JURISDICTION	**:**	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	**:**	CORONERS ACT 1996
CORONER	**:**	SARAH TYLER, CORONER
DELIVERED	**:**	23 FEBRUARY 2026
FILE NO/S	**:**	CORC 2550 of 2021
DECEASED	**:**	CHILD MML

Catchwords:

Nil

Legislation:

Nil

Counsel Appearing:

Mr D McDonald appeared to assist the coroner.

Ms K Niclair and Mr J-D Hang (State Solicitor's Office) appeared on behalf of the Department of Communities and the Child and Adolescent Health Service.

Case(s) referred to in decision(s):

Briginshaw v Briginshaw (1938) 60 CLR 336

DRAFT

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

I, Sarah Tyler, Coroner, having investigated the death of ***Child MML (name suppressed)*** *with an inquest held at the Perth Coroner's Court, Central Law Courts, Court 85, 501 Hay Street, Perth on* ***2 December 2025*** *find that the identity of the deceased person was* ***Child MML*** *and that death occurred on* ***24 September 2021*** *at* ***Perth Children's Hospital*** *from* ***bronchopneumonia and small bowel necrosis with perforation, in a boy with multicystic encephalopathy and organised subdural membrane, on long term enteral feeding, with terminal palliative care*** *in the following circumstances:*

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DRAFT

SUPPRESSION ORDER

The deceased's name and any evidence likely to lead to the deceased's identification are suppressed from publication.

The deceased is referred to as Child MML.

Order made by SH Linton, A/State Coroner (11/07/2025)

INTRODUCTION

1. Child MML was an Aboriginal child born on 8 April 2010. When he was born, he had some health issues and he spent some time in Princess Margaret Hospital. These health issues resolved, and Child MML was discharged home from hospital to live with his mother and his siblings.

2. Other than the health issues identified at birth that had been addressed, there were no significant known concerns regarding Child MML's health until 18 December 2010, when he was eight months old.

3. On that day, he was taken to Princess Margaret Hospital by his paternal grandmother. He was unresponsive, and continuously fitting. Extensive medical tests revealed that Child MML had suffered a traumatic brain injury and various other injuries to his body. Child MML's mother and his then step-father were unable to give an explanation as to how Child MML had been injured, other than a suggestion that Child MML's step-father had been playing "*too hard*"[1] with him.

4. The nature of the injuries suggested that Child MML had suffered an abusive head trauma, a diagnostic term for infants and young children who suffer from inflicted intracranial and associated spinal injury.[2] This term encompasses both shaking and impact related brain and head injuries in infants and young children.[3]

5. An investigation by the Department of Communities (the Department) commenced the following day. The Department's investigation found that Child MML had suffered substantiated physical abuse and neglect while he was in the care of his mother and then step-father. That investigation concluded that Child MML's then step-father had caused significant harm to Child MML in relation to physical abuse, and Child MML's mother had caused significant harm to Child MML in relation to neglect.

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[1] Exhibit 1, Tab 9,1, p 5.
[2] Exhibit 1, Tab 12, p 23.
[3] Dillon, Hugh, et al. *The Australasian Coroners' Manual* The Federation Press, 2015, p 156.

6. At the conclusion of the Department's investigations, the Department determined that Child MML was a child in need of protection and care. Child MML was taken into provisional protection and care on 22 December 2010, at which time he remained in hospital, receiving medical attention. A Protection Order was subsequently made, and when Child MML was well enough to leave the hospital on 23 March 2011, he was placed into the care of his paternal grandmother by the Department.

7. As a result of the injuries Child MML had sustained, he had significant, profound lifelong physical and cognitive disabilities. Child MML required high-level, 24 hour care for the rest of his life.

8. Ultimately, no person was criminally charged with inflicting the abusive head trauma upon Child MML at the time of his injuries. However, both Child MML's mother, and then step-father, were criminally charged, and convicted, of charges of engaging in reckless or deliberate conduct that may result in a child suffering harm as a result of neglect. They were each sentenced to a term of imprisonment of four years and four months.

9. They were each sentenced on the basis that the significant delay in Child MML receiving medical attention after the onset of his symptoms was likely to have resulted in a worse outcome for Child MML. Time was of the essence for Child MML, and there was an unacceptable delay on the part of those responsible for Child MML's care, Child MML's mother and then step-father, in seeking medical assistance for him after it should have been obvious to them that he had been seriously injured. How the injuries occurred could not be determined.

10. Child MML spent the remainder of his life in the care of his paternal grandmother, under a Protection Order, which ultimately became an order that Child MML remain in care until he turned 18 years old.

11. In my view, the level of care that Child MML's paternal grandmother provided to Child MML during his time in her care is nothing short of exceptional. Child MML's paternal grandmother managed Child MML's complex medical needs with genuine care, skill and attention. She, and

other members of Child MML's extended family, all appear to have placed Child MML's best interests at the centre of their lives, and led by Child MML's paternal grandmother with the support of the Department, they managed to ensure Child MML's final years of life were filled with the love, support and care that every child deserves.

12. Child MML remained in the care of his paternal grandmother until he died on 24 September 2021 at the age of 11 years old. His death, although utterly tragic for a child so young, was not unexpected given the serious, life-limiting health issues he suffered throughout his short life as a result of his injuries.

13. As Child MML was under the care of the Department at the time of his death, his death came within the definition of a 'person held in care' under section 3 of the *Coroners Act 1996* (WA). In these circumstances, a coronial inquest must be held.

14. I held a coronial inquest at the Perth Coroner's Court on 2 December 2025.

15. At the inquest, I received detailed documentary evidence contained in the coronial brief, and the following witnesses gave oral evidence:

a. Dr Simon Williams, Perth Children's Hospital Head of Neurology;
b. Dr Lisa Cuddeford, Perth Children's Hospital Head of Paediatric Palliative Care Unit; and
c. Glenn Mace, the Department's Executive Director Service Delivery.

16. All of the witnesses gave their evidence in a thoughtful and considered manner, and their evidence was of great assistance to the court in investigating the circumstances of Child MML's passing.

17. The circumstances of Child MML's death were investigated by the police. At the conclusion of the investigation, a comprehensive report of the death was prepared, which was tendered as part of the coronial brief

at the inquest. Significant material was also provided by the Department, and by Child MML's treating medical team to assist in the coronial investigation, which was also tendered as part of the coronial brief at the inquest.

18. The inquest focused primarily on the care and supervision provided to Child MML after he entered the care of the Department following his injuries. That care was primarily provided by his paternal grandmother. To assist in that regard, Mr Glenn Mace, from the Department, was called to give evidence relevant to these issues. Evidence was also heard from the above two medical experts, who were involved in Child MML's medical care, and who provided an opinion on the quality of the care, treatment and supervision provided to Child MML in relation to his medical needs. All of the witnesses also assisted me to understand an issue that arose in relation to communication between the Department, and health services, in planning for Child MML's end of life care.

19. The evidence before me showed that Child MML was primarily cared for by his paternal grandmother from when he was able to be discharged from hospital following his inflicted injuries, until his death in 2021. As I have explained above, Child MML's paternal grandmother was committed to providing Child MML with a safe and loving environment, which continued until he sadly passed away in hospital following an expected deterioration of his health due to his underlying health issues.

20. Taking into account all of the circumstances, I am satisfied that the supervision, treatment and care provided to Child MML by the Department was of a very high standard. This was primarily due to the tireless and dedicated efforts of Child MML's paternal grandmother, but those efforts were well supported by the staff of the Department involved in Child MML's care. My reasons for this finding are outlined below.

EARLY MEDICAL HISTORY

21. Child MML was born at Swan Districts Hospital on 8 April 2010 after a complicated delivery, requiring resuscitation.[4]

22. The day after his birth[5], Child MML was transferred to Princess Margaret Hospital to investigate some concerns including low blood sugar and apnoea (temporary cessation of breathing[6]).

23. These early concerns about excess insulin secretions were adequately managed at Princess Margaret Hospital, and the insulin secretions normalised over the first week of Child MML's life, and were not an ongoing problem.[7]

24. Child MML was noted to have a hoarse cry, and noisy breathing[8]. This was investigated at Princess Margaret Hospital and a left sided vocal cord palsy was identified, however no definite cause of the vocal cord palsy was found. By the time Child MML was discharged from Princess Margaret Hospital the vocal cord palsy was not considered a clinically significant problem.[9]

25. Child MML underwent a chest MRI as part of the investigations into his left sided vocal palsy, and he was found to have an accessory right main bronchus (which is effectively an additional right main airway).

26. Child MML also underwent a brain MRI at Princess Margaret Hospital when he was six days old, as part of the investigations into his left sided vocal palsy.[10] The MRI showed a structurally normal brain, but the left side of Child MML's cerebellum was smaller than the right, and one of the relevant arteries looked too small.[11]

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[4] Exhibit 1, Tab 12, p 3.
[5] Exhibit 1, Tab 13, p 2.
[6] Cambridge Dictionary APNOEA | English meaning - Cambridge Dictionary
[7] Exhibit 1, Tab 12, p 3.
[8] Exhibit 1, Tab 12, p 2.
[9] Exhibit 1, Tab 12, p 3.
[10] Exhibit 1, Tab 12, p 3.
[11] Exhibit 1, Tab 12, p 3.

27. The remainder of Child MML's brain MRI was normal.

28. None of these findings were associated with any ongoing clinical problems for Child MML. The findings relating to Child MML's vocal cords, and having a smaller left side of the cerebellum were described by his treating doctor at the inquest as "*of no consequence developmentally or neurologically*"[12].

29. Child MML was discharged from Princess Margaret Hospital on 15 April 2010. At that time, Child MML was feeding well, his low blood sugar had resolved, and he was discharged in good condition, with no concerns about his neurological state at that time.[13] Each of the findings during that admission were described by Child MML's treating doctor at the inquest as having "*completely resolved*"[14] by the time of his discharge.

30. Child MML was discharged home into the care of his mother. Child MML's mother had been visiting him frequently in hospital and was actively engaged in his care throughout the admission to hospital, so there were no known concerns on the part of hospital staff at that time in relation to her capacity to care for him.

31. Child MML had been referred to his local child health nurse, and his general practitioner, for follow-up, upon his discharge from hospital.

32. As a result of the finding that the left side of Child MML's cerebellum was smaller than the right, and that one of the relevant arteries looked too small, Child MML was also enrolled in the neonatal development follow-up program at Princess Margaret Hospital. This program provided outpatient appointments to monitor a child's developmental milestones at ages 4, 8 and 12 months of life. This monitoring is designed to allow for referrals for other therapy (such as physiotherapy

[12] Transcript, p 9.
[13] Exhibit 1, Tab 12, p 3; Exhibit 1, Tab 13, p 2.
[14] Transcript, p 9.

or occupational therapy) if required.[15] Child MML was also referred to the Ear, Nose and Throat outpatient clinic, for follow up monitoring.[16]

33. Over the six months after Child MML was discharged from hospital, he was given ten outpatient appointments to attend with the neo-natal clinic, the audiology clinic, and with an Ear, Nose and Throat specialist. One of these appointments may have been cancelled by the neo-natal clinic, but the others remained scheduled. Child MML's mother did not take Child MML to any of the remaining nine appointments.[17]

34. Child MML's mother, who was Child MML's primary carer at this time, gave various explanations for her failure to take Child MML to his scheduled appointments. They include that she felt Child MML was developing normally, and therefore the appointments were not necessary[18], that she could not attend appointments in the early morning or late afternoon, and that she was "*too lazy*" to take Child MML to the appointments.[19]

35. There is no evidence that Child MML's mother's failure to take him to his scheduled appointments had any adverse impact upon Child MML's development or health.

36. However, by failing to attend these appointments, medical practitioners were deprived of the opportunity to monitor Child MML's wellbeing, and to fully assess whether Child MML was meeting his developmental milestones as he reached the ages of 4 and 8 months of age.

37. This failure on the part of Child MML's mother to take Child MML to scheduled appointments means that there is limited information available about Child MML's development in the early months of his life. It also means that other ancillary information about Child MML's home environment, such as any care concerns that might have been gleaned by health professionals involved with a family, was not available at the time.

[15] Exhibit 1, Tab 13, p 2.
[16] Exhibit 1, Tab 13, p 2.
[17] Exhibit 1, Tab 9.1, p 4.
[18] Exhibit 1, Tab 9.1 p 4.
[19] Exhibit 1, Tab 9.1 p 4.

EVENTS IN DECEMBER 2010

38. During the night of Friday, 17 December 2010, at about 11.00 pm, Child MML received a brain injury which caused a collection of blood between the brain and the skull (also known as a subdural haematoma).

39. He was only 8 months old.

40. The circumstances in which Child MML suffered this inflicted trauma are not known.[20]

41. The evidence establishes that Child MML was at his home that night. He lived in the home with his mother, his then step-father, and his three siblings, then aged 7, 6, and 4 years old.[21] Child MML's then step-father had been living in the home with them for about five months by that time. The family home was described as "*chaotic*"[22], with a cockroach infestation, hygiene concerns, and limited toys, food and bedding throughout the home.[23]

42. It appears that Child MML, his siblings, his mother, and his then step-father were the only people at the home that night.

43. Child MML's then step-father told police that at about 11.00 pm, he played with Child MML in an attempt to calm him down. He said that he had tossed Child MML into the air and caught him while he was lying on his back in the bed. Child MML's then step-father said that he might have played too hard with Child MML because he was drunk, but that he didn't mean to hurt him.[24]

44. Child MML's then step-father told police that while he was playing with Child MML, he noticed that Child MML had stopped breathing. Child MML's then step-father told police that he was frightened, as he

[20] Exhibit 1, Tab 9, p 3.
[21] Exhibit 1, Tab 16, p 2.
[22] Exhibit 1, Tab 9.1, p 3.
[23] Exhibit 1, Tab 16, p 5.
[24] Exhibit 1, Tab 9, p 4.

could see that something was not right with Child MML, and his neck was slowly getting weak.[25]

45. According to Child MML's then step-father, he ran out of the room, and called to Child MML's mother. She checked on Child MML, said he was breathing, put him in a cot, and gave him a bottle. Neither Child MML's then step-father, or Child MML's mother, suggested taking Child MML to the hospital at that time.[26]

46. Child MML's mother initially told police that she could not tell them anything about the injuries Child MML had suffered.

47. In a statement prepared after her first interview, Child MML's mother told police that at about 11.00 pm, she walked into the bedroom while Child MML's then step-father was holding Child MML by the waist as he was sitting on the bed. Child MML's head and arms appeared limp. Child MML's then step-father told her that Child MML was asleep, and she asked him to put Child MML back in his cot and left the room.

48. About ten minutes later Child MML's then step-father came walking out of the room panicking, and said that Child MML wasn't breathing. Child MML's mother rushed into the room, and found him breathing. She asked what Child MML's step-father had done to Child MML and he said "*nothing*"[27] so she put him back to bed, and Child MML went to sleep. At about 2.30 am on 18 December 2010, Child MML's mother heard Child MML crying, so she gave him a bottle, which he didn't grab as he usually would, and so she had to put it in his mouth. Child MML drank a little bit from the bottle, and she thought he'd go back to sleep.

49. At about 5.00 am Child MML woke up, and Child MML's mother attended to him. She said that he was not her baby any more "*like he's supposed to be*" as he made no eye contact with her, and one arm was sticking out to the side. His mouth was moving, his tongue was going in and out and he looked in some way retarded.[28] In her statement to police,

[25] Exhibit 1, Tab 9, p 4.
[26] Exhibit 1, Tab 9, p 4.
[27] Exhibit 1, Tab 9, p 5.
[28] Exhibit 1, Tab 9, p 5.

Child MML's mother said that Child MML woke up at about 8:30 am, and again something was not right with him. She said "*[h]is eyes looked like they were looking right through you, his head was lacking strength, and his left arm was stiff and sticking out*."[29]

50. Child MML's then step-father woke up at about 9.00 am or 10.00 am. He told police that when he checked on Child MML, his "*neck was wobbly and he was looking over to one side, not straight*".[30]

51. Neither Child MML's mother, nor his then step-father, made arrangements for Child MML to go to the hospital, despite the obvious signs that something was not right with Child MML.

52. At about 10:30 am, Child MML's mother took Child MML to a neighbour for advice, as Child MML was moving his head in the same manner in which the neighbour's child, who had Down's Syndrome, would do. The neighbour told Child MML's mother to take Child MML to the hospital.

53. Instead, at about 11.00 am or 11.30 am, Child MML's mother took Child MML to her mother's (Child MML's maternal grandmother's) house, which was nearby. The maternal grandmother was unable to take Child MML to the hospital, but called Child MML's maternal grandfather to come home. He arrived home at around noon, and offered to take Child MML to the hospital, telling Child MML's mother that she should do so. Child MML's mother said she thought there was nothing seriously wrong with Child MML and she was going to give it a few hours and come back if nothing changed.

54. Child MML's mother took Child MML home, and did not make any attempts to take Child MML to the hospital. In that time, Child MML's then step-father also took no action to get Child MML medical attention.

55. At about 5.00 pm, Child MML's paternal grandmother arrived at the home to visit Child MML. It was immediately obvious to her that he

[29] Exhibit 1, Tab 9, p 5.
[30] Exhibit 1, Tab 9, p 5.

needed to go to the hospital, and Child MML's paternal grandmother took him there herself.

56. As is apparent from the above, despite both Child MML's mother and stepfather observing obvious signs that Child MML required urgent medical assistance in the immediate aftermath of 11.00 pm on 17 December 2010, and even with prompting from neighbours and family on 18 December 2010, neither made any effort to obtain medical assistance for Child MML, electing to see if he recovered on his own.

57. When Child MML was finally taken to hospital by his paternal grandmother on 18 December 2010, it was evident that Child MML's health had undergone a fundamental and irreversible change.

58. When Child MML arrived at hospital, he was unresponsive, and experiencing continuous fitting.[31]

59. Medical investigations confirmed that Child MML had a bleed around his brain, which required a neurosurgical procedure known as a craniotomy, where part of the skull is removed to relieve pressure on the brain. Further investigations established that Child MML had sustained extensive, severe injuries, including:

a. Extensive left subdural haematoma (a bleed around his brain) with midline shift and hypoxic brain injury;
b. Retinal haemorrhage (a bleed at the back of the eye);
c. A buckle fracture to the right ulna (lower arm/wrist), with no signs of healing;
d. A suspected tiny buckle fracture of the right radius (lower arm/wrist), with no signs of healing;
e. A fracture of the base 3rd and 4th metacarpals (hand), with no signs of healing;
f. An impaction fracture of the right tibia (shin) with signs of healing; and
g. A left mid tibial shaft (shin) fracture, showing signs of healing.

[31] Exhibit 1, Tab 12, p 4.

60. Dr Williams explained that Child MML's brain injury meant that there was not enough oxygen getting to his brain, which resulted in cell death. Once brain cells die, they cannot be recovered. Child MML's injury was a "*whole brain injury*" which Dr Williams described as "*profound and extensive*".[32]

61. Child MML had bony fractures, some of which showed signs of healing. Dr Williams explained that it's very unusual for long bone fractures in a child to be caused by anything other than trauma, and Child MML had fractures involving the long bones. Dr Williams explained that the signs of healing in some fractures indicates there had been multiple episodes of trauma for Child MML, which is suggestive of inflicted trauma.[33]

62. The injuries were assessed by the treating medical team as non-accidental.

63. No person has ever admitted to deliberately inflicting injuries on Child MML. No person has ever been convicted of causing the injuries that Child MML suffered.

64. In evidence at the inquest, Dr Williams was asked some questions about potential causes of Child MML's injuries.

65. Dr Williams gave evidence about possible mechanisms that may cause a "*whole brain injury*" of the type that Child MML suffered. Dr Williams explained that there are three basic mechanisms that could result in injuries of the severity Child MML suffered:

a. A high speed motor vehicle accident where there is sudden deceleration, so the body is held in place (for example, by a seatbelt) and the head flicks forward;
b. A fall from height, typically of more than 10 metres high, with the impact and deceleration forces then passing through the skull; or

[32] Transcript p 11.
[33] Transcript, p 11.

c. A child being held and vigorously shaken.[34]

66. Dr Williams explained that there are other possible occasions where a whole brain injury may occur, such as through impairment of breathing (suffocation), or through infection or disorders of the immune system.[35]

67. I am satisfied that there is no evidence that Child MML suffered any infection or disorder of the immune system that may explain his whole brain impairment or severe neurological impairment as having arisen by natural means.

68. I am satisfied that there is no evidence that Child MML was involved in a high speed motor vehicle accident. In particular, no one responsible for the care of Child MML suggested that there had been any such accident around the time of Child MML's injuries, and there was no suggestion of any child seat-belt or restraint type injuries one would expect if this explanation was put forward.

69. I am satisfied that there is no evidence that Child MML fell from height. Child MML did not suffer the external injuries one would expect had he suffered a fall from a significant height, such as an impact injury to the skull (a fractured skull).

70. In Dr Williams' opinion, that left remaining the mechanism of Child MML's injury as resulting from being held, and vigorously shaken.[36]

71. Dr Williams was asked about the evidence of Child MML's then step-father, in relation to the suggestion that he may have played too hard with Child MML, or played roughly with him, before he observed him to stop breathing. Dr Williams explained that the degree of force required for the injuries that Child MML suffered would not arise from

[34] Transcript p 15; Consistent with evidence given by Dr Alice Johnston, Consultant Paediatrician, in the criminal proceedings at Exhibit 1, Tab 9.1, p 10.
[35] Transcript, p 15.
[36] Transcript, p 16.

"*just normal play*" and that it would need to be "*very vigorous shaking, very aggressive shaking*"[37].

72. Dr Williams was asked about other scenarios that may explain Child MML's injuries.

73. Dr Williams explained that it was "*not in the realm of possibility*" that Child MML's injuries were caused from, for example, a fall from a height of a cot. Dr Williams rejected the possibility that Child MML's injuries could have been caused by a parent playing with Child MML by throwing him up in the air and catching him, or even by throwing the child in the air and not catching them, causing a fall to the ground from perhaps two metres. Dr Williams explained:

> "*This was a severe injury. We do see, unfortunately, too many children who are shaken. And you can tell by the impact on Child MML; so the severity of his neurological impairment. Regardless of what MRI scans show or what other fractures or retinal haemorrhages, the fact that he was just devastatingly impaired; that – that – that's the most important element that tells us just how severe this injury was. So his injury was – and – and with – with the children who are shaken – with abusive head trauma there is a spectrum. And Child MML's was at the most severe end of the spectrum*."[38]

74. Dr Williams explained that in a scale of one to 10, with 10 being the most serious, Child MML's injuries were at around nine. While Child MML didn't die, Dr Williams felt he probably would have died without the care he received at Perth Children's Hospital.[39]

75. Dr Williams was asked whether the injuries could be explained by a possible strike, for example, by a sibling aged 5 to 7 years old. Dr Williams considered such a suggestion to be "*absurd*" and a prospect he would disregard entirely.

[37] Transcript, p16.
[38] Transcript, p 16.
[39] Transcript p 16-17.

76. He was asked whether it would be possible for a child of that age to have inflicted the injuries upon Child MML by shaking. Dr Williams considered the suggestion to be "*astonishing*" and explained that such a possibility would be "*very unlikely*". I pause here to say that while one of the children had previously suggested that Child MML's then step-father *and* one of the other children had "*dropped*"[40] Child MML, I consider there is no evidence to suggest that any of the children were in any way responsible for the infliction of Child MML's injuries.

77. I am therefore left with the accounts provided of the events of 17 December 2010 by Child MML's mother, and Child MML's then step-father, which are unable to satisfactorily explain what led to Child MML's severe injuries.

78. Both Child MML's mother, and Child MML's then step-father, were criminally charged, and sentenced on the basis that over a period of about 18 hours (from 11:30 pm on 17 December 2010 until Child MML's paternal grandmother arrived at about 5.00 pm on 18 December 2010), they each failed to arrange appropriate medical treatment for Child MML, in a situation where they were each reckless as to whether he required medical treatment, and reckless as to whether he might suffer harm if they did not arrange medical treatment for him.[41]

79. They were both sentenced on the basis that at least some of Child MML's serious disabilities would have been avoided, or would have been less serious, if either Child MML's mother, or then step-father, had arranged prompt medical treatment for him.

80. The Western Australia Police Force, and the Office of the Director of Public Prosecutions, determined there was insufficient evidence to criminally charge any person with causing the injuries inflicted upon Child MML. Accordingly, neither Child MML's mother, nor Child MML's then step-father, were charged or sentenced on the basis they had inflicted the injuries upon Child MML.

[40] Exhibit 1, Tab 16, p 4.
[41] Exhibit 1, Tab 9.1, p 11.

CONSEQUENCES OF CHILD MML'S INJURIES

81. As a result of Child MML's brain injury, he was diagnosed with severe neurological impairment. The health problems Child MML suffered were the direct result of his brain dysfunction caused by his whole brain injury.[42]

82. Child MML's severe neurological impairment meant that he could not develop normal brain function, normal intellect or normal cognitive function. However, Child MML showed some awareness of the world around him. He was able to be soothed by his paternal grandmother when he was agitated or upset, and he was able to smile in response to stimuli, such as being tickled.

83. Child MML's vision was significantly impaired to the extent that he was effectively blind, and his ability to respond to sound was inconsistent. He had no speech or language, and could vocalise some sound, but couldn't communicate effectively. When Child MML was uncomfortable or in pain, he would cry. Sadly, due to his condition and despite the best efforts of his carers, Child MML was often uncomfortable or in pain.[43]

84. Child MML had epileptic seizures throughout his life, which resulted in various hospital admissions for their management, and long-term medications to try to control the seizures. Despite the efforts of Child MML's treating medical team, Child MML's seizures were never able to be stopped altogether, although their intensity and frequency varied over time.

85. Due to his brain injury, Child MML had cerebral palsy, involving his whole body (quadriplegia, impairment of all four limbs). His cerebral palsy was graded at Level 5, which is the most severe form of impairment. This meant that Child MML couldn't move of his own volition, and he experienced painful muscle spasms and joint contractures.

[42] Transcript p 12.
[43] Exhibit 1, Tab 12, p 6.

86. Healthy brain function is essential to coordinate other bodily functions, such as swallowing and gut movements. As a result of Child MML's brain injury, he couldn't coordinate his swallowing muscles when eating or drinking, without the risk that whatever he was eating or drinking would spill into his lungs (known as aspiration). Other functions, such as Child MML's ability to cough, were impaired. This caused a risk of infection, as Child MML couldn't, for example, clear unwanted material from his lungs by coughing, as he would have done had his body functions not been impaired. Child MML's stomach and small intestine function was affected, causing reflux of stomach contents into Child MML's throat (causing again a risk of aspiration), and causing his large bowel to move too slowly, resulting in chronic constipation.

87. With severe neurological impairment, issues like respiratory and gut function are known to deteriorate over time. This is what happened to Child MML.

88. By the time Child MML was able to be discharged from the hospital after his brain injury in early 2011, it was apparent that Child MML would never be able to sit, roll over, hold any objects, or do many of the basic functions of daily life given the severity of his disabilities. He could not move himself, and could not chew food, and his seizures were ongoing.

89. A report prepared by his treating medical team for the purpose of an application to the then Disability Services Commission for funding for his ongoing care described Child MML as:

> "*a child with normal development who has suffered a severe acquired brain injury due to trauma and also hypoxic damage. He requires intensive rehabilitation; however he remains highly likely to have severe long term disabilities across multiple developmental domains necessitating a high level of skilled care for the remainder of his life*."[44]

[44] Exhibit 1, Tab 16, p 6.

90. On 21 February 2011[45] Child MML was discharged from the hospital into the care of his paternal grandmother, who was appointed as his full-time carer by the Department. As a result, the immense task of meeting Child MML's daily needs fell to Child MML's paternal grandmother, a task which she managed with dedication for the remaining ten years of Child MML's life.

PLACEMENT WITH PATERNAL GRANDMOTHER

Early Placement

91. On 21 December 2010, while Child MML was still in hospital receiving treatment for his injuries, it was explained to Child MML's mother that the Department would take Child MML into the protection and care of the Department if Child MML's mother tried to remove him from the hospital.[46]

92. On 22 December 2010, the Department made enquiries with Child MML's mother as to her views about Child MML being cared for by his paternal grandmother as a relative carer, if he couldn't be discharged back into her care in light of the ongoing criminal investigation as to the cause of his injuries. Child MML's mother was supportive of the paternal grandmother taking care of Child MML.[47]

93. Child MML's biological father was incarcerated for unrelated matters, and was therefore not available to take care of Child MML, however it appears that he was also supportive of his mother, the paternal grandmother, taking care of Child MML.[48]

94. In early 2011, preparations began for Child MML to be discharged into his paternal grandmother's care. The paternal grandmother's home was assessed for suitability, and no issues were identified.[49] The Department

[45] Exhibit 1, Tab 16, p 7.
[46] Exhibit 1, Tab 16, p 4-5.
[47] Exhibit 1, Tab 16, p 5.
[48] Exhibit 1, Tab 16, p 11, 24, 28.
[49] Exhibit 1, Tab 16, p 6.

assisted Child MML's paternal grandmother with purchasing a cot, bedding, a special bath and a car seat suitable for Child MML.[50]

95. In the meantime, Child MML's paternal grandmother attended Princess Margaret Hospital every day in the lead up to Child MML's discharge, learning from medial staff how to provide the specialist care Child MML required, and learning to manage his complex disabilities.[51]

96. From the early stages of Child MML's entry into the care of the Department, it is clear that the overall goal of the Department was to provide Child MML with a long term, stable placement with his paternal grandmother, to best meet his emotional, cultural and physical needs.[52]

97. I am satisfied that this placement was in Child MML's best interests, and that Child MML's paternal grandmother was the best possible person available to provide Child MML with a safe and loving home.

98. As outlined above, the majority of the specialised care Child MML required to meet his needs was provided by his paternal grandmother.

99. Child MML also had periods of regular respite, and Child MML's paternal grandmother was assisted with his care in the home by in home support services arranged through specialist disability services, and funded through a combination of Departmental funding, Disability Services Commission funding and then National Disability Insurance Scheme (NDIS) funding.[53]

100. These services included Lady Lawley College, Ability Centre, Sunflower Care Services, AVIVO, The Centre for Cerebral Palsy and Hannah's House, amongst many others.[54]

101. Child MML's paternal grandmother asked that the Department be the primary liaison point for coordinating respite services throughout

[50] Exhibit 1, Tab 16, p 7.
[51] Exhibit 1, Tab 16, p 7.
[52] Exhibit 1, tab 16, p 9.
[53] Exhibit 1, Tab 16, p 42.
[54] Exhibit 1, Tab 16, p 42.

Child MML's care,[55] and it is apparent that Departmental staff were responsive and proactive in ensuring arrangements were made to support Child MML's paternal grandmother in caring for him.

102. As a result of Child MML's inflicted brain injury and associated chronic health complications, Child MML required full-time care and could not be left alone.[56] He suffered daily seizures, and required extensive support for feeding and other bodily functions. Child MML's needs were so extensive that he often slept in the same room as his paternal grandmother, with Child MML's paternal grandmother waking regularly so that she could attend to his medical needs as required.

103. Given Child MML's severe neurological impairment, Child MML's medical needs alone were immense.

104. Child MML had specialist medical care plans related to his anaphylaxis risk (due to an egg allergy), a Continuous Positive Airway Pressure (CPAP) management plan, a nutrition management plan, a seizure management plan and a respiratory management plan, all of which were aimed to assist in managing Child MML's complex medical issues.

105. Many medical staff based in hospital services were involved in Child MML's care throughout the years, including the paediatric rehabilitation teams, the neurology team, the orthopaedic team, the immunology team, the spinal clinic, and the respiratory and sleep clinic, in both the hospital and outpatient setting, and the palliative care team, amongst others.

106. Child MML also saw various allied health professionals separately to his hospital care, which included speech pathology, physiotherapy, occupational therapy, dietetics and social work support.

107. Between Child MML's discharge from hospital and the date of his passing, he had been hospitalised on many occasions for ongoing health

[55] Exhibit 1, Tab 16, p 43.
[56] Exhibit 1, Tab 8, p 3.

issues, attended over 150 hospital appointments, and had attended countless more allied health appointments over the years.[57]

108. With appropriate supports and medical care plans in place, Child MML was able to attend day care. In 2014 when Child MML was four years old, he was enrolled in the Durham Road School, which is a specialist education provider for children with disabilities.[58] Child MML was able to attend that school up until his passing, receiving the benefit of a social environment with other children, targeted educational planning based upon his needs, and the support of specialist teachers and nursing staff to ensure his safety and wellbeing while in a school environment.

109. In 2016, with advocacy assistance from the Department, Child MML's paternal grandmother was able to move into a property that was purpose built for people with disabilities, including double width doors, and a specialised bathroom that could accommodate Child MML's wheelchair, and space requirements.[59] The Department consistently assisted Child MML's paternal grandmother with day to day issues that arose, including through advocacy, support, and specialist funding, when issues arose that may impact the quality of Child MML's life.[60]

110. The evidence demonstrates that while Child MML's needs were immense, Child MML's paternal grandmother (supported by other family members), the Department, and various service providers assisting Child MML worked very effectively together to ensure his needs were met. That cooperation contributed to Child MML being able to live a full life, from going to school, interacting with his extended family, listening to music, attending activities, and living in a safe and comfortable home, with safe respite care options when the need arose.[61]

[57] Exhibit 1, Tab 16, p 43-44.
[58] Exhibit 1, Tab 16, p 14.
[59] Exhibit 1, Tab 16, p 22.
[60] See for example, Exhibit 1, Tab 16, p 7, p 11, 20 and p 30, amongst many others.
[61] See for example, Exhibit 1, Tab 16, p 11, 12, 15, 20, 21, 22, 24, 26, 27, 28, 29, 32, 35, 41, 42, amongst many others.

EVENTS PRIOR TO THE DEATH

111. From around 2020, Child MML's health started to decline.[62]

112. This decline in health, while terribly sad for Child MML's family and those who loved him, was anticipated by his treating medical team, as deteriorating health is something often seen in children with severe neurological impairment.[63]

113. From the moment the severity of the injuries inflicted upon Child MML were understood, it was known that it would be unlikely for him to survive to adulthood, despite the best efforts of those involved in his care.[64]

114. As time passed, Child MML's ability to regulate his breathing, heart rate, and gut function in particular, deteriorated.[65] Child MML had been fed directly into his stomach for a number of years, through a percutaneous endoscopic gastronomy tube (also known as PEG feeds). From around 2020, Child MML began to struggle to tolerate this method of feeding, as his stomach contractions were causing him pain, and the food was being pushed the wrong way.

115. As a result, during a hospital admission between March and April 2020, Child MML's treating medical team changed from feeding Child MML through a tube in his stomach, to move the tube past the stomach into the first part of his intestine, called the jejunum (through a percutaneous endoscopic jejunostomy tube, also known as PEJ feeds).[66]

116. As 2020 progressed, Child MML's school Community Nurse raised some concerns about managing Child MML's breathing, his PEG and subsequently PEJ feeds, and his seizures at his school. The school were worried about Child MML's presentation at school, and his health appeared to them to be declining.[67]

[62] Transcript, p 19.
[63] Transcript, p 19.
[64] Transcript, p 21,
[65] Transcript, p 19.
[66] Transcript, p 20.
[67] Transcript, p 36.

117. As a result, a multidisciplinary team meeting was held at Child MML's school in August 2020, including members of Child MML's treatment team, Departmental workers, and school staff, although Child MML's paternal grandmother was unwell and unable to attend. In that meeting, it was agreed that Child MML's Paediatric Goals of Patient Care (Goals of Patient Care) needed discussion at a future date.[68] Exactly what is involved in establishing Goals of Patient Care is explored further below.

118. Child MML was hospitalised on a number of occasions at Perth Children's Hospital during 2020, for reasons including aspiration pneumonia, increasing seizures, and issues with PEJ feeds.

119. In a further meeting in October 2020 which included members of Child MML's treating team, Child MML's paternal grandmother, and Departmental workers, Child MML's difficult year was discussed, and it was felt at that time that Child MML's declining health indicated he was progressing towards the end of his life.

120. Child MML's condition meant that his ongoing decline was part of his neuro-disability, and there were no real treatment options for him. The focus therefore turned towards minimising his suffering, and managing his worsening symptoms.

121. In this meeting, Child MML's Goals of Patient Care were discussed.

122. Dr Cuddeford explained that when it becomes clear that a patient is experiencing irreversible and ongoing deterioration in their health, it is usual practice for clinical teams to ensure the family are aware of the clinical concerns, and to together formulate a plan to manage acute clinical deterioration, including limitations to treatment, to make sure that the care provided focuses on care that will improve the quality of the patient's life, rather than causing suffering with little to no gain for the patient. This is called a Goals of Patient Care conversation. That conversation is then documented, as part of a Goals of Patient Care form,

[68] Transcript p 36.

to assist clinical teams to manage a patient presenting with acute deteriorating health in an emergency situation.[69]

123. Dr Cuddeford explained that Goals of Patient Care are not legally binding. They simply document an agreed approach, where agreement can be reached, to manage a patient's clinical deterioration[70]. Goals of Patient Care may change and develop over time.

124. Dr Cuddeford and Dr Williams both emphasised that notwithstanding any agreed Goals of Patient Care, a doctor ultimately has a duty to provide ethical and appropriate medical care to a patient. Dr Williams explained that, in a hypothetical scenario, if he were directed to provide full resuscitation to a person where that resuscitation would provide only suffering to the patient to no medical benefit, he would have an ethical duty not to provide that care.[71] It is therefore central to end of life planning that the patient, family members, and other decision makers, understand what care can be appropriately and ethically provided, and that questions and concerns are compassionately and carefully addressed by the medical professionals involved in the patient's care.

125. In Child MML's case, treating medical professionals would most commonly interact with Child MML's paternal grandmother, as she was the person attending the majority of appointments, and managing Child MML's day to day needs. However, as a child in the care of the Department, the Chief Executive Officer of the Department was Child MML's legal guardian, and therefore the involvement, and preferably consent, of appropriate Departmental workers was required, as part of any formal end-of-life decision making.

126. There are legislative obligations[72] upon the Department, in terms of decision making regarding the best interests of children being family informed. In Child MML's case, this meant that the Department was obliged to consult, or attempt to consult, Child MML's family, including his mother and father, in making decisions for Child MML.

[69] Exhibit 1, Tab 14, p 2.
[70] Exhibit 1, Tab 14, p 2.
[71] Transcript p 25.
[72] Exhibit 1, Tab 16.1, p 2 – 4.

127. The complexities surrounding efforts to agree Child MML's Goals of Patient Care are discussed further under the heading ***Quality of the Supervision, Treatment and Care*** below.

128. In October 2020, Child MML's paternal grandmother felt that Child MML's father was struggling to cope with Child MML's declining health, and she wanted time to discuss Child MML's health with her family, before any decisions were made about his Goals of Patient Care. As a result, Child MML remained for full active treatment and resuscitation, in the event that he suffered a cardiac arrest.

129. Further meetings were held, which included Child MML's father, where his feelings of guilt for being unable to protect his son from the injuries he suffered as an infant were discussed. While all of Child MML's family wished for Child MML to avoid suffering, at this time, the family were unable to agree upon any ceilings of care, and Child MML's Goals of Patient Care were not formalised at this time.

130. Nonetheless, the palliative care team were closely linked in with Child MML's family, and provided ongoing support and discussion regarding Child MML's care at this time.[73]

131. In November and December 2020, Child MML was again hospitalised in Perth Children's Hospital. At that time, Child MML was unable to tolerate nutritionally effective feeds through his PEJ tube. Child MML's treating medical team explained to Child MML's family that Child MML was reaching the end palliative stage of his condition.

132. On 21 December 2020, a meeting was held between the treating medical team and Child MML's paternal grandmother and aunts, where Goals of Patient Care were discussed. The Goals of Patient Care agreed were that Child MML would not receive CPR and would not be transferred to the intensive care unit for admission or intubation, in the event that he suffered a cardiac arrest. However, he was still to receive active

[73] Exhibit 1, Tab 14, p 2.

treatment for reversible conditions, and medical emergency team calls if needed.

133. On 22 December 2020, a medical emergency team call was made after Child MML stopped breathing, but this episode resolved with stimulation, airway support and a period of bag mask respiration.

134. Two days later, on 24 December 2020, the palliative care team managing Child MML had multiple contacts with Departmental staff about Child MML's Goals of Patient Care.[74] Departmental staff, as Child MML's legal guardians, felt that they were unable to agree to Child MML's Goals of Patient Care without written consent from Child MML's biological parents. Child MML's father did not sign the Goals of Patient Care, and accordingly, the Department did not agree to the Goals of Patient Care that were discussed between the health professionals involved in Child MML's care and Child MML's paternal grandmother and aunts on 21 December 2020.[75]

135. In practice, this meant that in the absence of the Department agreeing to the Goals of Patient Care, Child MML was to receive full resuscitation, including CPR, if he suffered a cardiac arrest. This of course, would still require the treating medical professional to consider full resuscitation to be ethically appropriate care in the best interests of Child MML in the circumstances of the medical presentation.

136. Child MML was hospitalised on multiple occasions in the early part of 2021. During a hospital admission in March and April 2021 for aspiration pneumonia, Child MML's treating medical team formed the view that CPR, intubation, and intensive care unit intervention for Child MML would be futile, and not in Child MML's best interests. There was ongoing contact between the treating medical team, and the Department, in relation to efforts to agree Goals of Patient Care that were in Child MML's best interests.

[74] Exhibit 1, Tab 16, p 36.
[75] Exhibit 1, Tab 16, p 36.

137. On 21 March 2021, after a hospital meeting including Child MML's treating medical team, members of Child MML's family, and a crisis care worker from the Department (given the meeting occurred after hours), the crisis care worker from the Department signed Child MML's Goals of Patient Care.[76]

138. Child MML continued to receive treatment, including antibiotics, breathing support (such as CPAP, which is a machine that delivers pressurised air through a mask and tube to assist in breathing), and PEJ feeds, and eventually became well enough to be discharged home into the care of his paternal grandmother.

139. Child MML was again hospitalised on a number of occasions as the year progressed, and in July 2021, he was again admitted to Perth Children's Hospital with aspiration pneumonia. Child MML had a large amount of gas in the abdominal cavity around the abdominal organs, which was suggestive of an abdominal perforation. The site of a perforation was not identified at that time.

140. Child MML would not have survived abdominal surgery, and so his condition was managed with antibiotics and fluids. His PEJ feeds were recommenced, but he could not tolerate the full rate, and would vomit when this was attempted. As a result, Child MML was losing weight.

141. It was therefore apparent that Child MML was reaching the end stages of his life. On 29 July 2021 Child MML was discharged home with his paternal grandmother, who, with the support of palliative care and allied health professionals, alongside the Department, continued to provide the best possible care for Child MML as his health continued to deteriorate.

EVENTS ON 24 SEPTEMBER 2021

142. On 8 September 2021, Child MML was admitted to Perth Children's Hospital for the last time. He remained hospitalised until his death on 24 September 2021.

[76] Exhibit 1, Tab 18, p 2.

143. Child MML was taken to hospital by his paternal grandmother as his abdomen was increasing in size, and was particularly rigid. He also had black stools and black vomits.

144. It was suspected that Child MML had a perforated bowel. An x-ray was performed which showed a large volume of air in the abdominal cavity around the abdominal organs, which supported the suggestion that Child MML's bowel was perforated.

145. Child MML was given pain relief, and his anti-seizure medication was commenced. Child MML was well known to the treating medical team by this time, and he was closely monitored and reviewed by multiple treatment teams, including the palliative care team during this admission.[77]

146. Child MML initially showed some improvement, and he was recommenced on small volume PEJ feeds. However, he was unable to tolerate the feeds, and had increased vomiting, including vomiting digested blood.

147. It was apparent to Child MML's treating medical team that Child MML was dying, and there was a strong focus on ensuring Child MML was kept as comfortable as possible. Child MML's family, including his paternal grandmother, his father, and other family members, visited Child MML frequently during this final hospital admission.

148. At 8.40 am on 24 September 2021, Dr Easton confirmed that Child MML had passed away.

149. Child MML's paternal grandmother, father, and extended family were all allowed some time with him and the police were notified of Child MML's passing by hospital staff, given Child MML was a child in care and his death had to be reported to the coroner.

[77] Exhibit 1, Tab 20.

HOMICIDE CHARGE

150. After Child MML's death, the Western Australia Police Force Homicide Squad commenced Operation Ambrel, to investigate the circumstances of Child MML's death.

151. The police investigation identified two designated suspects in connection with Child MML's death: Child MML's former step-father, and Child MML's mother, on the basis of their original convictions for their neglect of Child MML.

152. Child MML's mother died from cancer less than four months after Child MML passed away.[78]

153. After a thorough investigation, Child MML's former step-father was arrested, and charged with manslaughter in connection with Child MML's death. That charge was laid on the basis that Child MML's former step-father's neglect of Child MML in obtaining medical assistance was a "*significant and substantial cause*" of Child MML's death. I emphasise that the criminal charge laid specifically did **not** suggest that the criminal charge arose due to an allegation that Child MML's former step-father inflicted the initial abusive head trauma.

154. The Office of the Director of Public Prosecution considered the charge that had been laid, and determined that there were insurmountable evidentiary issues in relation to this charge. On 18 September 2024, they discontinued the charge against Child MML's former step-father.[79]

155. This was on the basis that the available medical evidence cannot establish that the neglect was a "*significant and substantial cause*" of Child MML's death.

156. The available medical evidence was unable to quantify exactly what, if any, of Child MML's lifelong disabilities would have been avoided, if

[78] Exhibit 1, Tab 8, p 7.
[79] Exhibit 1, Tab 8, p 3.

his mother and then step-father had arranged prompt medical attention for him.

157. While Child MML's mother and then step-father were sentenced on the basis that "*at least some of the disabilities would have been avoided or would have been less serious if [Child MML] had received prompt medical attention*"[80], the medical evidence presented in the criminal proceedings could not quantify with any certainty which of Child MML's many medical conditions could have been avoided, and to what degree.

158. Dr Williams was asked in his evidence whether he would be able to effectively analyse Child MML's medical conditions and say which may have been prevented with immediate intervention. Dr Williams gave evidence consistent with the medical evidence presented in the earlier criminal proceedings.

159. He explained that all individuals are unique, and the progression of different injuries, in different people, varies depending on a range of factors. Dr Williams agreed that with earlier intervention, it would be reasonable to say that Child MML's outcomes would have been better, but he couldn't narrow that down into specifics.[81]

160. Accordingly, on the medical evidence presently available, it is not possible to establish whether the failure of Child MML's mother, and then step-father, to obtain prompt medical attention for him on 17 and 18 December 2010 was a "*significant and substantial cause*" of Child MML's death.

CAUSE OF DEATH

Post mortem examination

161. A full forensic post mortem examination was conducted on 4 October 2021. Together, two Forensic Pathologists, Dr Ong and

[80] Exhibit 1, Tab 9.1, p 12.
[81] Transcript, p 19.

Dr Downs, undertook a full internal examination of the deceased's body after being provided with some information about the deceased's medical history, and the circumstances leading to his death.

162. Dr Ong and Dr Downs noted that the lungs were congested, and microscopic examination showed acute infective changes within the lung, otherwise known as bronchopneumonia.

163. The small bowel showed changes in keeping with small bowel necrosis, with inflammatory changes present on the inner lining of the abdominal cavity (peritoneum).

164. Neuropathological examination of the brain showed chronic organised thin subdural membrane. A subdural membrane can be seen following a bleed around the brain, where after an acute bleed heals, a membrane or scar tissue remains.

165. The forensic pathologists observed changes to the brain in keeping with multicystic encephalopathy. Multicystic encephalopathy is an end stage change in the brain associated with multiple causes, the most common of which is the occurrence of severe cerebral hypoxic ischaemic encephalopathy (a brain injury that may occur when oxygen or blood flow to the brain is reduced or stopped). The forensic pathologist also observed the small left cerebellar hemisphere, which was observed in Child MML when he was first born, before he received any injury.

166. Microbiological testing from the lungs showed the growth of *pseudomonas aeruginosa* and *staphylococcus aureus*, but microbiology testing was otherwise non-contributory to the death.

167. Diagnostic molecular genetic testing for aortopathy (disease that affects the aorta, the main and largest artery supplying oxygenated blood) gene panel showed no clinically significant abnormality.

168. Toxicology analysis was undertaken, and detected the presence of several medications, in keeping with terminal medical care.[82]

[82] Exhibit 1, Tab 5, p 2.

Cause of death

169. At the completion of all investigations, Dr Ong and Dr Downs formed the opinion that the cause of death was bronchopneumonia and small bowel necrosis with perforation, in a boy with multicystic encephalopathy and organised subdural membrane, on long term enteral feeding, with terminal palliative care.[83]

170. In very simple terms, Child MML's ability to regulate his own breathing, heart rate and in particular, gut function, deteriorated over time as a result of his severe neurological impairment following his traumatic head injury.[84]

171. As Dr Williams explained at the inquest, good lung health is predicated on whole body movement. For Child MML, who could not move his own body, his ability to clear mucus from his lungs was impaired, and therefore infections occurred. This, alongside long term PEJ feeding which was required given his inability to consume whole food, and his generally deteriorating respiratory functioning, left Child MML particularly vulnerable to infections such as bronchopneumonia.

172. Child MML then also experienced deteriorating gastrointestinal function. As Dr Williams further explained, the brain stem and spinal cord are essential to helping the gut move, and require organisation from a functioning brain. Children like Child MML, with severe neurological impairment, have a tendency to experience reflux and vomit, and vomiting was always a particular issue for Child MML.[85]

173. As Child MML's gut function deteriorated in a manner anticipated for a child with severe neurological impairment, his bowels did not move as they should, and he experienced severe constipation. As a result, Child MML's bowel tissue started dying (small bowel necrosis). That dying tissue was then vulnerable to perforation (a hole forming).

[83] Exhibit 1, Tab 5, p 1.
[84] Transcript, p 19.
[85] Transcript, p 14.

174. Therefore, Child MML died as a result of his deteriorating respiratory functioning and pneumonia, and the perforation of his bowel. These conditions were on the background of Child MML's severe neurological impairment (including multicystic encephalopathy[86] and organised subdural membrane[87]) which developed after he suffered an inflicted injury ten years prior.

175. I accept and adopt the conclusions of Dr Ong and Dr Downs as to the cause of death.

Manner of death

176. The manner of Child MML's death is a more complex question.

177. In determining Child MML's manner of death, I must be mindful of the fact that no person has ever been criminally convicted of inflicting injuries upon Child MML. Child MML's mother and then step-father were criminally convicted only of failing to arrange appropriate medical treatment for Child MML, in a situation where they were each reckless as to whether he required medical treatment, and reckless as to whether he might suffer harm if they did not arrange medical treatment for him.

178. While both Child MML's mother and then step-father were sentenced on the basis that at least **some** of Child MML's serious disabilities would have been avoided, or would have been less serious, if either Child MML's mother, or then step-father, had arranged prompt medical treatment for him, exactly which serious disabilities may have been avoided, and to what degree, cannot be quantified, and whether the disabilities that may have been prevented were the disabilities that ultimately led to his passing cannot be known.

179. I must therefore consider whether the available evidence allows me to make a finding as to the manner of Child MML's death.

[86] This is essentially cysts (or holes) within the brain.
[87] This is effectively scar tissue, or a membrane, that forms after a bleed around the brain has had time to 'heal' to the extent that can occur.

180. In considering this issue, I am guided by the principles set out in the High Court's decision in the case known as *Briginshaw v Briginshaw*[88] (the Briginshaw case).

181. The Briginshaw case is authority for the proposition that a consideration of the nature and gravity of the relevant conduct is required when deciding whether a finding adverse in nature has been proven on the balance of probabilities.

182. Further, I must be mindful that section 25(5) of the *Coroners Act 1996* (WA) prohibits a coroner 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 any offence.

183. I find that on 17 December 2010, Child MML suffered an abusive head trauma. This finding is consistent with the findings in separate criminal proceedings. The fact that Child MML suffered an abusive head trauma is not a finding of criminality, or a finding that a particular individual intentionally inflicted injuries upon Child MML.

184. Consistently with the findings of superior courts in separate criminal proceedings, I find that the available evidence does not allow me to draw a conclusion, to the standard of proof required, about how Child MML's abusive head trauma occurred.

185. Further, I find that the medical evidence presently available does not allow me to draw a conclusion, to the standard of proof required, about whether the failure of Child MML's mother, and then step-father, to obtain prompt medical attention for him on 17 and 18 December 2010 was a "*significant and substantial cause*" of Child MML's death.

186. Ultimately, Child MML died as a natural consequence of the deterioration of his respiratory function and pneumonia, and small bowel necrosis and bowel perforation. These conditions occurred in the setting of a catastrophic traumatic brain injury, and severe neurological impairment, inflicted upon Child MML ten years earlier.

[88] (1938) 60 CLR 336, per Dixon J at p 361-362

187. From one perspective, Child MML died from the natural deterioration of his health over many years, in the context of a known reduced life expectancy[89]. In considering all of the circumstances of Child MML's death, including that his death occurred following long term terminal palliative care, I consider that the circumstances of his death could be said to have occurred by way of natural causes.

188. However, the available evidence suggests that Child MML's abusive head trauma was the cause of Child MML's brain injury and severe neurological impairment. As anticipated by treating medical professionals involved with Child MML's care, Child MML's severe neurological impairment led to an expected deterioration of his health associated with that condition over the years, and appears to have caused his death. In those circumstances, I am not satisfied that the cause of Child MML's death should appropriately be found to be natural causes.

189. The available evidence does not allow me to determine, to the requisite standard, how Child MML's original injuries occurred. However the evidence raises the possibility that Child MML developed a severe neurological impairment as a result of an intentional criminal act by a person or persons unknown, or by virtue of an unintentional act by a person or persons unknown.

190. I am therefore unable to draw a conclusion, to the requisite standard informed by the Briginshaw case, about how Child MML's abusive head trauma occurred, and other verdicts, including homicide, and accident, appear open in this case.

191. The evidence indicates that Child MML's cause of death (bronchopneumonia and small bowel necrosis with perforation, in a boy with multicystic encephalopathy and organised subdural membrane, on long term enteral feeding, with terminal palliative care) would not have arisen, had he not suffered an abusive head trauma in his infancy.

[89] Transcript, p 21.

192. However, I acknowledge that many years intervened between Child MML suffering an abusive head trauma and his death, and note that Child MML received long term palliative care over many years before his decline and death. In those circumstances, there is a degree of uncertainty that remains not only about how Child MML's abusive head trauma occurred, but also its relevance to the death.

193. In light of the uncertainty that arises in this case as to how Child MML's abusive head trauma occurred, and its relevance to the death, I make an **open finding** as to how the death occurred.

194. This finding is not intended to minimise the terrible wrong that was done to Child MML, in terms of the circumstances leading to his injury which are tragically today still not known, but also in terms of the lack of care he experienced following that injury, until Child MML's paternal grandmother was able to come to his aid.

QUALITY OF THE SUPERVISION, TREATMENT AND CARE

195. Under section 25(3) of the *Coroners Act 1996* (WA), when a death investigated by a coroner is of a person held in care, the coroner must comment on the quality of the supervision, treatment and care the person received while they were in that care.

196. I have carefully considered the evidence before me in assessing the standard of the supervision, treatment and care Child MML received from his carer, his paternal grandmother, while he was in the care of the Department.

197. It is apparent that Child MML's paternal grandmother did everything she possibly could to ensure Child MML's safety and well-being from the moment she became aware of his need for urgent medical attention on 18 December 2010, until his death in 2021.

198. Child MML's paternal grandmother provided care that was described at the inquest as "*exemplary*"[90] and "*exceptional*"[91] in circumstances where Child MML's complex care needs required high dependency, 24 hour support.

199. I am satisfied that the Department was appropriately supportive of Child MML, and his paternal grandmother, throughout Child MML's time in care. The relationship between Child MML's paternal grandmother and Child MML's case workers from the Department appears to have been a positive and child-centred one.

200. Save for one matter explored further below, I have found that the quality of the supervision, treatment, and care provided to Child MML while he was in the care of the Department was exemplary.

Paediatric Goals of Patient Care

201. As outlined in paragraphs [117] to [138] above, some communication issues arose between workers from the Department, and health workers, when it came time to discuss end of life planning for Child MML.

202. These communication issues seem to have arisen due to two factors:

a. Staff within the Department do not appear to have had an accurate understanding of the steps involved in developing a palliative care case plan, including the development of Goals of Patient Care; and
b. Staff within Perth Children's Hospital did not appear to have a full understanding of the legislative responsibilities of Departmental staff in relation to children in care, including specifically their obligation to consult relevant family members of a child in care, particularly in relation to such immensely significant decisions as decisions around end of life care.[92]

[90] Transcript, p 21.
[91] Exhibit 1, Tab 16, p 39; Exhibit 1, Tab 14.2, p 33.
[92] Exhibit 1, Tab 16.1, p 7.

203. From the outset, I think it is important to state that it was apparent from the evidence at the inquest that everyone involved in the Goals of Patient Care discussions regarding Child MML, whether they were from the Department or from Perth Children's Hospital, were doing the best they could in very difficult circumstances to meet not only their professional and legislative obligations, but also to assist Child MML and his family at a particularly difficult time in their lives.

204. Goals of Patient Care are defined under Child and Adolescent Health Service policy as describing "*the aim of the child's medical treatment and discussed between the child (if appropriate), their parents and healthcare team. Medical goals of care may include; treatment aimed at cure of a reversible condition, trial of treatment or therapy, treatment of symptoms and ensuring comfort for the child. Non-medical goals of care may also include; returning home, attending school, going to a special event*."[93]

205. The Goals of Patient Care Form is prepared to provide a record of discussions undertaken between the child, the family, and treating medical professionals, with the aim of preventing unnecessary repetition of potentially distressing conversations, and to help families consider their wishes and preferences in respect of the medical care of the child.[94] The Goals of Patient Care Form is described in Child and Adolescent Health Service policy as "*a care planning tool to aid clinicians with goals of care discussions*." Child and Adolescent Health Service policy specifically states that the Goals of Patient Care Form is "*not a binding directive, it promotes shared decision making...to ensure appropriate and timely care is provided to the child*."[95]

206. From the perspective of health staff involved in Child MML's care, the Goals of Patient Care Form was an important document, as Child MML's health was deteriorating significantly from around December 2020. Health staff involved with Child MML's family had spent many months, if not years, in discussion with Child MML's

[93] Exhibit 1, Tab 14.1, p 9.
[94] Exhibit 1, Tab 14.1, p 9.
[95] Exhibit 1, Tab 14.1, p 10.

paternal grandmother and other family members about Child MML's prognosis, and had worked very hard to assist Child MML's paternal grandmother and other family members to put together a plan to manage Child MML if he experienced an acute deterioration in his health. The purpose of this plan was intended to focus Child MML's care on interventions that would improve his quality of life, rather than cause suffering with little or no gain to Child MML.[96]

207. A meeting was held between the Department and Perth Children's Hospital medical staff in December 2020, to afford the Department, as Child MML's legal guardians, the opportunity to consider a draft Goals of Patient Care Form for Child MML. By the time Child MML was discharged from hospital on 24 December 2020, no plan had been agreed by the Department.

208. The significance of the Goals of Patient Care Form is that without a plan, all children generally undergo resuscitation, which may include painful interventions, until a senior clinician can review the case, and make a clinical decision to discontinue resuscitation efforts in line with the ethical care considerations a clinician must uphold.[97] When a Goals of Patient Care Form is agreed, the clinicians present can make an assessment of the presentation, and move to a comfort focused approach when that is appropriate, ensuring that care is directed to comfort, and connection with loved ones towards the end of a life.[98]

209. From the perspective of health staff involved in Child MML's care, the focus of the Department upon consulting with Child MML's family, including his father and his mother, before providing any agreement to the proposed Goals of Patient Care Form, seemed to them to be the Department focusing on the wellbeing of Child MML's family, instead of placing Child MML's best interests at the heart of their decision making.[99] An example of this was a well-intentioned, but ultimately misguided query by a Departmental worker as to whether Child MML could be intubated and kept alive for family to visit and say goodbye, in

[96] Exhibit 1, Tab 14, p 2.
[97] Exhibit 1, Tab 14, p 3.
[98] Exhibit 1, Tab 14, p 3.
[99] Exhibit 1, Tab 14, p 5.

the event his health deteriorated significantly during a hospital admission in March 2021. The General Paediatric Consultant caring for Child MML during that hospital admission explained that such an intervention would not be in Child MML's best interests. It would risk precipitating his death, would not benefit Child MML, and could place Child MML's family in the difficult position of being asked to withdraw ventilation, which can be a very challenging decision for families. Dr Cuddeford, who gave evidence at the inquest, explained that this appeared to health staff to be an example of Departmental staff not placing Child MML's best interests at the centre of their decision making, instead prioritising the needs of Child MML's family.[100]

210. From the perspective of the Department, there was a perception that providing consent to the Goals of Patient Care Form for Child MML would be akin to the Department making an end-of-life care decision. This is because the Goals of Patient Care Form has nothing on its face specifying its legal effect, and appeared to authorise end-of-life decisions.[101] For obvious reasons, this type of decision is considered to be **the most significant** decision that can be made for a child under the care of the Chief Executive Officer of the Department, and the Department therefore considered that they were obliged to engage in consultation, including consultation with Child MML's family, before any decision could be made.

211. The Department proactively commenced extensive consultations in relation to this question, including [this list is not exhaustive]:

> Consulting the District Director within the Department
> Consulting with Departmental lawyers
> Consulting with an Aboriginal Practice Leader, and Communities Senior Consultant Aboriginal Practice, both of whom recommended seeking the views of the family;
> Preparing a briefing for the Director General (also known as the Chief Executive Officer) of the Department

[100] Exhibit 1, Tab 14, p 5.
[101] Exhibit 1, Tab 16.1, p 7.

> Consulted with Child MML's paternal grandmother, obtaining her written consent to the proposed Goals of Patient Care
> Consulted with Child MML's father, who did not consent to the proposed Goals of Patient Care
> Attempted contact with Child MML's mother, without success[102]

212. These consultations took place over a period of time, and from the perspective of the Department, given Child MML had been discharged from hospital, there was no apparent significant urgency for the draft Goals of Patient Care Form to be finalised swiftly.[103]

213. Throughout 2021, the Department, and health staff, including Dr Cuddeford, discussed Child MML's Goals of Patient Care Form. It appears that given Child MML's father had expressed the view in a conversation with the Department on 24 December 2020 that he did not consent to the draft Goals of Patient Care Form, the Department maintained the decision to "*respect the decision of the family around end-of-life care*"[104], which I understand to mean not consenting to the draft Goals of Patient Care Form, and therefore requiring active treatment of Child MML, including resuscitation if required, until a senior clinician could be consulted.[105]

214. In light of that decision, Dr Cuddeford explained to the Department in March 2021 that Child MML's condition had deteriorated. He would experience distress from such procedures, and that the focus of Child MML's care should be on Child MML, "*his comfort and dignity*" and that "*an escalation in care would not be in his best interests as it would likely prolong his suffering*."

215. A meeting took place between health staff at Perth Children's Hospital, Departmental staff, and members of Child MML's family, including Child MML's father on 21 March 2021. After a detailed, clinician led discussion, Child MML's family, including his father, provided their consent to the Goals of Patient Care Form, which outlined the decision

[102] Exhibit 1, Tab 16.1, p 7.
[103] Exhibit 1, Tab 16.1, p 7.
[104] Exhibit 1, Tab 16.1, p 8.
[105] Exhibit 1, Tab 16.1, p 9.

that Child MML was not for resuscitation in the event of a further deterioration in his health.[106] The after-hours Crisis Care Departmental worker attending that meeting provided the consent of the Department to that decision, following agreement by the parties attending.[107]

216. Importantly, the evidence at the inquest overwhelmingly confirmed that Child MML was never subject to any medical intervention to extend his life that a treating clinician considered was not in his best interest, as a result of any delays in agreeing Goals of Patient Care for Child MML.[108] Rather, the evidence suggested simply that having agreed Goals of Patient Care may have avoided repeated difficult conversations around end of life care for the family, and may have streamlined decision making for the clinicians involved in Child MML's care.

217. In his evidence at the inquest, Mr Mace, Executive Director Service Delivery on behalf of the Department, explained that with the benefit of hindsight, the Department could have organised a meeting with Child MML's family and Perth Children's Hospital clinicians in December 2020 to discuss Child MML's Palliative Care Case Plan, enhance understanding of the role of the Goals of Patient Care Form and the barriers to its completion from a Departmental perspective, improve the Department's responsiveness to treatment decision making including by developing a plan for how the Department should be contacted if Child MML deteriorated out of normal business hours, and to identify a review date to ensure that Child MML's Palliative Care Case Plan was revisited.[109]

218. Mr Mace explained that there is a "*very small cohort of children in care*"[110] whose care is directed to palliation. In that case, Mr Mace explained that the Department is considering methods to ensure there is a greater level of tracking of these children by those in the executive level of the Department, whether that is the Director General, District Director, or in fact Mr Mace as the Executive Director Service Delivery,

[106] Exhibit 1, Tab 16.1, p 9.
[107] Exhibit 1, Tab 18, p 2.
[108] Transcript, p 25.
[109] Exhibit 1, Tab 16.1, p 10.
[110] Transcript, p 64.

so that decisions requiring high level authorisation can be made swiftly, and authoritatively, when required.[111] A possible option under discussion is a regular briefing of the executive team of the status of children in care on the palliative care pathway, so that when called upon to make urgent decisions, the executive decision maker is well informed as to the status of that child.[112]

219. Mr Mace explained that if a similar situation arose today, and the health staff involved in the care of a child in the care of the Department required access to a senior 'decision-maker' within the Department regarding issues like a Goals of Patient Care Form, then there would be a member of the Department's executive team on call after hours, and they would be available to enable a decision to be made in a timely manner.[113]

220. Further, Mr Mace explained that the Department, and the Child and Adolescent Health Service, have been working together to develop a shared understanding between their services, as to what needs to occur around end-of-life care planning in those rare instances when such planning is required for children in the care of the Department. Mr Mace said:

> "*it's really around clarity of purpose around what's being asked, making sure that frontline staff understand what is being asked of them, who is the decision-maker, and how to escalate*."[114]

221. Importantly, both the Department and Child and Adolescent Health Services agree that conversations with family members about end-of-life planning, including Goals of Patient Care and directing care to palliation, are conversations that should be led by a qualified medical clinician. These conversations are medically complex, and highly emotional conversations, and the skill and expertise of highly trained experts in palliative care, such as Dr Cuddeford, in leading these discussions cannot be underestimated. It is apparent that the compassionate and careful discussions that clinicians had with Child MML's extended

[111] Transcript, p 64.
[112] Transcript, p 68.
[113] Transcript, p 71.
[114] Transcript, p 76.

family were central to Child MML's family coming to understand when Child MML had reached the end of his life, and assisted them to direct their attention to Child MML's ongoing comfort, instead of medical intervention that would have caused him suffering.[115]

222. It goes without saying that end of life care discussions are complex, emotional, difficult, and thankfully quite rare where it comes to children in the care of the Department given the limited number of children in the care of the Department whose care is directed to palliation.

223. The communication difficulties that arose in this case were at least in part due to the fact that the need for these discussions is rare. As a result, Child MML's case highlighted an area in which the Department, and health services have identified a need to work together more effectively to greater support children in care, and their families, when discussing end of life care.

224. It was heartening to hear evidence at the inquest of the work undertaken by both the Department and the Child and Adolescent Health Service to understand each other's perspectives surrounding end-of-life care obligations, and to hear of the work being done to embed that shared understanding in policy and guidance for staff of both organisations, should a similar situation arise in the future.

225. In light of the evidence of Mr Mace at the inquest, which emphasised the ongoing work being done between the Department and the Child and Adolescent Health Services on these matters, I do not propose to make any recommendations on these issues.

CONCLUSION

226. Child MML was a young Aboriginal boy who sustained severe, life limiting disabilities as an infant after he suffered inflicted abusive head trauma, and was then seriously neglected by his mother and then

[115] Exhibit 1, Tab 14.2, p 31-32.

step-father, who failed to ensure he received timely medical care for his injuries.

227. As a result, the deceased was taken into the care of the Department, and he remained in the care of the Department until he passed away.

228. Child MML was injured by a person or persons unknown, and was then neglected by those who should have protected him, ten years before his passing. No child should have been treated the way Child MML was treated at that time.

229. The quality of the care provided to Child MML by his paternal grandmother in the years following his injury stands in stark contrast. Child MML's paternal grandmother immediately sought help for Child MML upon discovering he had been injured, and immediately volunteered to care for Child MML as a relative carer, when he was taken into the care of the Department.

230. Child MML's paternal grandmother was a devoted, loving, and attentive presence in Child MML's life, and it was clear in the evidence during the inquest that her commitment to providing Child MML with a safe and loving home was nothing short of inspirational.[116]

231. Child MML required high dependent, 24 hour care, and Child MML's paternal grandmother provided that care with genuine skill.

232. While Child MML's paternal grandmother provided exceptional care to Child MML, I must also acknowledge the very high standard of the care provided to Child MML by workers from the Department, and from the Child and Adolescent Health Service.

233. Child MML's case workers from the Department worked very well with Child MML's family, and ensured that Child MML's case was very well managed in line with their obligations regarding care planning, family involved decision making, and compliance with their legislative responsibilities. The evidence established that Child MML's paternal

[116] Transcript XX.

grandmother trusted Departmental case workers to assist her when assistance was needed, and relied upon Departmental workers to coordinate the extensive supports required to manage Child MML's day to day needs. I have no doubt that the support these workers provided to Child MML's paternal grandmother, and his broader family, was gratefully received, and greatly assisted Child MML's paternal grandmother in providing Child MML with a safe and loving home.[117]

234. The evidence also establishes that Child MML was very well supported through health services, particularly the Child and Adolescent Health Service, and that health services extended their support and care to Child MML's paternal grandmother, and Child MML's broader family, particularly Child MML's father.

235. Other than the one issue discussed above regarding communication difficulties that arose regarding Child MML's Goals of Patient Care, which I am satisfied did not result in Child MML being subject to any interventions that were against his best interests, I am satisfied that all involved in Child MML's care during his time in the care of the Department worked together very well to provide exceptional care to a young boy with significant needs.

236. The fact that Child MML lived his final years in a loving family environment, while appropriately supported and protected, is a testament to all involved in his care.

237. In the course of the evidence at the inquest, witnesses who gave oral evidence, and the legal representatives appearing at the inquest who appeared on behalf of the Department, and the Child and Adolescent Health Service, sought to offer their condolences to Child MML's family for their loss.

238. The Child and Adolescent Health Service wished to specifically acknowledge Child MML's paternal grandmother, emphasising the loving care that she provided to Child MML during his life.

[117] Transcript, p 72.

239. In the words of the Child and Adolescent Health Service:

> "*It was obvious to our staff who got to know Child MML and his family over many years that Child MML was much loved. It was a privilege for our staff to have known and cared for Child MML*."

240. The loss of a child is an unspeakably tragic event, and I cannot begin to fathom the grief and pain which Child MML's family have endured since his death. I also wish to extend to Child MML's paternal grandmother and Child MML's extended family and friends, on behalf of the Court, my very sincere condolences for your terrible loss.

241. Finally, I thank the Department, and the Child and Adolescent Health Service, for their positive engagement with the inquest process. It was apparent to me that significant work had been done in the lead up to the inquest, to try to make sure that the difficulties that arose in relation to end of life care decisions for Child MML do not arise for other families, who may be faced with similar difficult decisions surrounding end of life care for children in the care of the Department.

S Tyler
Coroner
23 February 2026