;

f) he took the precautionary step of consulting with a paediatrician, and was reassured by his advice to take a further blood test in seven days; and

g) the haematological results were a confounding factor and outside the ordinary experience of a GP.[44]

65. Before Dr Spencer wrote his letter dated 25 February 2011, upon noting the finding of thrombocytosis made on PT's blood tests, Dr Spencer had contacted a paediatrician and had discussed PT's haematological results with that paediatrician. The paediatrician's advice was to repeat the test in a week.

[44] ts 283 to 286.

66. Dr Spencer's letter dated 25 February 2011 addressed to whom it may concern made the following comment: "*the child has a haematological disorder that predisposes to bruising*." Through his counsel Dr Spencer accepts that, with the benefit of hindsight, a purported diagnosis to that effect was outside his area of expertise. As it transpired, the diagnosis was incorrect.

67. Dr Spencer's letter dated 25 February 2011 also states: "*I do not think DCP should be involved any further with this child*." Through his counsel, Dr Spencer accepts this portion of his letter was ill-advised.

68. The difficulty with the sequence of events is that DCP knew that objectively speaking, a bruise on the face of a non-ambulant child was in effect a red flag, and Dr Spencer did not know that, and he was not directly contacted and informed about the specific risk. He did however know that DCP had a concern about the bruise being non-accidental. It serves to show the importance of clear and unequivocal communications. This is addressed in greater detail immediately below.

69. The risk of such a misunderstanding in similar circumstances in the future has now been addressed by clear guidance in the High Risk Infant Policy, referred to under the heading *Improvements*, later in this finding.

Comments on DCP interactions with GP prior to hospitalisation

70. At the inquest I heard evidence from Mr Glenn Mace, executive director, State-wide Services and South East Metro, Department of Communities, regarding DCP's interactions concerning PT, prior to her hospitalisation. One of the issues for me to consider concerned the question of whether DCP ought to have taken greater or more proactive steps to directly confer with Dr Spencer.

71. Mr Mace agreed that with the benefit of hindsight it would have been preferable for Dr Spencer to have been told what DCP thought had happened to PT, and that essentially it would have been helpful for him to

know the grounds for the concern that DCP held, and also to have been told of the concerns held by the Community Health Nurse.[45]

72. Mr Mace explained that as at 2011, when PT's mother took her to be seen by Dr Spencer at the request of the DCP Senior Field Worker, the expectation was that Dr Spencer would review PT and write back to DCP. He explained that allowing the mother to take the steps (with an expectation that she would relay the concerns to Dr Spencer) was part of an assessment of parenting capacity, and willingness to show protectiveness. DCP wanted to allow the parents to facilitate the initial exchange (with Dr Spencer). If the contact with the GP had not occurred, then DCP would have followed up.[46]

73. At the inquest Mr Mace was questioned about Dr Spencer's evidence to the effect that he did not know he was writing a report for DCP. Mr Mace responded that at the time there was also an assumption by the DCP, having made the request for the child to be assessed by the GP, either personally or through the caregiver, that the assessing GP would understand the requirements.[47]

74. Essentially in 2011, there was no perceived obligation for DCP to separately make contact with Dr Spencer. At the inquest Mr Mace confirmed that due to changes implemented by DCP (now Department of Communities) the practices now are different. Mr Mace provided his responses on the newer practices by reference to the High Risk Infant Policy implemented by Department of Communities in November 2018, and referred to in greater detail under the heading *Improvements*, below.[48]

75. Mr Mace explained that now the child protection worker is required to endeavour to consult with a paediatrician, if possible with experience in the child protection area, in relation to unexplained injuries to a child under the age of two years. If possible, it is now preferable for the child

[45] ts 180.
[46] ts 159.
[47] ts 163; ts 181.
[48] Exhibit 4, tab 7; ts 159.

protection worker to attend the consultation themselves, and have a discussion with the assessing doctor.[49]

76. Where it is not possible for the child protection worker to attend an appointment in person, contact is nonetheless expected, by telephone, including the provision of information to the assessing paediatrician. The paediatrician is asked for his/her medical opinion on the child's injuries, and whether the bruising is accidental or non-accidental.[50]

77. At the inquest Mr Mace agreed that, with the benefit of hindsight, there were opportunities to improve the practices in 2011, to be more prescriptive about what needed to happen when they are working with infants of this age with possible head injuries.[51]

78. However, Mr Mace drew attention to Dr Spencer's reference to the DCP in his letter, and remained firmly of the view that Dr Spencer knew the purpose of his letter, which he described as a report, and who it was for.[52]

79. Mr Mace confirmed that at the material time, as at 2011, and up to and including the present, there have been no impediments upon the DCP/Department of Communities providing information to a GP about a child such as PT, who was not yet in care, but where an investigation had commenced. He explained that information exchange is fundamental to the Department of Communities' work and the guiding principle is the best interests of the child.[53]

80. I have considered the communications that led to PT's mother taking her to see Dr Spencer. It is important that such communications be considered within the context of the prevailing DCP policies and/or practices in 2011, and regard is to be had to what was known and/or communicated to medical practitioners in 2011 about bruising in a non-ambulant child. Clearly the communication has improved significantly at a general level by the implementation in November 2018 of the High Risk Infant Policy.

[49] Ibid.
[50] ts 161 to 162.
[51] ts 162 to 163; ts 181 to 183.
[52] ts 168; ts 181.
[53] ts 169.

81. It would have been preferable for there to be direct conferral between the DCP and Dr Spencer in February 2011. This lack of direct conferral may have adversely impacted upon Dr Spencer's understanding of the purpose for which he was reviewing PT on 25 February 2011, and the purpose of his letter dated 25 February 2011, as understood by DCP. Through its counsel, DCP accepts this may have had such an impact.[54]

Hospitalisation

82. Initially, on 1 March 2011, PT had been taken to the Regional Hospital Emergency Department by her mother and grandmother, expressing concern that PT was not feeding. PT had last fed the previous night at 6.00 pm. She was seen the by the Registered Nurse, who noted the bruise on PT's face. Supplemental medical records written the next day reflect that PT's mother appears to have referred the Registered Nurse to Dr Spencer's letter, produced for the purpose of stating that the GP did not believe the bruising was due to abuse. The extent to which the letter allayed any concern on the part of the clinicians at the time of PT's presentation is not known.[55]

83. The Registered Nurse discussed the case with the doctor, and it was noted that observations and examination were reported as normal. PT's mother was advised to keep trying to get PT to take fluids, and if there was no improvement by lunchtime, the mother was to present PT to the GP for review.[56]

84. Later that same day (1 March 2011) PT was taken to see another GP, with lethargy and poor oral intake. Alarmingly, PT was pale, had bruising to her face, her fontanel was bulging, her left eye was deviated and her left arm and leg were jerking. PT was immediately transferred to the Regional Hospital by ambulance and it was suspected she had an intracranial bleed. She was given intravenous antibiotics and fluids, intubated and ventilated and a morphine/midazolam infusion commenced in consultation with ICU doctors from PMH. A further transfer to PMH was arranged and PT was

[54] ts 290 to 293.
[55] Exhibit 3.
[56] Ibid.

admitted to the Paediatric Intensive Care Unit at PMH that afternoon (1 March 2011). She was placed on full life support.[57]

85. An urgent CT brain scan on PT's arrival at PMH showed bilateral subdural bleeds, diffuse cerebral oedema and a left parietal skull fracture. It was readily apparent that the injuries were considered to be non-accidental, and the Child Protection Unit at PMH were informed. The DCP was also informed and on 2 March 2011 a Safety and Wellbeing Assessment was opened for PT, on the grounds of alleged physical harm.[58]

86. On 4 March 2011, the Child Protection Unit at PMH advised DCP that there would be a Serious Injury Planning Meeting, to include representatives from DCP's Regional Office and from the Western Australia Police Force. That meeting took place on 9 March 2011, as a consequence of which PT was placed into the Provisional Protection and Care of the DCP (this aspect is addressed in further detail later in this finding under the heading: *Placement into Care of DCP*).[59]

87. PT had a long and complex stay at PMH. According to her treating paediatrician Dr Kate Langdon, on discharge from ICU she had highly abnormal neurological signs. She had ongoing seizures, was visually unresponsive, had difficulty feeding and abnormal tone and limb movements. These signs were indicative of PT's eventual outcome and high level of disability.[60]

88. Dr Goh, the paediatrician from the Child Protection Unit at PMH (whose evidence is referred to previously) provided a report at the material time, outlining PT's injuries, and she gave evidence at the inquest, elaborating on her outline. The injuries, which Dr Goh described as being at the extreme end of inflicted injury, were as follows:

    a) Bilateral subdural haemorrhages and intra-parenchymal haemorrhages with associated cerebral oedema and diffuse axonal

[57] Exhibit 1, tab 7; ts 59; ts 60.
[58] Exhibit 2, tab 19; ts 59 to 60.
[59] Ibid.
[60] Exhibit 1, tab 7; Exhibit 3.

injuries and a subdural hygroma (collection of older blood that has become clearer);

b) Soft tissue injuries of the posterior neck area;

c) Bilateral retinal haemorrhages;

d) Fractures:
   i. Left parietal skull fracture with possible extension into the left side of the occipital bone and a possible small right parietal skull fracture;
   ii. Metaphyseal fractures of the left femur (thigh bone);
   iii. Metaphyseal fractures of the left radius (forearm bone);
   iv. Posterior rib fractures with callus formation (two on the left, seven on the right;
   v. Left anterior 7th and 8th rib fractures with no callus formation;
   vi. Left clavicle fracture with callus formation; and
   vii. Bruising over the left facial cheek.[61]

89. At the inquest Dr Goh explained how various injuries occur and heal. She had reviewed PT's injuries, with respect to possible causative factors, and age of the injuries. Dr Goh opined as follows:

a) With respect to the head injury, PT had suffered at least two episodes of traumatic head injury; a severe acquired brain injury with acute haemorrhage and diffuse axonal injury; and older injuries including healing skull fracture/s and hygroma; at the inquest Dr Goh explained that the former description relates to bleeding within the lines of the brain, as a result of tearing or shearing of the bridging veins, and can be related to trauma, in the context of acceleration/deceleration (such as rotational forces or a shaking mechanism); the other (subdural hygroma) represents an older injury; Dr Goh explained that these injuries do not come from normal parental handling; the lack of

[61] Exhibit 1, tab 12; Exhibits 11.1 to 11.8; ts 61 to 66; ts 205 to 228.

explanation for both these injuries is highly suspicious of inflicted causes.[62]

b) With respect to soft tissue injuries, PT had radiological signs of soft tissue injury around the back of her neck area and specifically at the craniocervical junction and the upper cervical spine. Dr Goh opined that this is suspicious of blunt trauma including repeated flexion/extension neck injuries such as in shaking;[63]

c) Posterior rib fractures are highly specific for inflicted injuries; in the absence of major trauma posterior rib fractures are usually caused by forceful chest encirclement and compression by adult hands; PT had multiple posterior rib fractures with callus formation, which indicated healing; these fractures were at least 10-14 days old and whilst likely present when Dr Spencer reviewed PT, an x-ray would have been required to detect and assess them; the left anterior rib fractures did not have evidence of healing and were more likely to have occurred recently (being less than five to seven days) prior to presentation;[64]

d) Dr Goh explained that corner (metaphyseal) fractures are highly specific for inflicted injury and occur as a result of gripping with twisting or twisting with pulling; these fractures cannot accurately be aged;[65]

e) PT's clavicular fracture was associated with callus formation, indicating it could have been due to an injury 10 to 14 days old or longer; Dr Goh opined this was unlikely to have been a result of birth trauma;[66]

f) PT had extensive bilateral retinal haemorrhages that were noted six days after admission to PMH; she had significant problems with raised intracranial pressure resulting from her head injuries; Dr Goh

[62] ts 61 to 63.
[63] ts 63.
[64] ts 64 to 65.
[65] Ibid.
[66] Ibid.

opined that it is possible that this raised pressure contributed to the haemorrhages, however given the severity of the haemorrhages, it is more likely to be associated with inflicted head trauma; at the inquest Dr Goh described these as similar to the mechanisms of the effect of shaking on the brain, with shearing of the blood vessels at the back of the eye, being highly suspicious of an inflicted injury, but it was not possible to comment on the potential age of these injuries;[67]

g) Dr Goh was asked to comment on PT's bruises; Dr Goh reported that bruises due to accidents in non-ambulatory infants are extremely rare; bruises on the face, ears and buttocks and those away from bony prominences are suspicious for inflicted injury; medical examination showed that PT did not have evidence of a bleeding disorder at the time of admission and additional testing to rule out more specific bleeding disorders were negative;

h) Dr Goh commented on the matter of PT's high platelet count (thrombocytosis) previously documented (and that Dr Spencer had seen); Dr Goh posited that this can occur as a result of inflammation, trauma, infection, acute bleeding, fractures, burns and tumours; in Dr Goh's experience, it is exceptionally rare for this condition to cause clotting or bleeding problems and she considered that it is possible that the raised platelets related to inflicted injury in the preceding two weeks.[68]

90. Overall, Dr Goh found that PT suffered at least two episodes of traumatic head injury, in addition to multiple older healing fractures. Dr Goh had interviewed PT's parents on 3 April 2011. When asked what may have caused the injuries, the parents were unable to offer an explanation. Dr Goh posited that the lack of explanation was highly suspicious for inflicted injury.[69]

91. Dr Goh opined that PT's head injury was life threatening. In her clinical prognosis she stated that PT would most certainly have long term

[67] Ibid.
[68] Exhibit 1, tab 12; ts 65.
[69] Ibid.

neurological deficits, though at that stage it was difficult to predict a final outcome with accuracy. She noted that PT was showing clinical signs of cerebral palsy and would likely have an intellectual disability, visual impairment and a seizure disorder. Dr Goh had no doubt that those conditions were as a result of the injuries suffered by PT, and this view was also supported by independent expert Dr Nair, whose evidence is referred to previously.[70]

92. Dr Goh's opinions and concerns as reflected in her written report were promptly conveyed to DCP on 9 March 2011.[71]

PLACEMENT INTO CARE OF DCP

93. As outlined above, DCP had medical evidence of PT's injuries being non-accidental, and her parents were unable to explain the injuries. With physical harm being substantiated by DCP, on 9 March 2011 the Regional Office of the DCP applied for a Protection Order, on the grounds that PT's injuries were serious and the perpetrator was unknown.[72]

94. A Protection Order (time limited) was granted on 13 June 2011, with an extension subsequently granted on 5 May 2014. PT was brought into the Provisional Protection and Care of DCP on 25 March 2011, when she was approximately two and a half months of age.[73]

95. Police investigations, undertaken separately to DCP inquiries, did not identify any persons of interest in connection with PT's injuries. It was noted that the parents and maternal grandmother were not the only persons who had looked after PT, or been alone with her. These police investigations and assessments were carried out in March 2011, and continued into May 2011.[74]

96. On 13 April 2011 when PT was three months old, she was discharged from PMH to live with foster carers appointed by DCP, consistent with the

[70] Exhibit 1, tabs 7 and 12; ts 69.
[71] Exhibit 1, tab 12.
[72] Exhibit 2, tab 19.
[73] Ibid.
[74] Exhibit 1, tab 7; Exhibit 2, tab 19.

Protection Order. She had frequent medical and allied health appointments at PMH and in the community. She was primarily managed by paediatrician Dr Kate Langdon from the Department of Paediatric Rehabilitation. Other teams involved in her care included orthopaedics, ophthalmology, general surgery, physiotherapy, social work, dental, occupational therapy and dietetics. Case management meetings were held with DCP and The Ability Centre (formerly The Cerebral Palsy Centre).[75]

97. A case manager was allocated for PT through the Acquired Brain Injury Service at PMH until the end of 2013. The majority of PT's attendances were at outpatient appointments. There were booked inpatient stays for insertion for feeding tubes and other procedures such as Botox injections for flexion contractures. Additional services and equipment were provided in the community by The Ability Centre.[76]

98. The PMH medical records reflect that PT had very infrequent Emergency Department presentations and a single unscheduled admission in 2012. Her seizures were infrequent and well managed. PT attended PMH appointments mostly with her foster carers, and sometimes accompanied by her biological parents.[77]

99. From June 2011, and throughout most of 2012, DCP made arrangements for PT to have weekly supervised contact at a Metropolitan Office with her parents, who had relocated to Perth to be closer to their daughter. During this time, PT remained in the care of her foster carers.[78]

100. Police and DCP investigations into PT's non-accidental injuries continued between May and July 2012. Further information was obtained regarding other persons who may have had unsupervised access to PT. As a consequence of the new information, DCP decided to alter the substantiation of "*physical harm*" to "*lack of supervision*" on the part of PT's parents. This led to planning around PT's transition to her parents, commencing in August 2012.[79]

[75] Exhibit 3.
[76] Ibid.
[77] Ibid.
[78] Exhibit 2, tab 19.
[79] Ibid.

101. For this purpose, on 26 September 2012, DCP developed a Safety Plan in support of reunification of PT with her parents. This plan took account of the unknown circumstances surrounding PT's non-accidental injuries, and included a requirement for daily in-person contact with members of the DCP Safety Network while PT was in the care of her parents, for PT's protection and wellbeing.[80]

102. Consistent with the plan for PT's transition back to her parents, during the terms of the Protection Orders (and while those Orders remained in place) there were brief periods of reunification with her parents. However, on each occasion these ended when further unexplained injuries were discovered:

    a) a brief period of reunification in 2012 was ended when further unexplained injuries were discovered;

    b) reunification was again considered in 2014 and 2015 but again unexplained injuries were discovered and planning ceased.[81]

103. The details concerning these unexplained injuries, and actions taken, are referred to below under the heading: *Further Injuries*.

104. At the time of PT's death in 2016, the Department of Communities had made an application for a Protection Order (until the age of 18 years) which was being contested by her parents.[82]

FURTHER INJURIES

2012 Injuries

105. The child PT was gradually transitioned from her foster carer's care to that of her biological parents, under the management of DCP. She returned to her parents' full time care on 15 November 2012, when she was just under

[80] Ibid.
[81] Ibid.
[82] Ibid.

two years old, but remaining under the existing time-limited Protection Order.[83]

106. As at 3 December 2012, PT had been living with her biological parents for approximately three to four weeks, but had nonetheless spent some time with her foster carers for respite. On that date, PT's foster carer took PT to a physiotherapist, because PT's mother was attending to another appointment. The physiotherapist noticed bruising on PT's face (left cheek) and on her left hand. PT's mother had already reported the bruise on the left cheek to the foster carer, and they discussed it, but they had not reported it to DCP.[84]

107. The physiotherapist alerted DCP to the bruising, which immediately resulted in an Interaction Report being opened. As a consequence PT was placed back with her foster carers, and DCP officers commenced inquiries with her parents, to seek an explanation for the bruising. PT was reviewed at Swan District Hospital (3 December 2012) and then Princess Margaret Hospital (4 December 2012), in connection with the bruising on her left cheek. She was then taken to GP Dr Richard Martin (Dr Martin) in Midland (5 December 2012), regarding a separate matter.[85]

108. Relevantly, the reviews of PT resulted in the following separate and distinct assessments, with opposing conclusions:

a) On 4 December 2012 PT was examined by the Paediatric Registrar from the Child Protection Unit at PMH. This was a very thorough examination that included photographs, blood tests and a skeletal survey. PT was found to have pinpoint petechiae below her right ear, an abrasion on the left side of her scalp, a bruise on the left side of her cheek and some marks on her arms and legs. The Paediatric Registrar concluded in her summary that was co-signed by the Consultant Paediatrician that: *"[PT] is a 22 month old girl with a previous inflicted head injury and limited mobility. She has presented*

[83] Ibid.
[84] Ibid.
[85] Exhibit 1, tab 8.

with unexplained injuries to her face and scalp. These injuries are suspicious for inflicted injury";[86]

b) On 5 December 2012 PT was taken to Dr Martin by her mother and foster carer following her review at Swan Districts Hospital and PMH referred to above. In a letter addressed to the officer of the DCP, Dr Martin detailed his findings and assessment of PT. He noted the small bruise on PT's face on the inner part of her left cheek, and a small mark on her forehead (the latter he considered most likely eczema). Within that letter Dr Martin stated: "*In my professional opinion there has been complete over investigation in her case. This is not typical of physical abuse, but a simply explained small bruise on her face. The people who instigated this investigation for this type of simple bruise are misguided in their approach. This investigation was not warranted in the first place.*"[87]

109. At the inquest Dr Martin was questioned about this letter. He explained that when PT was brought in for him to review on 5 December 2012, it was because she had a cold, and the mother was concerned she had trouble with breathing. There had been no request by DCP for PT to be examined by him. Dr Martin was also informed by the mother that PT had been taken to the two hospitals recently, where bruising had been noted and assessed. Dr Martin had not seen PT previously, nor her biological parents.[88]

110. Dr Martin explained that whilst he looked at PT's bruise, he did not do a full examination of PT because he was aware she was under the care of the Child Protection Unit of PMH. He thought they were undertaking the investigation. Having noted the presence of the foster carer, he made the assumption, correctly as it transpired, that PT was in the care of DCP, and that the mother was allowed limited access to her.[89]

111. At one stage during this consult, the foster carer left Dr Martin's room, at which point the mother became highly distressed, expressing to Dr Martin

[86] Exhibit 1, tab 7; Exhibit 3.
[87] Exhibit 1, tab 14; ts 143.
[88] ts 134 to 135; ts 296.
[89] Exhibit 2, tab 18; ts 136 to 140; ts 149.

her fears that PT would be taken away from her. After expressing her fears, the mother then settled and Dr Martin observed her to become attentive and loving towards PT. Dr Martin's evidence was that he was deeply affected by the mother's elevated levels of distress. The consult lasted approximately 30 minutes.[90]

112. Dr Martin was persuaded that there was a loving bond between PT and her mother, and as a result he offered to help PT's mother by writing the letter to DCP. At the inquest Dr Martin explained essentially that he thought, but then dismissed, the prospect of contacting the Child Protection Unit for some more information about PT, referring to past experiences where he had not received information he had sought, in circumstances where he had been asked to do a medical assessment of a patient.[91]

113. At the inquest Dr Martin stated that in hindsight he should never had written the letter dated 5 December 2012 to DCP. He said he felt emotional due to the mother's obvious distress, and he had regard to the very important relationship between a mother and child. He said he was not trying to stop the Child Protection Unit investigation, as it was ongoing, and that if he had had access to information about some of PT's history, he would not have written that letter. Dr Martin did not know that PT had come into the care of DCP after suffering severe non-accidental injuries.[92]

114. Dr Martin testified that at the material time in 2012, he did not think PT was in danger, otherwise he would have reported the matter to DCP. If he had this time again, Dr Martin also testified that he would instead contact DCP and advise them of the bruise on an immobile child, and he would also inform DCP of the positive aspects of the bonding that he had observed between mother and child.[93]

115. The matter was also reported to the Western Australia Police Force, resulting in the commencement of an investigation. That investigation

[90] ts 137.
[91] ts 138 to 139; ts 151.
[92] ts 144; ts 147; ts 149.
[93] ts 145; ts 151.

was concluded without any person being charged, and on 26 March 2013, the reasons were recorded:

> "*There are no identifiable witnesses to the injuries. There is no medical evidence to indicate that the injuries are inflicted. In fact, in the opinion of one medical practitioner who examined the child the day after CPU, the matter has been "over investigated" and is not a case of physical abuse. There is no available evidence to indicate that any possible offence has been committed by any person. No further investigation is possible.*"[94]

116. The author of the police report was aware that PT had been examined at PMH and Swan Districts Hospital and referred to the Paediatric Registrar at PMH, and Dr Martin, as being expert witnesses. It appears police placed greater weight on the opinion of the GP Dr Martin, over the specialised Child Protection Unit doctor. Dr Martin did not know that his letter was going to be relied upon by police in this way, and he felt it would have been important for him to know background medical information and to have had communication from DCP, in order for this to occur.[95]

117. Whilst Dr Martin's letter did not have any effect upon the medical investigations of PT's bruise, or any of DCP's decisions, it is clear that it was taken into account by police, who did place some degree of reliance upon it in the decision to conclude their investigation.[96]

118. Independent expert Dr Nair, senior consultant paediatrician, whose evidence is referred to previously, reported to the coroner that it would have been good medical practice for Dr Martin to have contacted the Child Protection Unit at PMH after he saw PT on 5 December 2012, to discuss his views or any new information he had acquired. In commenting on Dr Martin's statement about the over-investigation, Dr Nair opined that Dr Martin had formed an expert opinion on a matter that had been well outside his general area of expertise.[97]

[94] Exhibit 1, tab 7.
[95] ts 153.
[96] Exhibit 1, tab 7.
[97] Exhibit 1, tab 8.

119. I have considered Dr Martin's letter dated 5 December 2012, and taken account of the information before me, and his submissions through his counsel. It was relevantly submitted to me by Dr Martin that:

    a) he had not received any education about the implications of a bruise on the face of a non-ambulant child;

    b) he was seeing PT for the first time on 5 December 2012, and he had no information about her prior complex medical and child protection history (it is to be borne in mind that DCP had not requested Dr Martin to review PT);

    c) he knew the foster carers and thought them to be good people;

    d) PT's mother appeared to have a good bond with her, and was appropriately protective of her; and

    e) he was of the understanding that PT's bruise was being investigated, having been told that she had been referred to PMH by Swan Districts Hospital for the purpose.[98]

120. Through his counsel at the inquest Dr Martin accepted that his letter of 5 December 2012 was ill-advised, in stating: "*The people who instigated this investigation for this type of simple bruise are misguided in their approach. This investigation was not warranted in the first place*".[99]

121. At the inquest it was clear that the case had a profound impact upon Dr Martin. He had a very clear recall of the child PT, and he expressed his concern for the difficulties she had undergone, and he also pointed to the unique trauma and sorrow that attends the separation of children from their parents.[100]

122. Whilst PT's facial injury and scalp abrasion were not seen as significant or life threatening, DCP determined that the risk of continuing harm and

[98] ts 286 to 287; ts 295.
[99] ts 287 to 288.
[100] ts 155.

physical injury remained high, and that it could not be appropriately managed though a Safety Plan. The DCP determined that PT's injuries were suspicious for inflicted injury.[101]

123. Therefore as a consequence of the unexplained bruising, that occurred only a few weeks after PT's parents were allowed unsupervised access to her, DCP decided that PT would remain in the full time care of her foster carers, and their efforts to transition her back to her biological parents ceased.[102]

124. Subsequently PT's parents were permitted weekly supervised contact with their daughter, and were allowed to be present at medical and therapeutic appointments. It was noted that they made efforts to be present at all significant appointments at the Centre for Cerebral Palsy.[103]

125. From April 2013 onwards, on various occasions, DCP officers considered the question of whether reunification with PT's parents should again be trialled. Attempts were made to balance the risk of reunification, as against the genuine attachment between PT and her parents. Discussions amongst DCP officers also concerned the question of whether a Protection Order (Until 18) was warranted, whilst the parenting capacity was assessed. Various views were presented from within that department and the matter was carefully considered. At that stage, the Time-Limited Protection Order was due to expire on 13 June 2013.[104]

126. The DCP proceeded to make an application for a Protection Order (Until 18) and the matter was set down for trial. A further parenting capacity assessment was undertaken by a psychologist, who had reported that the parents appeared to have capacity to parent effectively. Notwithstanding this, concerns remained within DCP around how PT's parents would be able to care for her based upon her level of disability. Ultimately, on 19 May 2014, a further Protection Order (Time-Limited) was made, for two years.[105]

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[101] Ibid.
[102] Exhibit 2, tab 19.
[103] Ibid.
[104] Ibid.
[105] Ibid.

2015 Injuries

127. In October 2014, at a Signs of Safety Planning meeting DCP again considered whether it would be appropriate to begin working towards unsupervised contact for PT's parents, in anticipation of overnight stays and eventual reunification. It was noted that PT's parents had fulfilled conditions set out in the parenting plan in relation to the care of PT.[106]

128. The DCP determined to work towards reunification of PT with her parents. Unsupervised contact started in November 2014 once weekly, moving to twice weekly, and by February 2015, it was four times a week. In May 2015, DCP was satisfied of the appropriateness of an eventual reunification, and started planning towards this.[107]

129. However, in June 2015 PT's mother contacted DCP to inform them of bruising to PT's cheek (that had been pointed out to her by PT's foster carer when she had been dropped off) and bruising to her chest, that appeared to be a bite mark (that had not been mentioned by PT's foster carer). There was no explanation for either of these injuries. By this stage PT had been having unsupervised overnight contact with her parents since April 2015.[108]

130. On 2 June 2015, PT was referred for assessment to the Child Protection Unit at PMH by DCP staff, who collected her from school for that purpose. The Consultant Paediatrician reviewed PT and formed the view that this bruising to her right cheek, and further bruising to her left chest were suspicious for inflicted injuries. PT was immobile and therefore unlikely to injure herself accidently. The Consultant Paediatrician reported that the face and chest are typically more common sites for inflicted bruising; however, accidental causes such as banging her face or chest with a toy could not be excluded.[109]

[106] Ibid.
[107] Ibid.
[108] Ibid.
[109] Exhibit 1, tabs 7 and 8.

131. The Consultant Paediatrician concluded as follows:

> "*It is of great concern that after sustaining serious life threatening inflicted injuries as a baby, [PT] has now had 2 presentations with suspicious injuries whilst reunification with her parents occurs. On this occasion she also had an adult bite mark to her chest.*"[110]

132. With respect to PT's bruise on the right side of her chest, a forensic odontologist had been consulted, who concluded that the pattern of injury had characteristics of a human bite mark inflicted by an adult.[111]

133. As a consequence, PT's unsupervised contact with her parents was immediately suspended by DCP, and police again commenced an investigation, in relation to this unexplained bruising. Police ultimately concluded that there was insufficient evidence to substantiate criminality by any specific person.[112]

134. In September 2015, DCP again considered the appropriateness of making an application for a Protection Order (Until 18) due to the history of unexplained injuries and PT's level of vulnerability, given that she was non-mobile and non-verbal. Soon afterwards, PT's parents were informed, and they were upset and they in turn questioned the level of care being provided by her foster carers.[113]

135. On 21 November 2015 PT was transported by her foster carer to see her parents for a contact visit, and her foster carer showed the DCP staff member a small mark on PT's temple. In light of PT's previously unexplained injuries, DCP opened an inquiry to investigate the issue of the mark not being reported immediately.[114]

136. A further report of an injury on 16 December 2015 by PT's mother was also reviewed by DCP. It was a scratch and a blister on the inside of PT's arm. It was posited these occurred at the school (that initially reported

[110] Ibid.
[111] Exhibit 1, tab 7; Exhibit 2, tab 19.
[112] Ibid.
[113] Exhibit 2, tab 19.
[114] Ibid.

them). Upon review by DCP the injuries were no longer visible, and no further action was taken.[115]

137. At this stage, DCP held concerns about the history of unexplained injuries when PT had unsupervised contact with her parents, and they developed additional concerns about PT's foster carers not reporting all marks and bruises as per the agreed Safety Plan. The DCP continued to work with the foster carers to reinforce the Safety Plan and protocols. The DCP was also still considering the appropriateness of applying for a Protection Order (Until 18), and again a range of views were being expressed within DCP on this matter.[116]

138. The existing Protection Order (Time Limited) was going to expire in May 2016. There was a lot of thought given to the question of whether to continue to work towards reunification, or to apply for the longer Protection Order. This was still under consideration when PT tragically died in January 2016.[117]

EVENTS LEADING UP TO DEATH

139. On 17 November 2015, approximately two months prior to her death, PT had her last appointment at PMH with her usual paediatrician, Dr Langdon. She had received Botox injections in her legs two months previously for spasticity of her leg muscles. The consultation documented the need for additional equipment for school and home including standing frames, shower chairs, hoist sling and hospital bed. The next scheduled appointment was planned for April 2016.[118]

140. The foster carers prepared an appropriate list of equipment required for their home, including a new bed. At this stage, PT was approaching five years of age. The Ability Centre assessed and ordered a new bed for PT that was delivered and installed by the manufacturer on 24 January 2016.[119]

[115] Ibid.
[116] Ibid.
[117] Ibid.
[118] Exhibit 1, tab 8.
[119] Exhibit 1, tab 7.

141. The child PT had been medically stable in the two months prior to her death. Over the 72 hours prior to her death, PT's foster carers had noted that she had been a little more lethargic, and that she was sleeping more than usual. The usual medications that had been prescribed to PT at this stage were Topiramate (an antiepileptic), Clonazepam (a benzodiazepine) and Omeprazole (an antacid).[120]

142. On 26 January 2016 at approximately 8.00 pm, PT's foster carer put her to bed, positioned lying on her side. She had been sleeping in the new bed, which included a change from sleeping on her right shoulder to sleeping on her left shoulder. Just before 10.30 pm that night PT was found by her foster carer lying with her face down onto the pillow. Alarmingly, she was unresponsive; she was not breathing and a pulse could not be found. CPR was commenced and St John Ambulance (SJA) was called.[121]

143. Records reflect that SJA received a call at 10.24 pm on 26 January 2016, and arrived at the scene at 10.51 pm. PT's foster parents had been doing CPR for approximately 25 minutes prior to their arrival. The SJA was staffed by volunteer ambulance officers. The volunteer ambulance officers continued CPR for a further 20 minutes before ceasing. Two minutes after CPR was ceased the Community Paramedic arrived and they advised that CPR should be re-started as a defibrillator had not been attached and without analysis of the deceased cardiac rhythm, they did not meet the criteria for termination of CPR. Upon a subsequent review, independent expert Dr Nair did not consider that this would have changed the outcome in any way.[122]

144. CPR was continued along with insertion of a laryngeal mask and interosseous access. Adrenalin and fluid resuscitation was given. Cardiac rhythm remained in asystole. The SJA conveyed PT to St John of God Midland Hospital arriving at 12.14 am on 27 January 2016.[123]

[120] Ibid.
[121] Exhibit 1, tab 7.
[122] Exhibit 2, tab 24.
[123] Exhibit 1, tab 8.

145. Further resuscitation efforts were continued without success. A blood gas taken was diluted from intravenous fluids, but showed severe acidosis with a pH < 6.8. Resuscitation efforts were ceased by the resuscitation team that included paediatricians and emergency doctors. At 12.40 am on 27 January 2016, tragically, PT was pronounced dead.[124]

146. At the inquest, Dr Goh's opinion was that, having regard to PT's disabilities as a consequence of her injuries, her sad and tragic death was always a possibility, and not unexpected.[125]

CAUSE AND MANNER OF DEATH

147. On 29 January 2016 the forensic pathologist Dr C T Cooke (Dr Cooke) made a post mortem examination on the body of the child PT. At the end of that examination further tests were ordered, and became available to Dr Cooke as follows:

a) microscopic examination confirmed the presence of congestion of the lungs, showing aspiration of regurgitated stomach contents into the small airways and a localised area of consequent early pneumonia;

b) testing for significant viral infection was negative; microbiology testing showed the presence of a bacterial organism (Staphylococcus aureus) in tissue samples of tonsil and both lungs;

c) neuropathology examination showed the brain to be small (microencephaly) with ulegyria in the distribution of the anterior and middle cerebral arteries (ulegyria refers to cerebral cortex scarring, which results from a perinatal ischaemic brain injury);

d) toxicological analysis showed the presence of alcohol in a urine sample (0.039%) with no alcohol detected in the blood sample (this is to be interpreted with caution as it likely relates to post mortem production of alcohol, as opposed to ingestion); in respect of

[124] Exhibit 1, tab 8; Exhibit 2, tab 1.
[125] ts 70.

medications, toxicological analyses detected PT's prescribed medications Clonazepam (a benzodiazepine) and Topiramate (an anti-seizure medication).[126]

148. On 18 July 2016, taking account of all of the examinations Dr Cooke formed the opinion that the cause of PT's death was aspiration of vomit, with microscopic early pneumonia, in a child with a history of cerebral palsy and epilepsy.[127]

149. Dr Cooke also opined that, from the information available it appears that PT died as a consequence of the pre-existing medical conditions of cerebral palsy and epilepsy, the proposed likely mechanism being aspiration of regurgitated stomach contents during a seizure.[128]

150. I accept and adopt Dr Cooke's opinion on the cause of PT's death and **I find that PT died from aspiration of vomit, with microscopic early pneumonia, in a child with a history of cerebral palsy and epilepsy**.

151. At the inquest Dr Goh, the Paediatrician from the Child Protection Unit at PMH (whose evidence is referred to previously) explained, in the context of this cause of death, that children who have cerebral palsy cannot control their secretions very well, and may not be able to lift their heads. Therefore when they vomit there is a high chance of it being aspirated into the lungs.[129]

152. It is known that PT suffered from a seizure disorder. Dr Goh posited that if PT was also having a seizure at the time of vomiting, this would increase the risk of aspiration of vomitus. Independent expert Dr Nair described aspiration pneumonia as probably the commonest cause of death in children with cerebral palsy, and he reported that the predominant manner of death would have been regurgitation and aspiration of the stomach contents into the airways occurring either on its own or secondary to a seizure. [130]

[126] Exhibit 1, tabs 4 to 6 and tab 9.
[127] Ibid.
[128] Ibid.
[129] ts 79.
[130] ts 79; ts 226.

153. These opinions were consistent with those expressed at the inquest by Dr Langdon, consultant paediatrician in Paediatric Rehabilitation Medicine, and PT's clinician (whose evidence is referred to earlier). Dr Langdon described PT's cerebral palsy as severe, and in the case of PT, this resulted in gastro-oesophageal reflux disease. Dr Langdon opined that PT's condition resulted on poor postural control, no head control, the risk of seizures, spasms and involuntary movements. She described PT's risks "*….it is known, in the context of severe cerebral palsy, that respiratory infection and aspiration is, in that group, very common and the most common cause of death*."[131]

154. The question was posited as to whether PT's medications had been properly administered to her shortly before her death. The concern was that dosages might have been missed, raising the question of whether this contributed to her death, by a failure to control her seizure disorder. Further toxicological analyses were undertaken and then reviewed by Professor David Joyce, Physician, Clinical Pharmacology and Toxicology (Professor Joyce).[132]

155. I have taken account of the toxicological analyses and Professor Joyce's report to the coroner and am satisfied that the foster carer's drug management of PT's seizure disorder was in accordance with her doctors' instructions. I adopt Professor Joyce's conclusions as follows:

    a) the detection on Clonazepam in the blood and detection of its metabolite 7-aminoclonazepam in blood and urine confirm that PT was receiving this medication and the results are consistent with her receiving the full prescribed dose; and

    b) the detection of Topiramate in blood at a concentration of approximately 4 mg/L confirms that PT was receiving this medication, and the measured concentration is consistent with her receiving the full prescribed dose.[133]

[131] Exhibit 4, tab 4; ts 95.
[132] Exhibit 1, tabs 5 and 9.
[133] Exhibit 1, tab, tabs 4 to 9; ts 79; ts 226.

156. In making my finding on how PT died, I take account of the fact that no person has been identified as having caused her injuries, that her injuries were most likely non-accidental, and that her resultant conditions, particularly her cerebral palsy, predisposed her to aspiration pneumonia. I also take account of the fact that she had been medically stable in the months prior to her death.

157. The conditions that PT had, including her symptoms from her cerebral palsy and seizure disorder, were all able to be managed with appropriate care and medication, and they were not invariably fatal. It is not appropriate to apply a "*but for*" test, meaning but for PT's inflicted injuries in 2011, she would not have died in 2016, because this casts too wide a net.[134]

158. I am satisfied that PT received a consistently good level of care from her foster carers and that they ensured she was taken for her medical and allied health appointments. Tragically PT died as a consequence of her conditions, that were being appropriately managed, in circumstances where her death was not inevitable, but neither was it entirely unexpected. **I find that the manner of PT's death is by way of natural causes**.

QUALITY OF SUPERVISION, TREATMENT AND CARE

159. Immediately before her death, PT was a person held in care and under s 25(3) of the Coroners Act, I must comment on the quality of her supervision, treatment and care while in that care.

160. This is separate to the comments I have already made about care and treatment of PT prior to her hospitalisation on 1 March 2011. After her hospitalisation, DCP acted appropriately and promptly to apply for the Protection Order that resulted in PT being brought into the Provisional Protection and Care of DCP on 25 March 2011.

161. The DCP arranged for PT to be placed into the care of a family where the parents had prior experience of caring for a disabled child, and due to such

[134] Jervis on Coroners.

experience, they were appropriately considered to have capacity to manage PT's complex medical needs. The first exclusive placement with the foster carers was until November 2012. During this period, DCP arranged regular meetings with PT's medical and allied health teams, and records reflect that these appointments were attended and that the foster carers were observed to be providing an appropriate level of care to PT. Also during this period, and appropriately so, DCP arranged for PT to have regular supervised contact visits with her biological parents.[135]

162. In 2012, DCP received information that reasonably caused them to consider a reunification with PT's biological parents. To this end, a Safety Plan was developed that included daily in person contact with the Safety Network, and PT was transitioned back to her parents, returning to their full time care in November 2012. For the avoidance of doubt, the information that DCP received did not relate to the foster carers, they continued to provide a good quality of care when PT was residing with them.[136]

163. In December 2012, a month after PT's reunification with her parents, PT was noted to have bruising on her face, and DCP appropriately referred the matter for investigation by the Child Protection Unit at PMH. In the circumstances of the bruising being unexplained, DCP acted appropriately in deciding that PT would remain in the full time care of her foster carers and efforts to transition her back to her parents promptly ceased.[137]

164. There was some liaison between DCP and the foster carers to ensure that all aspects of PT's care were attended to, including grooming, and PT continued to reside with them. Between April 2013 and October 2014 DCP again appropriately began to consider the merits of a reunification with PT's biological parents, noting that her parents had weekly supervised contact with her, and that they displayed commitment in being present at her medical appointments.[138]

[135] Exhibit 1, tab 8.
[136] Ibid.
[137] Exhibit 1, tab 8; Exhibit 2, tab 19.
[138] Ibid.

165. This resulted in PT having periods of unsupervised contact with her parents, commencing in November 2014, and gradually increasing in frequency, under DCP's guidance. However, when in April 2015, PT was found to have further unexplained injuries (bruise and bite mark), DCP again appropriately referred the matter for investigation by the Child Protection Unit at PMH, extended the Safety Plan to include the foster carer's obligation to report any bruises, marks or injuries, and efforts to transition PT back to her parents were ceased again (having regard to objective factors that included the timing of her injuries).[139]

166. Towards the end of 2015, having taken PT's history into account, together with some further unexplained injuries, DCP began to consider the merits of a Protection Order (Until 18) and this was still under consideration when PT tragically died. As would be expected, various views were posited within DCP. The matter was complex, and some of the options required the making of finely balanced judgements, that would have a profound impact on PT's future. It was therefore important to carefully consider all of the relevant ramifications.

167. Overall, PT's safety and wellbeing was the paramount consideration for DCP. It was desirable and proper to take account of the importance of fostering regular contact with her biological parents, who continued to express a desire for contact. The attempts at reunification were carefully planned by DCP, but on both occasions, they did need to cease, due to the unexplained injuries and the overriding consideration of PT's safety and wellbeing.

168. I am satisfied that DCP made decisions in respect of PT's supervision, treatment and care that were appropriate and reasonable, based upon the information they had at the material time. Further, that DCP took proper steps to apprise themselves of the information reasonably necessary to enable such decisions to be made.

169. I am also satisfied that PT's foster parents diligently attended to her numerous medical and allied health appointments, and that clinicians appropriately reported back to DCP. PT was reported as doing well with

[139] Ibid.

her foster carers, who supported her emotional wellbeing, and managed her physical care within and outside the home. They managed her seizures with medication, and in addition to the primary appointments for her medical care, they attended to her immunisations, occupational therapy, physiotherapy and other needs such as dieticians and disability services.[140]

IMPROVEMENTS

170. At the inquest counsel for the Department of Communities drew attention to s 23 of the *Children and Community Services Act* 2004, and I am satisfied that there is no legal impediment to the sharing of information by DCP about a child in their care, with a clinician who has a direct interest in the child's wellbeing, such as the child's doctor. This is clearly now supported by the High Risk Infant Policy, referred to in this part of the finding.[141]

171. At the inquest the DCP Senior Field Worker explained that for about four to five years now, and obviously following PT's tragic death, the Regional DCP Office is able to make direct contact with the PMH Child Protection Unit, to consult. For example, DCP would now be able to send an image of a bruise on a child to PMH, and seek advice.[142]

172. The DCP Senior Field Worker also informed the court that in November 2018, the Department of Communities published the High Risk Infant Policy in its Communities' Casework Practice Manual. The policy has specific directions about non-mobile infants and bruising, and now mandates that such bruising is assessed by a paediatrician preferably with child protection experience.[143]

173. One of the purposes of the High Risk Infant Policy is to provide information and practice guidance to Child Protection and Family Support workers on responding to abuse and neglect of high risk infants. Guidance is given as to how to determine risk factors (parental, environmental and infant) and when to commence a Priority 1 Child Safety Investigation.

[140] Exhibit 1, tab 7.
[141] ts 291.
[142] ts 46 to 47.
[143] Exhibit 4, tab 1.

There are also parameters set with the aim of avoiding a premature closing of the Child Safety Investigation.[144]

174. At the inquest, the DCP senior field worker referred to the improvements as a result of the High Risk Infant Policy, stating that further medical consultation at the material time could have prevented PT's serious injuries. It is noted that the High Risk Infant Policy relevantly refers to the following processes:

a) "*If you suspect that an infant may have been harmed, or where an infant is found to have an injury or symptoms of injury, the infant must be medically assessed on the same day by a paediatrician, preferably with child protection experience*."

b) "*Bruising is not common in infants because they are non-mobile. As such, any bruising or symptom of injury located on a non-mobile infant must be further assessed by a paediatrician, preferably with child protection experience*."

c) In relation to regional and remote areas: "*When a paediatrician may not be available on the same day, you **must** arrange to attend either the local medical service (GP or hospital) with the infant and request that they consult with the on call paediatrician*." and

d) "*Any non-accidental or suspicious injury to an infant **must** be referred to the WA Police*."[145]

175. There is further specific advice given in the High Risk Infant Policy about bruising, to alert the reader about the research in the context of infants:

a) "*Bruising in non-mobile infants is unusual and highly suggestive of non-accidental injuries*";

b) "*Non-mobile babies very rarely cause injuries to themselves and therefore must be considered at high risk of abuse*";

[144] Exhibit 4, tab 7; ts 50.
[145] Exhibit 4, tab 7.

c) "*Infant deaths from non-accidental injuries often have a history of minor injuries prior to hospital admission*"; and

d) In connection patterns of bruising suggestive of physical child abuse, information is conveyed about higher risk in connection with: "*bruises that are away from bony prominences*" and "*bruises to the face*."[146]

176. The court was informed that training was being arranged with respect to the High Risk Infant Policy as at September 2019.[147]

177. At the inquest Mr Mace, executive director, State-wide Services and South East Metro, Department of Communities (whose evidence is referred to previously) also referred to the High Risk Infant Policy. As part of a process of continual improvement, he explained that there are ongoing opportunities to align language between his agency and the Health Department, to ensure that the language is directive, and that there is clarity around what is expected from clinicians who make assessments.[148]

178. Mr Mace also referred to additional improvements as follows:

a) mandatory training presented by the Department of Communities around how to conduct a child safety investigation, with specific references to high-risk groups;

b) a central review team within the Department of Communities with responsibility for analysing recommendations from oversight agencies such as the Ombudsman, and coronial recommendations, so that a system-wide approach is taken in respect of specific issues that have been identified where incidents have occurred;

c) a central State-wide referral team within the Department of Communities, so that concerned persons (be it clinicians or

[146] Ibid.
[147] ts 58.
[148] ts 178.

community members) may make a report to a specialist unit, tasked with making the relevant inquiries, and providing consistent responses.[149]

179. The improvements by reason of the High Risk Infant Policy are substantial, and the situation as it arose with PT would not arise today, where the Policy is followed.[150]

180. At the inquest the Team Leader of the Child Protection Unit at PMH testified that the letters written by Dr Spencer and Dr Martin, essentially saying the injuries sighted on PT are not indicative of child abuse, are the only two such letters she has seen, and they were both in connection with the same child. She has not seen such letters since. I am satisfied that the High Risk Infant Policy would operate to guide the inquiry by medical practitioners and mitigate the risk of such letters in the future.[151]

RECOMMENDATION

181. This inquest highlighted the risks of injury to non-ambulant children, leading to a consideration of how events in similar circumstances could be prevented in the future. This is in addition to fostering compliance with the High Risk Infant Policy. The aim of the recommendation is to mitigate the risk of a missed opportunity to intervene, because serious injuries may be preceded by injuries of lesser seriousness that should be regarded as sentinel injuries in a non-ambulant child.

182. At the inquest, the DCP Senior Field Worker agreed that it would be very helpful for there to be a requirement for mandatory reporting of cases of neglect of children. This was considered in some detail, and various opinions were canvassed at the inquest, with the aim of formulating a workable recommendation regarding mandatory reporting.[152]

183. At the inquest Dr Goh, the paediatrician from the Child Protection Unit at PMH (whose evidence is referred to previously) agreed that there is

[149] ts 179.
[150] ts 294.
[151] ts 118 to 119.
[152] ts 48.

presently no legislative requirement in Western Australia to report child abuse (unlike the position regarding sexual abuse, where such requirements exist). Dr Goh's opinion was that suspicious bruising should be reported to the Department of Child Protection and Family Support, and she has often given advice to that effect.[153]

184. Dr Goh supported the potential for legislative mandatory reporting for certain injuries in children under the age of two years. Bruising in a non-ambulant child, should be flagged as having a high index of suspicion (a red flag was referred to). The doctor referred to the need to resource such an initiative, and the importance of educating and training practitioners, as to risk factors and matters to take into account in forming a reasonable belief in connection with the suspected abuse. She cited the culture of "*speak up for safety*" where there is a concern. Even if it is attended by some doubt, the matter should be raised, so as to trigger consultation with child protection agencies.[154]

185. At the inquest independent expert Dr Nair also referred to bruising in a non-mobile child as "*a significant red flag for inflicted or non-accidental trauma*" warranting a careful assessment where there is no reasonable adequate explanation. It would require consultation with a specialist in the field, consistent with the High Risk Infant Policy, and he referred to the availability of specialists for consultation in the Child Protection Unit or Emergency Department of Perth Children's Hospital.[155]

186. Dr Nair noted that other jurisdictions have mandatory reporting requirements for physical abuse and/or neglect of children that are broader, and include children up to the age of 16 years. Dr Nair specifically referred to the importance of protecting children who are pre-verbal, referring to children under the age of two years as being the group that is most at risk. Dr Nair was supportive of a recommendation for mandatory reporting to the Department of Communities, and referred to the importance of mandatory training in this area, but cautioned against a

[153] ts 72.
[154] ts 73 to 78; ts 92; ts 113 to 114.
[155] ts 230.

recommendation of too great a breadth, that may result in over-reporting.[156]

187. In response to a questions about a specific proposal for mandatory reporting of an injury in a non-ambulant child, Dr Nair expressed his support, referring to this group as being at the highest risk. He explained that a non-ambulant child is a very young child who is not walking, not crawling, cannot roll or sit up, therefore most likely to include infants up to the age of four to six months. It would have included PT. Such infants should not in the ordinary course of handling by caregivers have injuries, and they are unlikely to be able to injure themselves.[157]

188. The concerns around bruising in a non-ambulant child were also reinforced at the inquest by the Team Leader of the Child Protection Unit at PMH (whose evidence is referred to previously), involved in educational courses: "*Generally we say non-mobile children don't bruise. So if they're not crawling yet, not pulling to stand, not….toddling, then they shouldn't be getting bruises….we're very clear on that*."[158]

189. The Team Leader agreed that if mandatory reporting of physical abuse was required, it would likely lead to a greater comfort for health practitioners in disclosing physical abuse, and that at present there might be concerns around privacy, confidentiality, and losing their relationship with the family. This is one of the benefits of mandatory reporting.[159]

190. At the inquest, Dr Langdon, who specialises in paediatric rehabilitation, also supported the mandatory reporting of the abuse of children, and from her perspective, having regard to the terrible consequences when injuries inflicted to the brain are not detected. She referred to the prospect of avoiding the worst inflicted injuries if the earlier injuries are detected.[160]

191. In his report to the coroner, Mr Mace, executive director, State-wide Services and South East Metro, Department of Communities (whose

[156] ts 234 to 235.
[157] ts 243 to 247.
[158] Exhibit 8; ts 113.
[159] ts 121.
[160] ts 96.

evidence is referred to previously) did not consider that child safety in Western Australia would be improved by introducing a mandatory reporting requirement for the reporting of all types of child abuse. He initially informed the court that there are no plans to extend the scope of mandatory reporting laws in Western Australia to include abuse types other than sexual abuse.[161]

192. However, at the inquest Mr Mace was asked to consider a narrower category of mandatory reporting, namely the mandatory reporting of bruising on non-ambulant children. He expressed some support for this, if it were confined to children under the age of two years, but he cautioned about over-reporting, and the difficulties that Child Protection and Family Support Officers would face if their efforts are unnecessarily diverted into triaging cases. The difficulties would be alleviated by additional resourcing, but not just for the Department of Communities. Mr Mace referred to the need to resource clinicians, care providers and police, and agreed a regulatory impact study would be of benefit.[162]

193. At the inquest, after considering the matter, the Department of Communities through its counsel supported the recommendation in respect of mandatory reporting of any injuries in a non-ambulant child.[163]

[161] Exhibit 4, tab 7.
[162] ts 173; ts 198 to 199.
[163] ts 289.

Recommendation

I recommend that the Western Australian Government considers the undertaking of a regulatory impact review and if appropriate, introduces:

(a) an amendment to the *Children and Community Services Act* 2004 (WA) to include a duty to report any injuries in a non-ambulant child, in similar terms to the reporting structure for the reporting of sexual abuse of children requirements contained in Division 9A of Part 4 of the *Children and Community Services Act 2004* (WA); and

(b) an extension to the current mandatory training program jointly provided by the Department of Communities and the Department of Health – Child and Adolescent Health Services regarding the reporting of sexual abuse of children requirement contained in Division 9A of Part 4 of the *Children and Community Services Act 2004* (WA) to include education on the duty to report any injuries in a non-ambulant child.

CONCLUSION

194. PT was brought into the care and protection of the DCP at the tender age of approximately two and a half months after suffering horrific and life-threatening injuries that were likely to have been non-accidental. This finding has been accompanied by a warning to the effect that the contents may be particularly distressing to readers because the contents refer to inflicted injuries suffered by a very young infant.

195. For all those who knew and loved PT, it may be of some comfort to know that she was placed with foster carers who provided a warm and loving environment, and who assiduously took care of her medical needs. The foster carers looked after her, and when PT was not with them, they stood ready to support her, from the age of three months until her tragic death at

the age of five years. They were very attached to her. PT was able to experience joy and love from the contact she had with all the persons who cared for her.

R V C FOGLIANI
State Coroner
23 September 2020