
**CORONERS COURT**
**OF NEW SOUTH WALES**

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| **Inquest:** | Inquest into the death of Baylen Pendergast |
| **Hearing dates:** | 3 to 6 April 2018 at Tamworth<br>18 to 20 April 2018 at Glebe<br>25 September 2018 at Glebe<br>7 to 10 November 2022 at Lidcombe |
| **Date of Findings:** | 23 June 2023 |
| **Place of Findings:** | Coroners Court of New South Wales, Lidcombe |
| **Findings of:** | Magistrate Derek Lee, Deputy State Coroner |
| **Catchwords:** | CORONIAL LAW – Suspicious death of a child – cause and nature of paediatric head injuries – whether head injuries were non-accidental - care provided at Tamworth Base Hospital – management of paediatric head injuries – management of paediatric patients with suspected non-accidental injuries – whether report to child protection authorities should have been made – management of paediatric patients by way of a "gate pass" – provision of discharge summaries |
| **File number:** | 2013/361922 |

**Representation:** Ms D Ward SC & Ms A Richards, Counsel Assisting, instructed by Mr J Herrington & Ms T Bird (Crown Solicitor's Office)

Ms R Mathur SC for Dr T Conallin, Dr A Kshatriya & Dr C Trethewy, instructed by Avant Law

Ms E Elbourne for Dr S Newell & Everlight Radiology, instructed by HWL Ebsworth Lawyers

Mr M Lynch for Hunter New England Local Health District, instructed by Hicksons Lawyers

Mr P Massey for Ms Z Merlin

Mr R O'Keefe for the Pendergast family, instructed by Everingham Solomons Solicitors

Ms P Robertson of New South Wales Nurses and Midwives' Association for R Johnson & E Wood

Mr T Saunders for Dr A Khan, instructed by Meridian Lawyers

**Findings:** Baylen Pendergast died on 30 November 2013 at the Sydney Children's Hospital, Randwick NSW 2031.

The cause of Baylen's death was complications of blunt head injury resulting from at least two separate acts of trauma. It is most likely that these acts of trauma occurred on 17 and 28 November 2013. Any contribution to death arising from the injuries sustained on 17 November 2013 cannot be entirely excluded. However the traumatic event on 28 November 2013 alone was sufficient to cause death. This latter incident involved the application of significant non-accidental force that was sufficient to cause the left-sided subdural haematoma, the laceration of the dorsal splenium and retinal haemorrhages.

The expert medical evidence establishes that it is most likely that Baylen's injuries were not the result of accident or misadventure. Rather, the injuries were the result of the application of significant force by another person or persons. However, the mechanism by which this force was applied cannot be established on the available evidence.

**Recommendations:** See Appendix A

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## 1. Introduction

1.1 Baylen Pendergast was a bright, happy-go-lucky and much loved little boy who tragically died when he was only 21 months old. In the early hours of the morning on 17 November 2013, Baylen was heard to be crying in his bedroom. He was checked on by his mother and found to have some injuries to his face although what caused this was not known. Over the next several days, Baylen was noted to be unwell and vomiting at different times. On 22 November 2013, Baylen was behaving unusually and noted to not be his usual self.

1.2 Baylen's mother took him to Tamworth Base Hospital where he was assessed and a number of investigations were performed including a computed tomography (**CT**) scan of the brain. Baylen was admitted and remained at hospital until he was sent home on the morning of 24 November 2013.

1.3 After leaving hospital, Baylen was still not himself over the next several days. Baylen's mother took him to see a general practitioner on 27 November 2013. The next day, Baylen spent some time with his father and was again seen to be behaving unusually. Baylen later returned home with his mother.

1.4 Later that night at around 8:30pm, shortly after being put to bed with a bottle of milk, Baylen was found in his bedroom unconscious and unresponsive, after having vomited. Emergency services were contacted and resuscitation efforts were initiated and continued until the arrival of paramedics. Baylen was taken to the local hospital but later transferred to a hospital in Sydney. Investigations revealed that Baylen had suffered significant head and brain injuries. Due to Baylen's poor prognosis, a decision was made to withdraw advanced life support. Baylen was tragically pronounced deceased on the evening of 30 November 2013.

## 2. Why was an inquest held?

2.1 Under the *Coroners Act 2009* (**the Act**) a Coroner has the responsibility to investigate all reportable deaths. This investigation is conducted primarily so that a Coroner can answer questions that are required to be answered pursuant to the Act, namely: the identity of the person who died, when and where they died, and what was the cause and the manner of that person's death.

2.2 Baylen's presentation to hospital on two occasions, only six days apart, raised a number of immediate questions about the cause and manner of his death. Further, the circumstances in which Baylen was reportedly found in his bedroom on 17 and 28 November 2013 were unclear and lacking in detail. These circumstances raised additional questions regarding how Baylen may have sustained the injuries that were later identified at hospital and following the post-mortem examination after his death. Finally, considerable uncertainty remains regarding the extent of any investigations conducted during Baylen's admission to Tamworth Base Hospital, which is situated within the Hunter New England Local Health District (**HNELHD**), between 22 and 24 November 2013, and the circumstances in which he was allowed to leave hospital and return home. For all of these reasons, an inquest was required to be held.

2.3 In this context it should be recognised at the outset that the operation of the Act, and the coronial process in general, represents an intrusion by the State into what is usually one of the most

traumatic events in the lives of family members who have lost a loved one. At such times, it is reasonably expected that families will want to grieve and attempt to cope with their enormous loss in private. That grieving and loss does not diminish significantly over time. Therefore, it should be acknowledged that the coronial process and an inquest by their very nature unfortunately compels a family to re-live distressing memories several years after the trauma experienced as a result of a death, and to do so in a public forum. This is an entirely uncommon, and usually foreign, experience for families who have lost a loved one.

2.4 It should also be recognised that for deaths which result in an inquest being held, the coronial process is often a lengthy one. The impact that such a process has on family members who have many unanswered questions regarding the circumstances in which a loved one has died cannot be overstated. Regrettably in Baylen's case, the usually lengthy process has been prolonged even further, due in part to the impact of the COVID-19 pandemic and challenges associated with identifying a suitable and available venue and period of time for the inquest to be held.

2.5 By the time of these findings, if he had lived, Baylen would have been 11 years old. The impact that the coronial investigation and inquest proceedings has had on the lives of Baylen's family members and loved ones who still miss him enormously cannot be accurately described or quantified by those who have not had to live through that experience. However, it can be recognised and acknowledged that that experience has been traumatic, burdensome and one which, fortunately, few families in our community have to experience. The resilience and dignity that Baylen's family have shown throughout their experience should also be recognised and acknowledged.

## 3. Baylen's life

3.1 Inquests and the coronial process are as much about life as they are about death. A coronial system exists because we, as a community, recognise the fragility of human life and value enormously the preciousness of it. Understanding the impact that the death of a person has had on those closest to that person only comes from knowing something of that person's life. Therefore, it is important to recognise and acknowledge the life of that person in a brief, but hopefully meaningful, way.

3.2 Baylen was born on 19 February 2012 to Zoe Merlin and Luke Pendergast. He was the first grandchild of his paternal grandparents and his father describes him as a gift from God.

3.3 Baylen was a bright and intelligent little boy who was known to be advanced for his age. He was good at counting, had a wide vocabulary and was able to speak in sentences with adults. He adored his twin girl cousins and never had any difficulty telling them apart.

3.4 Baylen enjoyed being out and about, getting dirty and learning new things every day. He loved spending time with his dad, helping him to wash the car or fix something or simply enjoying his company doing everyday things.

3.5 Baylen was loved dearly by his parents, grandparents, aunts and uncles and extended family. He brought them enormous joy and happiness. His poppy gave Baylen the nickname, "Snowy" because of his snow white hair. Baylen loved cuddles and snuggles at all times of the day and had the wonderful ability of being able to bring a smile to the faces of those closest to him, no matter what kind of day they were having.

3.6 Baylen's special mate was the family dog, Axel. They would often be found sitting together inside and outside, and occasionally had a nap together on the lounge. In fact, Baylen loved all animals. He also had a fondness for cars and trucks and enjoyed nothing more than being driven around in his dad's car with the sunroof open, watching the sky with a big smile on his face.

3.7 Baylen's family have so many fond memories of him. One fond memory that his father has is of Baylen's first Christmas when he understandably received so many presents that they filled the entire lounge room of his home. But when it came time for Baylen's first birthday two months later, his family did not know what to get him.

3.8 These are the memories of Baylen that will last a lifetime for his family but will never replace the hole in their hearts caused by his absence.

## 4. Overview of relevant factual matters

4.1 Sometime in around mid-2013, Ms Merlin and Mr Pendergast separated. Baylen was about 16 months old at the time. Mr Pendergast returned to live with his parents, Ruth and Shane Pendergast, but continued to see Baylen regularly. Baylen also spent time with his paternal grandparents, aunts and uncle.

4.2 By November 2013, Ms Merlin had formed a new relationship with Anthony Rogers. At the time of Baylen's death Mr Rogers was, in essence, living full-time with Ms Merlin and Baylen in a house at [redacted], Tamworth. Mr Rogers' son ([redacted]), who was only a few months older than Baylen, also stayed at the home on occasion. Ms Merlin and Mr Pendergast had previously shared a home with Mr Rogers and his then partner.

4.3 Before Ms Merlin and Mr Pendergast separated, Mr Pendergast and the paternal family bought Baylen a bed in the shape of a racing car. It was placed in a bedroom for Baylen which he moved into after his parents' separation.

### *The events of 17 November 2013*

4.4 At around 3:00am on 17 November 2013, Ms Merlin heard Baylen making sounds from his bedroom. When Ms Merlin went to check on Baylen it is not clear whether she found him in his bed or elsewhere in his bedroom. Ms Merlin observed that Baylen had vomited and that he had some injuries: a bruise on his face, his nose had bled with blood on his face, he had a split lip, and he had a linear mark on his face towards one ear. However, the nature and extent of these injuries is not entirely clear. Ms Merlin's response to finding Baylen in this way is also not clear: on one account, Ms Merlin thought that a person had broken into her home; on another account she described Baylen as being "fine".

4.5 What happened after Baylen was found is also unclear. It seems he was either kept awake for the next few hours so that Ms Merlin could monitor him, or he went back to sleep (and later woke at around 7:00am to 7:30am) whilst only Ms Merlin stayed awake to watch over him. At some point during the morning, Ms Merlin called her mother, Michelle Bryan, who went to the home about five minutes later.

4.6 At 9:44am, Ms Merlin called Medibank Health Solutions (**Medibank**), a telehealth service. Ms Merlin reported that Baylen had struck his face on the wing of his racing car bed, resulting in a bleeding nose, a bruise on his eye with a linear mark that extended from his eye to his ear and Baylen vomiting once. Ms Merlin reported that Baylen did not lose consciousness and that she had kept him awake for four hours after finding him. Ms Merlin described Baylen as being fine and his normal self although his face did hurt.

4.7 Ms Merlin also told the call taker that Ms Bryan wanted Baylen to be taken to hospital. The call taker told Ms Merlin what signs to look out for and how to respond if Baylen deteriorated. No other medical assistance was sought for Baylen on this day.

### *Observations of Baylen between 18 and 21 November 2013*

4.8 On 18 November 2013, Ruth Pendergast, Baylen's paternal grandmother, sent a text message to Ms Merlin asking how Baylen was. Ms Merlin reportedly replied indicating that Baylen had a bruise after hitting his head on the bed but was otherwise good. Later on the same day, Amy Pendergast, Baylen's paternal aunt, also sent a text message to Ms Merlin asking if she could pick up Baylen. Ms Merlin reportedly replied that Baylen had bruised his face and that she did not want people "*to get the wrong idea*".

4.9 Amy Pendergast later went to see Baylen and saw that he had a swollen right eye which he could not open, and a left eye which was mostly closed. Baylen was also observed to have a large bruise from his right eye to his right ear. Ms Merlin reported that she had called Medibank but that she was still concerned that something was not right. Amy took some photos of Baylen and noticed that he was fidgety, not eating much and not his usual self.

4.10 Later that afternoon, Baylen's maternal grandmother and maternal uncle, Jesse, went to watch Baylen whilst Ms Merlin went grocery shopping. Ms Bryan noted that Baylen's bruising looked "*a bit worse*" but that he was behaving normally. Whilst there, Ms Bryan and Jesse removed the wing from the back of Baylen's bed.

4.11 On 19 November 2013, Baylen began vomiting. Ms Merlin formed the view that Baylen might have caught a virus from her as she had been feeling unwell herself the previous afternoon. Despite the advice from Medibank that medical assistance should be sought if Baylen developed any new symptoms, no medical assistance was sought.

4.12 On 20 November 2013, Baylen was playing on the lawn outside his home when he fell over, causing a mark to the right side of his face. No medical assistance was sought as a result of this incident.

4.13 On 21 November 2013, another incident involving Baylen occurred although the circumstances of it are unclear. On one account, Ms Merlin described Baylen falling over at the end of her bed. Although she did not see the fall, Baylen was crying afterwards. Ms Merlin also reported Baylen falling down in the hallway a short time later and that he was "*very sooky*" afterwards. In a second account, Ms Merlin described Baylen as throwing a tantrum and flinging his head backwards, causing his head to strike a bedframe, and Baylen vomiting afterwards. Again, no medical assistance was sought on this day.

### *The events of Friday, 22 November 2013*

4.14 At around 5:00am on 22 November 2013, Mr Rogers brought Baylen to Ms Merlin who was in bed at the time. Mr Rogers reported that Baylen had been making "*funny noises*" and that he did not know what to do. Ms Merlin noted that Baylen appeared to be in a "*sort of deep sleep dream*", being awake and alert but not moving and making strange noises similar to sobbing between breaths. After approximately five minutes, Baylen appeared to wake up and was reportedly his usual self.

4.15 Ms Merlin rang her mother who reportedly told her to contact a "*sleep doctor person*". Ms Merlin indicated that she would look into this on Monday, 25 November 2013.

4.16 During the day, Baylen was reportedly his usual self, although still described as "*clingy*" and reportedly vomiting after eating food.

4.17 However, by the evening, Baylen appeared to experience another episode that was described as a "fit". He was heard to make strange noises and appeared to move as though he were in a dream, even though his eyes were open. After a short time, Baylen again recovered spontaneously, as if waking from a nap.

### *Baylen's first presentation to hospital*

4.18 Due to concerns for his welfare, Ms Merlin took Baylen to Tamworth Base Hospital (**Tamworth Hospital**), arriving at 6:36pm. Baylen was triaged in the Emergency Department (**ED**) and seen by Dr Suruchi Amaresena, emergency physician. Dr Amaresena recorded that Baylen lived with his mother. On examination, Baylen was found to be alert and rousable, although difficult to engage and in apparent distress. It was noted that Baylen had a black-coloured bruise to his lower right eyelid, and that he had a healed laceration of about 1 centimetre in size at the same location. After discussing Baylen's presentation with Dr Esther Lok, another emergency physician, Baylen was referred to the paediatric team for further management.

4.19 Dr Melissa Hope (as she was then known), Senior Resident Medical Officer (**SRMO**) in paediatrics, assessed Baylen at around 8:00pm in the presence of Ms Merlin and Ms Bryan. Dr Hope was initially alerted to the possibility that Baylen's injuries might be suspicious in nature as they reportedly occurred as a result of an unwitnessed fall. Dr Hope also recorded that Baylen lived with Ms Merlin and noted that she had contacted Medibank at the time of the injury. During her discussion with Ms Merlin and Ms Bryan, Dr Hope noted that a male person came into the room who she presumed was Ms Merlin's partner, and was most likely Mr Rogers.

4.20 In an addendum to a progress note entry, Dr Hope recorded that in her discussion with Ms Merlin, she indicated that only herself and Baylen lived at home, and that no one else lived with them. Further, Dr Hope recorded that Ms Merlin indicated that no one else was at home with her and Baylen on 17 November 2013.

4.21 Dr Hope subsequently discussed Baylen's presentation with Dr Ahmed Khan, the Postgraduate Fellow in paediatrics. Dr Hope recorded that this discussion involved her impression that Baylen's presentation was suspicious for non-accidental injury as the incident giving rise to the injuries had been unwitnessed and there had been a delay in Baylen's presentation. A query was also raised regarding whether Baylen had ongoing symptoms of brain injury and/or concussion. A plan was made for Baylen to be admitted and for a CT scan of the brain to be performed.

### *Performance and interpretation of the CT scan on 22 November 2013*

4.22 The CT scan took place late on the evening of 22 November 2013 and was remotely reported on by Dr Seamus Newell, radiologist, who at the time was in the United Kingdom. Dr Newell initially reported on the CT scan in this way:

> There is no intracerebral or subarachnoid haemorrhage. There is no extra-axial collection. The basal cisterns and ventricles are unremarkable in their appearance and anatomy.
> […]
> No significant subgaleal haematoma is evident. No definite skull base or calvarial fracture is identified.
> CONCLUSION:
> No acute intracerebral abnormality is identified. Further evaluation with MRI could be considered.

4.23 Dr Stephen McIlveen, the ED Senior Registrar, reviewed the CT Scan images and noted the suggestion of a small skull fracture and/or intracranial bleed visible. Dr McIlveen discussed these observations with Dr Newell who, after being provided with further information about Baylen's presentation, was not confident that a fracture or bleed was visible. Dr Newell recommended that a different modality of imaging be performed, namely magnetic resonance imaging (**MRI**), to obtain greater clarity. Dr Newell subsequently issued an addendum to his original report (**the Addendum Report**) in the following terms:

> This addendum is provided after further clinical information from the referring doctor.
> A lucency is noted extending through the right occipital bone posteriorly from the lambdoid suture superiorly to its inferolateral margin. This may represent a fracture however the possibility of an accessory suture line is raised. No underlying extra-axial collection is identified. No overlying subgaleal haematoma is evident.
>
> Further evaluation with an MRI is recommended. Correlation with the patient's clinical history and examination is suggested. These findings were discussed with [Dr McIlveen] at the time of reporting.

4.24 Dr McIlveen conveyed his discussion with Dr Newell to Dr Jeremy Friend, the ED Registrar. On his review of the imaging, Dr Friend considered that there was a small extradural bleed with a possible overlying fracture. Dr Friend recorded the following in the progress notes:

> CT scan reported as normal. We have seen 1 slice that shows ? extradural bleed [right] occiput. Also ? fracture underlying this area.
> Discussed by [Dr McIlveen] with radiologist, not convinced of bleed probable tentorium as only shown in 1 slice.
> Agrees there may be a fracture, sub optimal scan.
> Could benefit from MRI
> Discussed with neurosurgical registrar [John Hunter Hospital]. No need for transfer down to [John Hunter Hospital]. He suggests MRI scan to confirm findings
> Plan: Admit under paediatrics as per original plan.
> Social investigation into suspicious injury and presentation.
> MRI scan if possible.
> Plan discussed with paeds registrar and parents.

4.25 Dr Amaresena recorded this entry in the progress notes on 23 November 2013:

> Spoken to [John Hunter Hospital] neurosurgeon on call. To send the CT his phone for further discussion. Handed over to Night oncall doctor for further management.

4.26 Dr Ranjit Singh Dhillon was the on-call neurosurgical registrar at John Hunter Hospital (**JHH**) in Newcastle. According to Dr Dhillon, he had the following discussions with clinicians at Tamworth Hospital on 23 November 2013:

(a) A call from an ED physician at around 2:00am prior to the CT Scan being reported. According to Dr Dhillon, he was told that an occipital extradural haematoma was suspected. Dr Dylan asked for some representative images to be sent to his iPhone.

(b) A second call from the same ED physician who advised that the CT Scan did not show an occipital extradural haematoma but a prominent transverse sinus with an overlying undisplaced right occipital bone fracture. Dr Dhillon advised that he would review the images when he arrived at JHH at 7:00am and would call if he had any concerns.

(c) A third call, by which time Dr Dhillon had reviewed the images and discussed them with his consultant, during which Dr Dhillon advised that an under slate occipital bone fracture did not require surgical management and was to be managed conservatively. Dr Dhillon also advised the clinician from Tamworth that he spoke to that there was no extra-axial haematoma but a fracture overlying the appearance of a prominent sinus could be consistent with a traumatic transverse sinus thrombosis and that if this matched the clinical picture, consideration should be given to either an MR venogram or neurology referral.

### *Baylen is admitted to the paediatric ward*

4.27 At around 3:00am on 23 November 2013, Baylen was admitted to the paediatric ward, formally as a patient of Dr David MacDonald, but effectively under the care of Dr Khan. At around 7:15am, Baylen was seen by Dr Amit Kshatriya, paediatric registrar. However, Baylen was too upset to allow for any neurological examination to be performed and Dr Kshatriya's review was limited to inserting an intravenous (**IV**) cannula to allow fluids to be administered. Dr Kshatriya recorded the following in the progress notes:

> History noted. Fall from ½ metre bed.

4.28 A short time later, Dr Khan assessed Baylen on the ward with Dr Thomas Conallin, a second year Resident Medical Officer (**RMO**) in paediatrics who was acting as scribe. Dr Khan obtained a history from Ms Merlin which included a note that Baylen had "*hit head falling out of bed*". As a result of this review, the following entry was made in the progress notes:

> [Impressions.] Unclear aetiology: either
> I) head injury + past injury concussive syndrome
> II) two separate pathology
> → head injury → then viral gastroenteritis
> Plan
> 1. Will d/w neurosurgical service again
> ?[Transfer] for MRI/observation
> vs
> Observe in [T]amworth further 24 [hours].
> 2. Continue 24Hs neuro obs.

3. ↓ IVT to 10ml if eating and drinking

4.29 Dr Conallin later reviewed Baylen again at around 8:00pm and noted that he was lethargic and had experienced some vomiting after eating solid foods. However, on clinical examination Baylen was noted to be stable with no obvious concerns.

### *Baylen's release from hospital on a gate pass*

4.30 On 24 November 2013, Dr Khan and Dr Conallin reviewed Baylen during the morning ward round. Dr Khan formulated a plan for Baylen to be released on what was known at the time as a "gate pass", with follow-up to occur in six weeks, and any concerns identified at this time to be followed up with the neurology team. Instructions were also given for Baylen to be returned to hospital, or for a call to be made to hospital, if any concerns were identified. At 12:50pm an entry was made in the progress notes which recorded the following:

> Pts encouraged to contact ward any time if concerned & present to ED. If no problems call ward between 1200-1300 hrs for d/c information (to make appointment @ paed clinic)

4.31 Before leaving hospital, Ms Merlin signed what was described as a "*terms of agreement*" sticker in Baylen's progress notes which indicated that she was to call the hospital by 1:00pm on 25 November 2013 to discuss Baylen's progress.

### *Observations of Baylen after leaving hospital*

4.32 After leaving hospital, Ms Merlin noted that Baylen was "*not very good*", "*very sooky and clingy*" and that "*he was still vomiting*".

4.33 On Monday, 25 November 2013, Ms Merlin reportedly called the hospital and someone at the hospital later called her back, although this is not clear.

4.34 On Tuesday, 26 November 2013, Baylen reportedly started vomiting again and appeared unwell seeking comfort from his mother and not wanting to play. Baylen spent some time with his father later that day and vomited up his dinner. When Ms Merlin came to collect Baylen, Mr Pendergast told her that Baylen would oscillate between playing for several minutes and then lying down on the floor. Mr Pendergast described Baylen as "*he was like laying there like he was half dying sort of thing on the floor*".

4.35 Later that night, Baylen vomited after being given a bottle of milk. Ms Merlin reportedly told her mother that at around midnight she observed Baylen having what she described as a "*funny episode*" where he was standing up saying, "*Stand up, stand up*" in a normal voice but with his eyes closed.

4.36 On Wednesday, 27 November 2013, Ms Merlin took Baylen to see his general practitioner, Dr Sonya Purcell. According to Dr Purcell, Ms Merlin reported that Baylen had fallen and hit his head about two weeks ago, describing it as a "*minor knock*", and that he had recovered without any issues. Ms Merlin also reportedly told Dr Purcell that Baylen had recovered from a "*gastro bug*", had another fall and minor concussion on 21 November 2013, had experienced a "*funny turn*" on 22 November

2013 resulting in hospital admission and discharge two days later, and had vomited formula after being fed on 26 November 2013.

4.37 On assessment, Dr Purcell noted that Baylen was irritable, agitated, clingy and that he had a slight temperature with a small bruise over his right eye. Dr Purcell told Ms Merlin to keep Baylen hydrated and to offer him food as tolerated.

### *The events of 28 November 2013*

4.38 On Thursday, 28 November 2013, Dr Khan noticed that Baylen had not returned to hospital for review on 25 November 2013 in accordance with the terms of the gate pass. Dr Khan called Ms Merlin and was told that Baylen had been seen by Dr Purcell the previous day because he was feeling off, and had been off his food. Ms Merlin also reportedly said that Baylen had not been vomiting and was back to his normal self. However, Ms Merlin had actually kept Baylen at home instead of sending him to day care.

4.39 Later that day, Baylen ate a full lunch and reportedly kept it down. Mr Pendergast picked up Baylen at around 5:00pm to spend some time with him. Mr Pendergast again observed that Baylen was behaving unusually, alternating between having periods of energy, and then lying on the ground in a lethargic state. He also noted that Baylen's eyes were fluttering strangely, that Baylen ate and drank very little apart from a bit of apple, and that something was not right. At around 7:30pm, Mr Pendergast took Baylen back to Ms Merlin, who at the time was having dinner with Mr Rogers and the Rogers family at the local RSL club. Baylen ate some chips and then went home with Ms Merlin and Mr Rogers, after Mr Rogers dropped his son off at his mother's house.

4.40 At around 8:30pm, Baylen was reportedly placed in bed by Ms Merlin with a bottle of milk. Sometime later, either Ms Merlin or Mr Rogers retrieved the bottle after Baylen finished it. Mr Rogers later went into Baylen's room and reportedly found Baylen standing up on his bed, saying, "*Stand up, stand up*". According to Mr Rogers, he picked Baylen up, placed him down on the bed and told him to go to sleep. Mr Rogers went to the bathroom before returning to Baylen's room. According to Mr Rogers, he found Baylen lying in bed, unconscious, with a small amount of vomit near him on the bed. Mr Rogers picked up Baylen and took him to Ms Merlin.

4.41 Ms Merlin ran to call for help from her neighbours who in turn called for an ambulance. Meanwhile, resuscitation efforts were initiated. Ms Merlin's neighbours observed that Baylen was limp and not breathing, with his eyelids open and his eyes rolled back into his head, with "*a little amount*" of wet blood on the side of his mouth. New South Wales Ambulance (**NSWA**) received the Triple Zero call at 9:45pm and paramedics arrived at the scene by 9:51pm.

### *Resuscitation efforts and Baylen's second presentation to hospital*

4.42 Baylen was found to be unresponsive, not breathing and without a pulse. It was also noted that he had some vomit around his mouth and chest and appeared very pale in colour which was thought to indicate that he was in cardiac arrest. The attending paramedics moved Baylen to the ambulance where resuscitation efforts continued. However, it was noted that Baylen's airway was totally obstructed and he was unable to be ventilated. The attending paramedics used suction and chest

thrusts to clear the obstruction, together with a laryngoscope in an attempt to visualise the obstruction. On a second attempt with the laryngoscope, small clumps of food were able to be visualised. This foreign matter was removed from Baylen's airway to allow for him to be ventilated.

4.43 Baylen was taken by ambulance to Tamworth Hospital. Suction and forceps were used to manually remove the foreign matter from Baylen's mouth. The larynx was identified and an endotracheal tube was passed into the trachea. Baylen remained in cardiac arrest but resuscitation efforts continued. About 30 minutes after Baylen was found to be in cardiac arrest, there was a return of spontaneous circulation.

4.44 Due to the need for more specialised care, Baylen was taken by a paediatric retrieval team to the Sydney Children's Hospital via an air ambulance, arriving at 6:45am on 29 November 2013. A CT scan showed a complete loss of grey-white matter differentiation and a right sided occipital fracture. An examination of Baylen's retinae revealed the presence of multiple haemorrhages in both eyes. As a result of the prolonged period of time before there was a return of spontaneous circulation, it was determined that Baylen had suffered severe brain damage leading to brain death.

4.45 Given Baylen's poor prognosis, advanced life-support measures were withdrawn at around 10:15pm on 30 November 2013 and Baylen was tragically pronounced life extinct a short time later.

## 5. Postmortem examination

5.1 Baylen was subsequently taken to the Department of Forensic Medicine where a post-mortem examination was performed by Dr Issabella Brouwer, forensic pathologist, on 2 December 2013. The following relevant findings were documented from this examination:

(a) extensive subgaleal haemorrhage on the right side of the back of the head extending into the right occipital, parietal and temporal areas;

(b) linear, non-displaced skull fractures present on the right side of the back of the head;

(c) bone sections collected from almost the entire length of the occipital skull fracture showed evidence of fracture healing, with the histological appearance in keeping with an injury sustained some days prior to death and within the reported time frame of between 17 and 22 November 2013;

(d) a thin layer of acute subdural haemorrhage covering both cerebral hemispheres;

(e) the brain was diffusely swollen, very soft and fragile; and

(f) three small recent bruises to the forehead: a poorly demarcated linear bruise just to the right of the anterior midline of the body; a poorly demarcated oval-shaped bruise on the left side of the forehead; and a small, faintly visible bruise present on the right side of the forehead.

5.2 A neuropathological review was also conducted by Dr Michael Rodriguez, neuropathologist, who made the following observations:

(a) marked symmetric cerebral swelling, with most of the cerebral changes observed being secondary to brain swelling and hypoxic/ischaemic injury following cardiorespiratory arrest two days prior to death;

(b) rare haemosiderin granules in the retina, some not associated with acute haemorrhages, raising the possibility of previous retinal haemorrhage;

(c) right convexity subdural haemorrhage approximately one to two weeks old;

(d) thin subdural haemorrhage over the left cerebral convexity that may be several days old;

(e) midline laceration in the dorsal splenium being recent and most likely occurring as a result of contact between the falx cerebri and the splenium, with these features being inconsistent with injury occurring nine days prior to death. However, the presence of focal haemosiderin in one area may suggest more than one episode of injury; and

(f) haemorrhages in the dorsal root ganglia and surrounding several of the dorsal roots, with it being unclear whether some or all of these changes were due to the severe hypoxic/ischaemic

injury resulting from Baylen's cardiorespiratory arrest two days before his death, or whether they were due to primary cervical trauma.

5.3 Full body x-rays were performed on 4 December 2013 and later reviewed by Dr Kristina Prelog, paediatric radiologist, who found the following:

(a) Linear right occipital skull fracture extending to the lambdoid suture;

(b) From the CT Scan: Right frontal parietal and possibly occipital region subdural haematomas that were less than approximately two weeks in age; and

(c) From the CT scan from Sydney Children's Hospital on 30 November 2013: Right acute frontal, parietal and occipital subdural haematoma and a very thin left subdural haematoma over the vertex.

5.4 Dr Brouwer noted the following in relation to the autopsy findings:

(a) The CT scans of 22 and 30 November 2013 showed similar traumatic injuries which concur with the autopsy findings;

(b) Meticulous histological examination of the skull fractures shows signs of fracture healing in all components. The features observed were in keeping with an injury sustained some days prior to death and falls within the timeframe of injury between 17 and 22 November 2013;

(c) The topic of whether a simple shortfall can cause a fatal head injury remains a controversial topic in forensic pathology literature. However, Dr Brouwer noted that large population studies of childhood injuries indicate that severe head injury from a shortfall is extremely rare;

(d) The location of the linear fracture may not correspond to the site of impact as outward bowing of the skull may occur at a relatively large distance from the primary site of impact. It cannot "*be dogmatically stated that the injury to the right side of the face does not represent the same impact causing the right sided skull fracture due to the close anatomical proximity of the observed bruising and the linear skull fracture*";

(e) Only approximately 15 to 30% of linear fractures are associated with intracranial injury;

(f) The clinical symptoms of nausea, vomiting, general malaise and possible convulsions were most likely due to the head injury that was present on 22 November 2013;

(g) The thin subdural haemorrhage over the left cerebral convexity may be several days old;

(h) The laceration in the dorsal splenium is recent and the features are not consistent with injury occurring nine days prior to death although the presence of focal haemosiderin in one area may suggest more than one episode of injury;

(i) The oldest component of the right convexity subdural haemorrhage is approximately one to two weeks old;

(j) The global hypoxic ischaemic brain injury is the result of out-of-hospital cardiac arrest followed by prolonged resuscitation, with an unknown insult resulting in cardiac arrest;

(k) The aspiration of stomach contents are likely secondary to the cardio-pulmonary resuscitation and are unlikely to have been the cause of the cardiac arrest. As Baylen had previously been observed to "*fit*" and "*convulse*", a question arises as to whether he may have had a convulsion as a result of the consequences of the head injury, followed by cardiac arrest and aspiration of stomach contents; and

(l) There appears to be a temporal relationship between the head injury and Baylen's death.

5.5 In the autopsy report dated 27 May 2014, Dr Brouwer opined that the cause of Baylen's death was hypoxic ischaemic brain injury following out of hospital cardiac arrest.

## 6. What issues did the inquest examine?

6.1 Prior to the commencement of the inquest a list of issues was circulated amongst the sufficiently interested parties, identifying the scope of the inquest and the issues to be considered. That list identified the following issues for consideration:

(1) What was the cause and nature of the injuries sustained by Baylen? When were they sustained and in what circumstances?

(2) Was the care and treatment provided to Baylen at Tamworth Base Hospital appropriate in the circumstances, considering in particular the following matters:

(a) Was there a failure to properly diagnose Baylen's head injuries when he was admitted to Tamworth Base Hospital on 22 November 2013?

(b) Were appropriate tests and examinations undertaken to investigate Baylen's injuries, including to investigate whether they were non-accidental?

(c) Did clinical staff take appropriate steps to escalate their possible concerns about the cause of Baylen's injuries, including to the Department of Family and Community Services (as it then was)?

(d) Was the decision to allow Baylen to leave Tamworth Base Hospital on a "gate pass" appropriate?

(e) Was appropriate follow-up conducted by clinical staff after Baylen's release from Tamworth Base Hospital on a "gate pass"?

(f) Were Baylen's carers given appropriate advice about his condition and possible precautions when Baylen left Tamworth Base Hospital?

(3) What caused Baylen to become unconscious on 28 November 2013?

(4) What was the cause of Baylen's death?

(5) Is it necessary or desirable to make any recommendations pursuant to section 82 of the *Coroners Act 2009*?

6.2 In order to assist with consideration of some of the above issues, opinions were sought from the following independent experts:

(a) Professor Michael Besser AM, emeritus consultant neurosurgeon paediatric emergency medicine physician at Monash Medical Centre;

(b) Professor Thomas Gibson, biomechanical engineer;

(c) Dr Linda Iles, forensic pathologist;

(d) Dr Kristina Prelog, paediatric radiologist;

(e) Dr Michael Rodriguez, neuropathologist; and

(f) Professor James Wilkinson, a senior paediatric cardiologist at the Royal Children's Hospital, Melbourne.

6.3 Each expert provided at least one report which was included in the brief of evidence tendered at inquest. Each expert, together with Dr Brouwer, participated in a conclave held on 22 December 2016 (**Expert Conclave**). During the Expert Conclave, the participants were invited to consider a number of questions regarding the issues identified above. A joint report was prepared at the conclusion of the Expert Conclave which answered the questions posed (**Expert Conclave Report**). Most of the experts also gave evidence during the inquest.

6.4 In addition, Associate Professor David McDonald, consultant paediatrician, was briefed on behalf of Dr Khan to provide an opinion and a report. He also gave evidence during the inquest.

6.5 Each of the above issues is dealt with below. For convenience it has been necessary to consider some issues jointly, and other issues separately.

## 7. Procedural history

7.1 An inquest into Baylen's death was held at Tamworth Court between 3 and 6 April 2018. The inquest was adjourned part-heard to the former State Coroner's Court in Glebe and continued on 18 to 20 April 2018. There was then a further adjournment of the inquest to 25 September 2018, again at Glebe.

7.2 On this last day, after hearing submissions from Counsel Assisting and one of the sufficiently interested parties, the inquest was suspended pursuant to section 78 of the Act. This is because I formed the opinion, having regard to all of the evidence given up to that time, that:

(a) the evidence was capable of satisfying a jury beyond reasonable doubt that a known person has committed an indictable offence;

(b) there was a reasonable prospect that a jury would convict the known person of the indictable offence; and

(c) the indictable offence would raise the issue of whether the known person caused Baylen's death.

7.3 Following suspension of the inquest, in accordance with section 78(4) of the Act, depositions taken to date at the inquest and a written statement (specifying the name of the known person and the particulars of the indictable offence concerned) were forwarded to the Director of Public Prosecutions for consideration as to whether criminal proceedings would be commenced.

7.4 On 9 September 2020, the Director of Public Prosecutions advised that a determination had been made that criminal proceedings would not be commenced against any known person for any indictable offence in relation to Baylen's death.

7.5 Accordingly, a determination was made pursuant to section 79(5) of the Act that the inquest would be resumed. It was understandably important for Baylen's family to attend the inquest in person rather than to observe the proceedings via an audio-visual link from a remote location.

7.6 However, due in part to the impact of the COVID-19 pandemic and public movement restrictions, the inquest could not be resumed until 7 November 2022. It continued with a further four days of hearing and concluded on 10 November 2022. A timetable was fixed at that time for Counsel Assisting and the sufficiently interested parties to prepare and file written submissions.

**8. What was the cause and nature of the injuries sustained by Baylen? When were they sustained and in what circumstances?**

8.1 On 24 November 2013, when Baylen was permitted to leave Tamworth Hospital on a gate pass, it was evident that he had sustained the following injuries:

(a) bruising to the right side of the face in the temporal and periorbital areas (as documented by various clinicians, including Dr Hope, Dr Amaserena, Dr Khan and Dr Conallin);

(b) multiple bruises over the bony surfaces of the forearm and shin;

(c) a healed laceration about 1 centimetre in size at the lateral margin of the right eye;

(d) small bruising to the left chest or rib region;

(e) a small right occipital subgaleal haematoma;

(f) right frontal parietal and possibly occipital region subdural haematomas; and

(g) non-displaced right occipital bone fracture.

8.2 Dr Prelog reviewed the imaging performed at the Sydney Children's Hospital on 30 November 2013 and identified the following:

(a) Right acute frontal, parietal and occipital subdural haematoma;

(b) Very thin subdural haematoma on the left which lies at the vertex;

(c) Diffuse cerebral oedema and cerebellar oedema, with overall decreased density of the brain. All extra-axial spaces are effaced with loss of normal grey-white matter differentiation. These features are consistent with global ischaemia;

(d) Herniation of cerebellum into foramen magnum, known as "coning"; and

(e) Linear fracture of the right occipital bone, extending to be lambdoid suture with soft tissue swelling.

8.3 In addition, the following injuries were also confirmed at the Sydney Children's Hospital:

(a) Bilateral retinal haemorrhages, including intra-retinal and pre-retinal haemorrhages including petechiae, flame shaped nerve fibre layer haemorrhages in the left eye's temporal peripheral retina. Retinal features have a possible mixed aetiology, e.g. ologies to be taken in context of history and other clinical findings.

(b) Bruises to the forehead and in particular, right forehead linear bruise in vertical orientation. Lateral to this bruise there was another 1cm x 0.5cm faint red bruise, left forehead dark blue

bruise 1cm x 0.5cm, temporal side right eye red healed abrasion, right pre-auricular faint red bruise 1cm x 1cm.

8.4 On 16 November 2013, Baylen spent time with his paternal family, going shopping and playing with his father. When Baylen was returned to Ms Merlin in the afternoon it was noted that he had no injuries when he left his grandparents' house. Photographs of Baylen taken on this day, which were provided to the NSWPF by Baylen's paternal grandmother, show him to be smiling and happy, with no injuries to his face.

8.5 There is no suggestion that Baylen sustained any of the above injuries during his admission to Tamworth Hospital. Therefore, the injuries were sustained some time prior to Baylen's presentation to hospital on 22 November 2013.

8.6 Therefore, the evidence suggests that the injuries which Baylen presented with at hospital on 22 November 2013 must have been sustained between 16 and 22 November 2013. For reasons which are discussed further below, there is no evidence that the injuries were sustained during either of the reported incidents on 20 and 21 November 2013. Instead, the evidence indicates that Baylen's injuries were most likely sustained in the early hours of the morning on 17 November 2013 at Ms Merlin's house.

8.7 Professor Gibson was briefed by the NSWPF to provide a biomechanical engineering report and opine as to whether the history of the events of 17 November 2013 supplied by Baylen's carers is consistent with the injuries that he sustained. The history of events supplied by Ms Merlin and Mr Rogers is that Baylen experienced an unwitnessed fall and it is assumed that his head impacted with the wing and/or another part of his racing car bed.

8.8 Professor Gibson conducted impact testing using a reconstruction of Baylen's bed and an instrumented biofidelic anthropomorphic 50$^{th}$ percentile adult male headform from a Test Device for Human Occupant Restraint (**THOR**). Relevantly, three impacts were performed at a number of selected impact sites: the spoiler, the edge of the bed, the horizontal surface and edge of the wheels and the carpet and underlay over concrete. The drop height was selected to match possible falls for an infant of Baylen's height with Professor Gibson choosing the worst case of Baylen standing upright on the spoiler or mattress. From the impact test results, a technique for estimating infant head impact responses using dimensional analysis to scale adult data was applied.

8.9 From the scaled impact test results, and a review of academic literature regarding paediatric head and neck injury as a result of short distance falls and the risk of infant skull fractures, Professor Gibson expressed the following opinion:

> If it is assumed that the impact to the right side of the head took place unobserved in Baylen's bedroom, then the drop testing indicates that the objects likely to have caused such injuries are the top surface of the wheels on the bed or the carpet and underlay covered concrete floor. These areas of the room have a significant risk of skull fracture for an 18 month old child when falling from a standing height on the bed.

8.10 During the Expert Conclave, Professor Besser described the dimensional analysis and scaling referred to above as "*pretty simplistic*", whilst empathising with the challenges faced by Professor Gibson in the attempted reconstruction. Professor Besser expressed some reservations about using such a technique to scale data using an adult sized test dummy to produce a likely outcome in relation to the skull of an infant. Professor Gibson addressed these reservations in this way:

> Yes, but your problem here is really there is only a certain amount of information about this. The place where this has been applied to the greatest depth is to do with design of crash test dummies, obviously. The process I used is the best available.
> […]
> That doesn't tell you a great deal, and I completely agree with what you're saying.

8.11 During the Expert Conclave Professor Gibson was asked whether the impact or impacts causing the skull fracture sustained by Baylen would have resulted in him ending up on the floor of his bedroom. Professor Gibson expressed this view:

> I think if we assume the standing on the spoiler - if you assume the standing on the mattress, all of these get reduced a bit because of [sic] the height of the drop is noticeably less and we're just talking about the energy of that part of the fall. So most likely it would involve hitting the wheel and then onto the floor.

8.12 It should be noted that Professor Besser expressed doubt that Baylen would have been able to get back into bed following such an impact, or series of impacts. Professor Gibson similarly indicated his view that it would have been difficult for Baylen to return to his bed following such a fall.

8.13 As to the assumed scenario which Professor Gibson was invited to comment on, and the reconstruction which he performed, Dr Iles opined:

> The biomechanical modelling performed by Dr Gibson indicates that [it] is possible that Baylen may have sustained a skull fracture if he had fallen onto the right side of his head from a standing height onto the floor, or onto the "wheel" of the bed (and presumably onto the floor - the mechanism of such a fall is unclear to me). All indications are that as a result of this episode Baylen had an impact to the right side of his face. This would imply a complex fall with impacts to two different planes of the head. I do not have any experience or expertise in biomechanical engineering, however I imagine this would make modelling of such an event considerably more complex. In this scenario, based on the described circumstances, Baylen would have to climb back into his bed after suffering facial bruising, subgaleal haematoma, large occipital skull fracture and subdural haemorrhage.

8.14 As to the possibility of non-accidental injury, Dr Iles expressed this view:

> If you were to consider whether this is due to accidental trauma I guess the question is, could this be caused by a single simple fall? My view on that would be no, and we can explore the reasons for that if people disagree. Could it be due to a single complex fall? I don't think so either. Or could it be due to more than one episode of accidental falls? Based on the series of CT findings and the final autopsy findings, I think the answer to that is no, based on the information that we have already been given.

8.15 In his report, Professor Besser referred to academic literature and noted that:

(a) large population studies of childhood injuries indicate that a serious head injury from a short, simple fall is extremely rare;

(b) in general, the average short fall in the home is most unlikely to produce either subdural or retinal haemorrhage although skull fractures may be seen as a focal injury; and

(c) falls of less than 1.5 metres very seldom lead to brain injury.

8.16 Ultimately, Professor Besser expressed this view:

> The history suggested of this unwitnessed injury (falling from his bed onto the wing of the wooden bed frame) is not consistent with the described trauma. To reiterate Baylen was 81cm in height and the so called "wing" was at eye level according to his mother. As the literature suggests a fall from this height or an infant of Baylen's size would not produce a complex, diastatic occipital skull fracture involving multiple sutures. As well the described bruise (linear from ear to eye) is opposite to the fracture and is more in keeping with a forceful blow rather than a fall.

8.17 Dr Brouwer agreed with Dr Iles that Baylen's injuries could not be explained by a simple fall, and agreed with Dr Rodriguez that consideration needs to be given to the circumstances and the "*whole picture*". Dr Brouwer went on to express this view:

> Just looking on the evidence of the medical findings, I don't feel comfortable to exclude this could have been from a fall; although maybe unlikely, looking at the literature and looking at what is available. But if the child had, for example, other evidence of child abuse, like healing fractures or other injuries that could have been indicative of child abuse, I may have had a different opinion. But in the absence of that, I don't feel comfortable to exclude completely that this could have been from a fall.

8.18 Ultimately, Dr Brouwer was unable to say that Baylen's injuries were most probably the result of deliberate trauma, but noted that significant force was required to cause a complex fracture of the kind sustained by Baylen. In addition, Dr Brouwer considered that it was not possible to determine whether the injuries were deliberately inflicted based on a review of the imaging alone.

8.19 For completeness, it should be noted that as part of the coronial investigation, enquiries were made with both the NSW Department of Fair Trading and the Consumer Product Safety Division of the Australian Competition and Consumer Commission. Neither agency had any record of any complaint or concern raised in relation to the type of bed that Baylen slept in as at November 2013.

8.20 **Conclusions:** In accordance with his instructions, Professor Gibson was invited to proceed on the assumption that Baylen's injuries were sustained as a result of a fall whilst standing on his bed resulting in one or more impacts. However, this assumption was problematic as the mechanism by which Baylen sustained his injures was, according to Ms Merlin, unwitnessed.

8.21 Notwithstanding, the reconstruction performed by Professor Gibson established that impact with the top surface of the wheels on the bed or the carpet and underlay covered concrete floor have a significant risk of skull fracture when falling from a standing height on the bed. However, Professor Gibson acknowledged the limitations associated with interpreting data obtained by using an adult-sized test dummy in the context of an assumed fall by an 18 month old child.

8.22 The expert biomechanical evidence establishes that it is not possible to exclude that such an assumed fall could account for the injuries sustained by Baylen. However, the expert medical evidence established this possibility as unlikely. First, available academic literature highlights the rarity of serious head injury in a child from a short, simple fall, particularly from the standing height assumed by Professor Gibson. Second, the described linear bruise to Baylen's right eye is more in keeping with a forceful blow than a fall. Third, the totality of injuries sustained by Baylen implies a fall more complex than the assumed fall considered by Professor Gibson. Fourth, both Professor Besser and Professor Gibson considered it unlikely that if Baylen had ended up on the floor he could have climbed back into his bed (where he was reportedly found by his carers) given the severity of the head injuries he sustained. Fifth, more than one episode of accidental falls could not account for the injuries sustained by Baylen.

8.23 The injuries sustained by Baylen were most likely the result of non-accidental trauma. They cannot be accounted for by the reported incidents on 17, 20 or 21 November 2013. Whilst the evidence establishes that some of the injuries are more consistent with forceful blow than an impact in the context of a simple fall, the precise mechanism of injury cannot be determined from the available evidence.

## 9. What caused Baylen to become unconscious on 28 November 2013?

9.1 There are four matters relevant to consideration of this issue:

(a) evidence of recent injury proximate to Baylen's presentation to Tamworth Hospital on 28 November 2013;

(b) the degree of force required to cause some of the injuries sustained by Baylen;

(c) whether any trauma occasioned to Baylen on 28 November 2013 was sufficient to cause death, independent of any previous trauma occasioned to him; and

(d) the timing of when any such trauma was occasioned relative to Baylen's collapse and cardiac arrest on 28 November 2013.

### *Evidence of recent injury*

9.2 First, when Baylen arrived at Tamworth Hospital on the evening of 28 November 2013 he was observed to have bruising to his forehead which was not evident during his earlier admission to Tamworth Hospital between 22 and 24 November 2013. Further, none of the adults who saw Baylen during the day on 28 November 2013 saw these bruises. Relevantly, when Ms Merlin was interviewed on 30 November 2013 at the Sydney Children's Hospital by clinicians and a senior social worker, she indicated that she first noticed the bruising to Baylen's forehead at Tamworth Hospital on 28 November 2013 following the resuscitation. During their interviews with the NSWPF neither Ms Merlin or Mr Rogers identified how this bruising might have been occasioned to Baylen.

9.3 The evidence regarding this bruising is significant because it indicates that Baylen experienced a degree of trauma after being returned to the care of Ms Merlin on the evening of 28 November 2013 and before he presented at Tamworth Hospital later that evening.

9.4 During the Expert Conclave, Dr Iles enquired whether any of the other experts had a view regarding this bruising. Dr Brouwer noted that there was no indication in the history provided as to what could have caused the bruising and indicated that its significance was uncertain. In oral evidence, Dr Brouwer acknowledged the difficulty with reliably estimating age of a bruise but expressed the opinion that by interpreting the colour of the bruising it appeared to be "*more recent*" with a timeframe of "*hours to days, weeks*".

9.5 However, Dr Iles expressed this view:

> I guess that what concerns me in a way is that indeed they indicate that there has been an episode of blunt trauma that seems to be at least proximate, since these are new bruises, and there's been no account of any mechanism for those occurring and that's what concerns me.

9.6 Second, Dr Rodriguez observed that the areas of subdural haemorrhage appeared to be of different ages. He noted that "*the oldest component of the right convexity subdural haemorrhage is approximately one to two weeks old*" whilst "*the thin subdural haemorrhage over the left cerebral convexity shows less advanced organisation and may be several days old*".

9.7 However, Dr Rodriguez explained that whilst the left sided subdural haemorrhage was more recent, it did not necessarily mean that there was a new traumatic event. When asked whether this represented a new injury at the right side parietal area, Dr Rodriguez explained:

> But it depends what you're meaning by injury. If you mean traumatic injury I can't say that. There was new injury to the vessels, the aetiology of which is unclear. During the process of healing of a subdural haemorrhage or a haemorrhage anywhere, you get new blood vessels which are thin-walled and fragile so minimal trauma or other things can cause those vessels to leak or to bleed which may give rise to the apparent appearance of new haemorrhage.

9.8 Third, Dr Rodriguez noted the following:

> The laceration in the dorsal splenium is recent and most likely occurred as a result of contact between the falx cerebral and the splenium, shortly before admission to [Tamworth Hospital on 28 November 2013]. The features are not consistent with injury occurring nine days prior to death although the presence of focal haemosiderin in one area may suggest more than one episode of injury.

9.9 Dr Iles expressed a similar view that having regard to the level of healing or organisation of this injury it had been present for "*less than a week*" before Baylen's death. Dr Brouwer agreed with Dr Iles' opinion as to the age of this injury.

### *Degree of force*

9.10 Professor Besser considered that "*a considerable degree of impact force would have been needed to produce*" the extensive and complex right occipital skull fracture associated with diastasis (separation) of the lambdoid, sagittal and coronal sutures. He opined that raised intracranial pressure would not have been sufficient to cause the diastasis because in a child of Baylen's age the sutures are already starting to fuse and that "*it takes a lot of force to separate them*".

9.11 Professor Besser and Dr Rodriguez considered that the diastasis represented another episode of force. Professor Besser and Dr Prelog opined that simple force would not have been sufficient to result in the diastasis. Dr Prelog explained:

> Splenial lesions are usually high impact injuries such as car accidents with acceleration/deceleration, rapid, to get that kind of a break. From my opinion, from the two sets of imaging, the fact that you had it did not look like there was subdural in the first place on the left and later, yes, it could have bled but it also is possible that there was more than one injury. My feeling is there was more than one injury.

9.12 Dr Brouwer considered that the event which resulted in the complex right occipital skull fracture was of "*significant force*".

9.13 As to the laceration of the dorsal splenium:

(a) Dr Rodriguez opined that the injury that would require the greatest force is the skull fracture and that the laceration to the dorsal splenium could arise from less force than would be required for a skull fracture;

(b) Professor Besser described the laceration of the dorsal splenium as "*an unusual injury*" and considered "*it would take a reasonable degree of force or impact*" to cause such an injury;

(c) Dr Iles also considered it to be an unusual injury and "*not observed very often*" but that not enough is known about the mechanism of this type of injury to be "*particularly specific*" regarding the degree of force required to cause such an injury.

9.14 As to the left sided subdural haematoma, Professor Besser explained:

> As an example, in an infant, skull fractures in infants are quite, are not unusual but it is very unusual to get an intracranial injury, so I think that shows you how much force is required to give a subdural haematoma in an infant.

9.15 Professor Besser agreed that this provided the basis for the joint view of the Expert Conclave that some additional trauma was occasioned to Baylen leading to the left sided subdural haematoma and laceration to the dorsal splenium.

### *Contribution of more recent trauma to Baylen's death*

9.16 One significant issue explored with the various experts was whether any trauma occasioned to Baylen on 17 November 2013 could be excluded as contributing to his death 13 days later. Dr Iles explained the issue in this way:

> If you have a second episode of trauma and you can document significant injury as a result of that episode of trauma, so in this instance subdural haemorrhage, splenial injury and some bruising, if you can document significant injuries associated with that trauma that occurs proximate to the time of death, and you can ascribe a mechanism of death to that trauma, so for example blunt head trauma and/or shaking in infants, it is well recognised to precipitate cardiorespiratory arrest, then there is, because of that proximity, a higher probability that that event caused the death, but can you exclude a contribution of a previous injury? I don't think that you can.

9.17 However, Professor Besser noted that there was no change in either Baylen's presentation or behaviour until the time of his cardiac arrest and that there is no explanation for the change in his presentation apart from a second episode of trauma. By this, Professor Besser agreed that a change in the form of a traumatic event led to Baylen's death.

9.18 Dr Rodriguez expressed this view:

> If there was no evidence of that previous injury and all we had were the acute changes, these are changes that we see in infants that die, the retinal haemorrhages, the subdural haemorrhages, the

> evidence of trauma with bruising and laceration independent of the previous injury, so it may have contributed but without it, there is still enough, in my opinion, that would explain the death.

9.19 When asked whether a further traumatic event occurring within an hour of the Triple Zero call being made on 28 November 2013 was sufficient, in isolation, to cause death Dr Iles explained:

> I would say it's highly probable that that second trauma is a very significant contributor to death. Is it the exclusive contributor? I could not say.

9.20 However, both Dr Iles and Professor Besser agreed that any such further traumatic event might be regarded as a substantial and operating cause of Baylen's death.

### *Timing of trauma*

9.21 In evidence, counsel for Ms Merlin postulated a number of questions to the experts premised upon Baylen having been "*flinging himself around on the floor*" prior to going to the RSL club for dinner. Using this as a premise, counsel for Ms Merlin sought to explore whether such an episode could have given rise to a second set of injuries.

9.22 First, it should be noted that there is no evidence that Baylen was "*flinging himself around on the floor*" in the manner described by counsel for Ms Merlin. When asked during an interview with the NSWPF about Baylen's behaviour before going to dinner, Mr Pendergast stated:

> Q: And when [Baylen] was at home at your place you said he was flopping around or…
> A: He wasn't flopping, he just sort of wanted to cuddle and just lie there and just wanted to sleep, um, he'd get up, you know, active and then just back down and he'd just get up, lay down again, just get up like just up and down just…
> Q: O.K. Was he say anything, was he…
> A: Mummy, daddy, daddy, mummy. Um, he was talking like he would but he wasn't excited like he was.
> Q: OK Is that, would we, so do you think he was tired or do you think he was, what do you think?
> A: When I was watching him his sort of eyes were fluttering and I, I just said, there's something not right but like Zoe had taken him to the doctor I'm like well the doctor said he's right so he must be just sick like. And just tired and just, you know what I mean. And, um, so I just dropped him back to Zoe and, um, I turned around and said, "This is bullshit like, him being there at a club when he's sick."

9.23 Notwithstanding the incorrect premise of the question posed, Dr Iles expressed this view:

> I'm not entirely sure what's meant by a child flinging themselves around but if you were to ask me do I believe that an 18 month year old child could have retinal haemorrhages, a splenial laceration and a subdural from flinging themselves around, the answer is no. Could they get bruising to the forehead, then the answer would be yes, but, but not the former injuries.

9.24 Dr Rodriguez observed that after the incident described by counsel for Ms Merlin, Baylen went to the RSL club, ate some hot chips and then returned home with Ms Merlin; in other words, he "*was eating and functioning relatively normally*". On this basis Dr Rodriguez considered it "*extremely unlikely*" that Baylen's terminal collapse could be accounted for in the absence of any traumatic event

between when he returned home and when the call was made to Triple Zero. Dr Rodriguez explained:

> [I]n nearly all but not a hundred per cent of children that have acute subdurals, retinal haemorrhages, there is no period between the injury and collapse. There's no lucid interval. So you're describing, if you're saying that the injuries that ultimately led to death occurred 45 minutes before the collapse, you're saying that there's a 45 minute lucid interval and I think that is extremely unlikely.

### *Events of 28 November 2013*

9.25 On 12 April 2018 Shaylee Coughlin, a friend of Ms Merlin, provided an account to investigating police in relation to a conversation that she had with Ms Merlin. The conversation occurred in early 2014 when Ms Merlin went to visit Ms Coughlin at her home in Budgewoi on the Central Coast. During the visit Ms Merlin spoke to Ms Coughlin about the events of 28 November 2013. In her statement Ms Coughlin said the following:

> [Ms Merlin] said [Mr Rogers] had gone in to check on Baylen. She didn't say how long after she had given him his bottle this was. She said she was in her room and [Mr Rogers] was in the lounge room. She heard a loud thump and she asked [Mr Rogers] what that was. [Mr Rogers] said that Baylen was standing up on his bed and that he had laid him back down and that the thump she had heard was that he had kicked his toe, meaning [Mr Rogers] had kicked his toe. I don't know where they were when that conversation took place.

9.26 Joel Raymond is Ms Coughlin's former partner. He and Ms Coughlin had two children together who lived with Ms Coughlin in Budgewoi. Mr Raymond accompanied Ms Merlin to Budgewoi in early 2014 so that he could visit his children. During the car trip there Mr Raymond and Ms Merlin had the following conversation regarding Baylen:

> [Ms Merlin] told me that she asked [Mr Rogers] to go and check on Baylen because he was crying or something. She said [Mr Rogers] left the room and went to Baylen's room and she heard a loud 'thump'. She told me that she had asked [Mr Rogers] about the 'thump' and he told her he had kicked his toe.

9.27 Mr Raymond went on to state:

> She told me that she was confused if [Mr Rogers] may have done something to Baylen or [Mr Pendergast] had done something to him prior to her picking him up. It was a short time after hearing the 'thump' that Baylen had to go to hospital.

9.28 On 30 November 2015 (the second anniversary of Baylen's death), Ms Coughlin contacted Ms Merlin via Snapchat. During a text message conversation, Ms Coughlin wrote the following:

> Okay zoey [sic] where was the toe injury? This is what I'm saying [Mr Rogers] didn't have one and if he kicked it that hard he would have! I'm only saying common sense You never really know what people r [sic] capable of unless they allow you to see it;
> […]

> Nothing else explains what happened to Baylen yeh [Mr Rogers'] toe would have been very sore for a while or broken if it was that hard of a kick to cause that much noise and yes some people have no remorse at all.

9.29 On around 14 September 2018 Ms Coughlin provided investigating police with further text messages from her Snapchat conversation with Ms Merlin on 30 November 2015. These messages relevantly record the following exchanges:

> **Ms Coughlin:** I want you to have a really good think please you told me about the toe incident…there are way too many fractures for an accident…you know [Mr Rogers] was angry that night you know Baylen was fine when we went to bed, you know it was caused from bling [sic] force trauma that caused cardiac arrest instantly after impact, these things r [sic] not normal zoey [sic] please…
>
> **Ms Merlin:** Why was [Mr Rogers] cranky Shaylee!? Because [Mr Pendergast] didn't want his son, he had to spend time with him and he didn't want him at all.
>
> **Ms Coughlin:** Doesn't it make sense to you? He may have been cranky about that but was it that or the fact that Baylen was gunna be around again?
>
> **Ms Merlin:** [Mr Rogers] was cranky because he had done nothing but fight to see his son and get to spend time with him and [Mr Pendergast] didn't even want the time he had with [Baylen].

9.30 Kylee Thomas, another one of Ms Merlin's friends made a statement to police in April 2018 in which she recounted a conversation she had with Ms Merlin in February or March 2014. Ms Thomas said the following:

> I recall Zoe talking about a conversation she'd had with Shaylee Coughlin which had made her overthink things about Baylen's death. Zoe said that Shaylee was basically pointing the finger at [Mr Rogers] having hurt Baylen and said something about hearing a thump. Zoe spoke more about the thump saying that she may have heard something like a thump but she couldn't be sure if she actually heard it or not. She said she wasn't sure if she was overthinking the matter or if she did actually hear a thump on the night.

9.31 Investigating police conducted an electronically recorded interview with Mr Rogers on 8 May 2018. He was informed that Ms Merlin had told a number of other people about hearing a thump on the evening of 28 November. Mr Rogers initially indicated that, on legal advice, he wished to make no comment. However when he was asked again whether he wished to make any comment about Ms Merlin's account he said this:

> No, I don't recall that at all, sorry.

9.32 Later in the interview (and after having again indicated that he wished to make no comment in response to other questions posed) Mr Rogers was asked the following:

> Q: Did you kick your toe on the night?
> A: I don't think so, but I, I can't remember.

9.33 **Conclusions:** The left subdural haematoma and laceration to the dorsal splenium sustained by Baylen cannot be attributed to the reported incidents on 17, 20 and 21 November 2013. In particular, the laceration to the dorsal splenium showed a degree of healing suggesting that this injury occurred more proximate to Baylen's presentation to hospital on 28 November 2013. The additional bruising observed to Baylen's face indicates the likelihood of a traumatic event also proximate to Baylen's presentation to hospital on 28 November 2013. It is therefore most likely that the traumatic event which caused Baylen's injuries occurred on 28 November 2013. More precisely, as Baylen was observed to be functioning normally before returning home the traumatic event which accounted for Baylen's terminal collapse occurred between the time when Baylen arrived home and when the call to Triple Zero was made.

9.34 Whilst any trauma occasioned to Baylen on 17 November 2013 cannot be entirely excluded as contributing to death, any trauma occasioned on 28 November 2013 was of sufficient severity, in isolation, to cause Baylen's death, and can be regarded as a substantial and operating cause of death.

9.35 Ms Merlin independently told three separate persons that on the evening of 28 November 2013 she heard the sound of a thump after she had asked Mr Rogers to check on Baylen. The verbal account provided by Ms Merlin to Ms Coughlin is corroborated by a contemporaneous record contained in a Snapchat conversation. Although Ms Merlin does not herself explicitly describe hearing a thump on 28 November 2013, it can be taken that the absence of any contradiction of the account provided by Ms Coughlin amounts to implicit acceptance of the veracity of the account. Therefore, the thump described by Ms Merlin is consistent with Baylen having been subjected to non-accidental injury on the evening of 28 November 2013.

9.36 The expert medical evidence establishes that it is most likely that the traumatic injuries suffered by Baylen on 28 November 2013 which caused him to lose consciousness were not the result of accident or misadventure. Rather, the injuries were the result of the application of interpersonal force of a reasonable degree sufficient to cause an unusual injury such as laceration of the dorsal splenium. However, the mechanism by which this force was applied cannot be established on the available evidence.

## 10. What was the cause of Baylen's death?

10.1 As noted above, Dr Brouwer described in the autopsy report the cause of Baylen's death as hypoxic ischaemic brain injury following out of hospital cardiac arrest. This reflects the period between around 9:45pm on 28 November 2013 (when the Triple Zero call was made) and 10:15pm (when there was a return of spontaneous circulation at Tamworth Hospital). During this period, Baylen had no cardiopulmonary function or cardiac output which resulted in hypoxic ischaemic brain injury. Relevantly, the attending paramedics confirmed that Baylen had no pulse at 9:51pm.

10.2 Despite the return of spontaneous circulation, Dr Christopher Trethewy, the medical officer in the Tamworth Hospital ED, noted that Baylen's pupils were fixed and dilated and they did not react to light. Dr Trethewy considered that Baylen had probably sustained an unsurvivable brain injury due to lack of oxygen. Upon Baylen's arrival at the Sydney Children's Hospital, Dr Hari Ravidranathan, intensivist, considered that the prolonged downtime of approximately 30 minutes fitted with the clinical picture of Baylen having suffered "*very severe neurological injury as he was demonstrating an absence of spontaneous respiratory effort, cough reflex, gag reflex or any signs of pupillary reaction to light*".

10.3 In her report Dr Iles considered that given the nature of Baylen's traumatic injuries and the proximity of episode(s) of head trauma to Baylen's death, a reasonable cause of death in the circumstances and with the autopsy findings would be complications of blunt head injury.

10.4 Relevantly, the Expert Conclave Report noted:

> The cause of Baylen's death was brain injury resulting from at least two separate acts of trauma, both caused by significant force. The accounts given by Zoe Merlin and Anthony Rogers may explain the circumstances of how the first trauma occurred but do not explain the subsequent trauma.

10.5 In this context, Dr Rodriguez and Professor Besser considered a second traumatic event to have more likely caused Baylen's death. Dr Rodriguez noted:

> [I]f all the injuries were about the same age - let's say he had a fall, had a fracture, got a subdural, then had seizures and then died from the seizure and aspiration, that would be fine. But you've got the more recent subdural and the laceration to the splenium which doesn't fit into that scenario.

10.6 Following on from the above, Professor Besser observed:

> And also I can't get past all those retinal haemorrhages: optic nerve, retinal, subretinal, pre-retinal. I mean the photographs in the history from the ophthalmologist that examined Baylen's eyes, I mean they're incredibly extensive.
> […]
> I've never seen that before from cardiac arrest - even from raised intracranial pressure.

10.7 Ultimately, Dr Rodriguez, Professor Besser and Dr Iles all agreed that *"there was a significant second injury immediately before [Baylen] was found*" or "*immediately before he was reported to be in extremis*" which would tend to explain the left-sided subdural haematoma, the splenium lesion, the

retinal haemorrhages and possibly the more recent bruises to Baylen's forehead. None of the other experts expressed a different view to this conclusion.

10.8 **Conclusions:** The cause of Baylen's death was complications of blunt head injury resulting from at least two separate acts of trauma. It is most likely that these acts of trauma occurred on 17 and 28 November 2013. Any contribution to death arising from the injuries sustained on 17 November 2013 cannot be entirely excluded. However the traumatic event on 28 November 2013 alone was sufficient to cause death. This latter incident involved the application of significant non-accidental force that was sufficient to cause the left-sided subdural haematoma, the laceration of the dorsal splenium and retinal haemorrhages.

**11. Was there a failure to properly diagnose Baylen's head injuries when he was admitted to Tamworth Hospital on 22 November 2013?**

11.1 Upon reviewing the imaging taken at Tamworth Hospital on 22 November 2013, Dr Prelog identified the following:

(a) A right frontal parietal subdural haematoma;

(b) A non-displaced right occipital bone fracture; and

(c) A small right occipital subgaleal haematoma.

11.2 None of this pathology was identified at the time on 22 November 2013 and was not reported on by Dr Newell on that day. Further, this pathology was also not identified at any stage during Baylen's admission before he was allowed to leave the hospital on 24 November 2013.

11.3 Dr Prelog gave evidence that whilst the subdural haematoma can be quite subtle her expectation was that a competent radiologist would be able to identify it. In relation to her description of subtlety, Dr Prelog explained:

> I think the question here is actually being able to see it in the, in the [a]mount of data provided. This is one slice and if you look at one slice really carefully you'll see everything. We scroll through images like you would a movie so it's up and down, side to side, and if one image is obvious you may skip that. It may not be in your radar. This is what we're taught to do to read hundreds and thousands of images in a very short time, so this is only one slice of many and if there are only two slices of 3 millimetres thick it is possible not to see it.

11.4 Dr Prelog explained that a radiologist would be reviewing a number of images across the sagittal, coronal and axial planes to identify any irregularities and "*put together a picture*". Dr Prelog acknowledged that the irregularity that she identified was only clear in relatively few frames.

11.5 **Conclusions:** A right frontal parietal subdural haematoma, a small right occipital subgaleal haematoma and a non-displaced right occipital bone fracture were all evident on 22 November 2013. Whilst the presence of such injuries were considered as possibilities, they were not diagnosed despite being evident on imaging.

11.6 It is uncertain whether the slices viewed by Dr Prelog subsequently were the same slices available to Dr Newell and the clinicians at Tamworth Hospital in November 2013. In addition, it is acknowledged that as a paediatric radiologist Dr Prelog brings a particular expertise to the task of interpreting and reporting on such imaging.

**12. Were appropriate tests and examinations undertaken to investigate Baylen's injuries, including to investigate whether they were non-accidental?**

*Clinical reasoning and decision-making*

12.1 Dr Khan gave evidence that:

(a) it was appropriate for a CT scan to be performed;

(b) it was hoped that the CT scan would provide some explanation for Baylen's clinical presentation;

(c) during handover at the morning ward round on 23 November 2013 he was aware of a concern raised by the ED team but had not seen Dr Friend's notes querying the possibility of an intracranial bleed and fracture in the context of a suboptimal scan and where performing an MRI was raised for consideration;

(d) he was looking for an explanation for Baylen's symptoms, acknowledging that one possibility for his presentation was some intracranial pathology which needed to be investigated with a CT scan;

(e) notwithstanding, a CT scan provided no assistance in understanding Baylen's history of lethargy, nausea and vomiting; and

(f) he was aware that there had been a discussion with Dr Newell which resulted in the preparation of the Addendum Report;

12.2 Dr Khan gave evidence that in taking a history he considered the possibility of head injury associated with suspicious injury. After taking this history, Dr Khan gave evidence that he did not think that Baylen had sustained a suspicious injury. When asked how he came to rule out this possibility, Dr Khan explained:

> [T]here were a few things, red flags, when, when it comes to abusive or inflicted injury. One was that is there a consistent history of further injury and what I heard from Dr Hope and Dr Kshatriya and what I heard from Zoe, the mother, when I took the rounds, was pretty much the same history.

12.3 By his use of "*consistent history*", Dr Khan gave evidence that he was referring both to Ms Merlin providing consistent accounts, and that account being consistent with Baylen's presentation. Dr Khan acknowledged that the account that he was provided with was that Baylen had suffered an unwitnessed fall. However, Dr Khan gave evidence that such an unwitnessed fall would only be concerning if there was some serious injury (such as "*a fracture of the femur or any of the long bones*") associated with it.

12.4 When asked whether he considered that the CT scan had excluded the possibility of brain injury, Dr Khan explained that Dr Newell's report "*clearly says that there was no subdural bleed*". Dr Khan went on to explain:

> As a clinician, I ask for a test and I expect to get the answer and the answer that I got from this test was that there was, that what, the thing I was looking for was absent. That was a bleed.

12.5 When asked whether he had a view as to why an MRI was suggested, Dr Khan gave this evidence:

> I had no, no clear thing of why a MRI was required because my question when I asked for the test was very clear, that I was asking for a head injury, looking for a fracture and a bleed, and the CT scan, even as a known radiologist, as a paediatrician who deals with this, I knew that that would be the, that would answer my question. The MRI was recommended and I followed through with that. I discussed it with the neurosurgical team to see what they would - that I had one report from one specialist. I'm not a specialist on imaging. I had a report from the radiologist which said there was no bleed but consider an MRI.
>
> Then I went to the next port of call, the neurosurgical team, and asked what they advised to see how should I proceed with it, but I had no idea what we were - if, if there had been more concerns or down the line if the child was still unsteady or something I would be considering an MRI, just to rule out there's deep axonal injury, which is not life-threatening but can have some implication for the child.

12.6 Dr Khan gave evidence that he did not speak to anyone from the neurosurgical team at JHH. This task was left to Dr Conallin. Dr Khan gave evidence that he was using the neurosurgical consult for a second opinion regarding the opinion given by Dr Newell and that this was discussed by Dr Conallin. Dr Khan agreed that he was not present when this discussion took place. He gave evidence that he had very specific questions which were not complicated and that he trusted Dr Conallin to ask those questions and obtain answers. Dr Khan agreed that he could have contacted JHH to seek an opinion from a paediatric radiologist if all that he was seeking was a second opinion. However this enquiry was not made.

12.7 Dr Khan agreed that even if a fracture had been identified this would not have changed Baylen's management. He would still have been managed conservatively. It was only if some bleeding had been identified that this would have resulted in a change in his management. A fracture alone would not be managed by the neurosurgical team. Dr Khan gave evidence that he only expected a call back from the neurosurgical team if there was a matter of some concern.

12.8 Dr Khan agreed that it was very important to rule out the possibility of any fracture. However, he explained:

> I went back and examined Baylen myself to make sure that there is no - I know that I - I accept that it's - sometimes it can be very difficult to make on a clinical outpatient but that's one of the things we - when we have a head injury, we don't do CT scans or X-rays on all children because of the risk of radiation. You have to go on clinical suspicion. I have already had a CT scan which did not confirm - which was, he could - did not tell me that there's a fracture. There's a possibility of an accessory suture. On my clinical examination, I did not find Baylen to be tender in that area, or I did not find - it can be - it was a - it could have been a linear fracture. But if it was a depressed fracture, I would have felt a depression. I did not find that, and he had no tenderness, and there was no subgaleal haematoma that I could feel

12.9 In a progress note entry written retrospectively on 29 November 2013, Dr Khan wrote:

> CT brain reportedly normal.
> Neurosurgical consult x 2 → nil intervention required as imaging was normal.

12.10 Dr Khan was asked in evidence whether during the period from 23 to 25 November 2013 he was under the impression that the CT scan was normal and therefore he did not need to be worried about a significant head injury. Dr Khan explained:

> That's, that's what I was under impression. The, the report said that there was a possibility of a occipital fracture but it was more like to be an accessory suture, there was definitely not subdural bleed. The discussion with the neurosurgeon was that, yes, he has - he did not make any changes with the management, he will speak - he would review the images and call back if there were any concern. That call never came back, so that, that implied to me that there was no concern.

12.11 Dr Khan agreed that he wanted more information about whether an intracranial injury could be excluded because these would have been matters of concern if present. He also agreed that he was content for the neurosurgery registrar to review the images and to contact him with any concerns. Dr Khan described this as "*an imperfect system but that's what happens in real life*".

12.12 Dr Khan eventually agreed that with the information that he had been provided he was unable to rule out the possibility of a fracture that had been raised in the Addendum Report. Dr Khan said that he considered the possibility of a fracture or an accessory suture and "*went with the likelihood that it might be an accessory suture*".

12.13 When it was suggested to Dr Khan that he would have considered the injury suspicious to invoke relevant child protection procedures, he gave evidence that he "*went through the red flags*" and found that the mechanism of injury was consistent, there was no inordinate delay in seeking medical attention, the observations of Baylen's interactions with his carers caused no concern, and no other suspicious injury was identified in circumstances where this was Baylen's first presentation to hospital.

12.14 In his report, Associate Professor McDonald provided the following opinion when asked whether Dr Khan failed to properly diagnose Baylen's head injury in the period between 22 and 24 November 2013:

> The correct assessment was made that a Brain CT scan was necessary and that was appropriate. The Brain CT was reported as normal. This is crucial. There was a subsequent addendum which reported that there was possibly an undisplaced lineal occipital fracture or possibly an accessory suture. There was no brain injury seen. Dr Khan did not consider there was clinical evidence of a fracture at the time. Linear skull fractures are not uncommon in children and can occur accidentally, falling from a standing height on to a hard surface.

12.15 In evidence, Associate Professor McDonald accepted that it would be more accurate to describe that Dr Khan was working with the knowledge that the brain CT raised the possibility of a fracture. However, Associate Professor McDonald sought to distinguish between a linear fracture and a comminuted fracture, describing the latter as a "*game changer*". Associate Professor McDonald later acknowledged that with the benefit of hindsight a linear fracture might be a "*game changer*". He

agreed that this could not be dismissed as not a significant or important piece of information included in an addendum report.

12.16 Associate Professor McDonald also gave evidence that a doctor in a regional centre would need to keep in mind that a CT scan was suboptimal when seeking to rely upon the scan to determine the management of a patient. In this regard, Associate Professor McDonald sought to explain that there are "*degrees of suboptimality*", but acknowledged that if there was any doubt about a fracture in Baylen's case he would have obtained a review from a tertiary radiology service.

### *Neurosurgical consult*

12.17 The progress notes record an entry made at 8:30am on 23 November 2013 by Dr Conallin:

> Plan
> 1. Will d/w neurosurgical service again
> ?[Transfer] for MRI/observation
> vs
> Observe in [T]amworth further 24 [hours].
> 2. Continue 24Hs neuro obs.
> 3. ↓IVT to 10ml if eating and drinking

12.18 Dr Conallin rang the neurosurgery registrar at 11:00am and left a message for Dr Dhillon to call him back.

12.19 The progress notes then record the following entry at 12:40pm:

> D/W neurosurgical reg → was familiar with case (on last night)
> 1 x vomit 4am today
> Otherwise vitals ok
> MRI can wait till Monday → could try unsedated? in Tamworth
> Addendum to CT report discussed
> No [change] to mgmt. if [fracture] present, observe + not for transfer now
> he will r/v films when next in hospital

12.20 In his statement Dr Dhillon said this about the conversation with Dr Conallin:

> I cannot recall the time of the call or to whom I spoke. I explained that an undisplaced occipital bone fracture did not require surgical management and was to be managed conservatively. Whilst there was no extra-axial haematoma, (bleeding outside the brain), I suggested that a fracture overlying the appearance of a prominent sinus could be consistent with a traumatic transverse sinus thrombosis (clot) and that if this matched the clinical picture, they should consider either an MR venogram (scan to assess whether there is a clot in the transverse sinus) or a neurology referral.

12.21 Dr Dhillon gave evidence that:

(a) he typically arrived at JHH at 6:30am and that he recalled looking at the images "*on the John Hunter system*" and then discussing the case with his supervising consultant;

(b) he expected that he viewed the reformatted images, which he was able to scroll through on a computer, and not the raw data;

(c) at the time that he reviewed images, he did not have available Dr Newell's report and was not aware of its existence;

(d) he was of the view that there was an occipital bone fracture but did not observe any other intracranial pathology; and

(e) he considered that there was the possibility of a traumatic transverse sinus thrombosis.

12.22 Although Dr Dhillon described a CT scan as the gold standard for excluding an intracranial mass lesion that requires surgical evacuation, he agreed that still provided no explanation for Baylen's symptoms and that was an ongoing cause for concern. Accordingly, Dr Dhillon recommended that a venogram be performed. Dr Dhillon could not recall whether he was told that a radiologist had made a recommendation for an MRI to be performed but agreed that this would have been of interest to him. Dr Dhillon agreed that it would have been his usual practice to make an enquiry as to whether Baylen's presentation fit into the category of non-accidental injury, but could not recall whether he did so or not. Dr Dhillon gave evidence that if he had obtained information that gave rise to a suspicion of non-accidental injury he would have done the following:

> I would have - so I would have first ruled out that the child didn't need any neurosurgical intervention and, if that was the case, then I would recommend that they refer on to whichever department deals with non-accidental injuries in Tamworth, for further investigation.

12.23 Dr Dhillon gave evidence that a venogram is an imaging study that looks at the patency of the size in the brain and is one of the sequences that an MRI can perform. Dr Dhillon rejected the possibility that he was mistaken in his statement when referring to a venogram instead of an MRI. He explained that it is not his usual practice to request that an MRI be performed following a fracture, and that the purpose of a venogram is to assess the patency of the sinus. It should be noted that Dr Dhillon's account of the consult was based on his written notes (later destroyed) and an undated statement drafted possibly in 2014 or 2015.

12.24 In his statement Dr Conallin acknowledged that he could not recall his exact conversation with Dr Dhillon but expressed the belief that he informed Dr Dhillon that Baylen was stable, that he had last vomited at 4:00am on 23 November 2013, and that on examination there was no neurological focus of concern. Dr Conallin then described the conversation in this way:

> I discussed the addendum to the CT head report which noted a lucency extending through the right occipital bone posteriorly which may represent a fracture but which could also be an accessory suture line, a normal anatomical variation.
>
> The registrar advised that there was no change in the management even if a fracture was present. There was no indication for urgent transfer or MRI and Baylen should be kept at Tamworth Hospital for a further period of observation. If there were any clinical concerns, the MRI could be done on the following Monday. We discussed potentially trying to perform MRI un-sedated in Tamworth.

> Dr Dhillon advised that in light of the addendum, he would review the images of the CT scan when he was next at the John Hunter Hospital and would contact me if any changes in management were required.

12.25 Dr Conallin gave evidence that he could not recall the precise nature of his conversation with Dr Dhillon, but said that they "*did talk about an MRI*". Dr Conallin said that Dr Dhillon did not tell him what he had been able to view or the circumstances in which he viewed it. Notwithstanding, Dr Conallin said this:

> Dr Dillon [sic] advised to me that even if there was, he wouldn't change what was happening at the moment, and he said he'd look at the films when he went back into the hospital in light of this addendum.

12.26 Dr Conallin said that he was unaware of an explicit decision to not follow Dr Newell's recommendation that an MRI be performed. When asked whether he knew who made such a decision, Dr Conallin said this:

> I don't. We consulted the neurosurgical team and I brought those findings back to Dr Khan and the neurosurgeons - you know, when there's an abnormal CT, they really have a - there's some level that they need to provide expert opinion in terms of what's next.

12.27 Dr Conallin gave evidence that he had no recollection of having a discussion with Dr Khan about performing an MRI. Dr Conallin agreed that he did not document in the progress notes anything about Dr Khan having considered, and then making a decision about, whether to perform an MRI or not. However, later in his evidence, Dr Conallin said that he might have had a discussion with Dr Khan on 24 November 2013 about deviating from the earlier plan to arrange an MRI the following day.

12.28 Dr Conallin was asked whether his discussion with Dr Dhillon proceeded on the basis that there would be an MRI sometime in the future. Dr Conallin gave this evidence:

> No, I don't think it was as concrete as that. It was the MRI could wait until Monday, he didn't need to be transferred immediately, is my recollection.

12.29 Dr Conallin agreed that this was an ambiguous situation as to whether an MRI should be performed or not, but that he did not feel that this needed to be clarified because Baylen had improved and Dr Khan was present on the ward on 24 November 2013.

12.30 Dr Conallin was asked whether Dr Dhillon's account of their conversation in his statement was consistent with his memory. Dr Conallin, after referring to his progress notes entry, said:

> Yes, and my handwritten notes would say, "MRI can wait until Monday", which I say I should have written "MRI could wait until Monday", which is consistent with what [Dr Dhillon]'s saying is they should consider an MR venogram.

12.31 There is no documented Tamworth Hospital record that Dr Dhillon reviewed the CT images, identified the presence of an occipital fracture, discussed this with his consultant and advised Tamworth Hospital of this.

### *Correlation with clinical history*

12.32 The addendum to the CT report suggested "*correlation with the patient's clinical history and examination*". It is noted that this might have influenced a decision to proceed with the MRI.

12.33 One aspect of Baylen's clinical history was the delay in presentation to hospital. Dr Khan acknowledged that one possible matter giving rise to a suspicious injury was the delay in presentation which is why he sought clarification about this during the ward round on 23 November 2013. Dr Khan gave evidence that ultimately he was reassured that there was no delayed presentation based on Ms Merlin's actions on "the Sunday morning". Dr Khan ultimately concluded that "*there was no inordinate delay or unexpected or unexplained delays seeking medical attention*".

12.34 However, Associate Professor McDonald described this as a "*minimum response*" and expressed some reservations regarding the adequacy of the response:

> Well, looking at the bruising and the extent of it, I don't think a helpline, particularly the helpline that existed at the time which doesn't have video, video capability, is quite as vigorous a response I would've expected for the extent of the bruising. The helplines are good, but they're, they're staffed by experienced nursing staff that give people pretty good advice the vast majority of the time, but it's not a comprehensive response.

12.35 Equally significantly, the delay in presentation was relevant to Dr Khan's examination of Baylen. During that examination, Dr Khan found no tenderness and could not feel a subgaleal haematoma. Dr Khan explained that he had "*lots of experience with subgaleal haematomas*" and that "*once you have felt a subgaleal haematoma, you will never forget it*". However, later in his evidence, Dr Khan acknowledged certain limitations with his examination:

> It's - you can't - you cannot forget the feel of a subgaleal. The thing about a subgaleal is it does not happen straight after a injury. It takes a few hours, at least six - four to six hours down the line. And it can be significant. And the natural progression then - it just - that's reabsorbing and also undergoing resolution, re-organisation. And if it is a re-organise thing - this was - Baylen had a fall on the 17th, and I was examining him on the 24th. By the time it is possible that it had become organised and then it's very difficult to find that clinically.

12.36 Associate Professor McDonald was also asked whether the passage of time made it very difficult to visualise on CT whether a subdural haemorrhage was present. He answered:

> Yes, but that's the observation of an experienced clinician.

12.37 Therefore, the evidence indicates that absence of any clinical injury at 22 November 2013 was less reliable than if examination had taken place closer to 17 November 2013.

12.38 During the morning ward round on 23 November 2013, Dr Khan took this history from Ms Merlin regarding Baylen's history of vomiting:

> I then asked her when the vomiting commenced. She told me that she herself had developed vomiting from what she thought was a vomiting bug on Tuesday (19th November 2013). Baylen developed vomiting on Wednesday (20th November 2013) and she had assumed that he had developed the vomiting bug as well. She described that it occurred mostly related to eating and was not forceful or projectile in nature. She said that there was no diarrhoea.

12.39 However, Associate Professor McDonald gave evidence that a history of vomiting with no reports of diarrhoea would potentially point away from the vomiting being associated with some sort of gastroenteritis-type illness.

12.40 Further, Dr Khan formed his opinion based upon his own observations, and those of others, regarding the interaction between Baylen and Ms Merlin on the ward. Whilst these observations were important, Dr Khan was unaware that Mr Rogers was also living with them. Dr Khan was therefore equally unaware that he did not have a complete picture of Baylen's home life.

12.41 Ultimately, Dr Khan agreed that on the information available to him he was unable to rule out the possibility of a fracture and that instead he "*went with the likelihood that it might be an accessory suture*".

12.42 Counsel for Dr Khan made a number of submissions regarding Dr Hope and her involvement in Baylen's care. On the one hand it was acknowledged in the submissions that Dr Khan was the "*captain of the ship*", the ultimate decision-maker with respect to Baylen's management and that the submissions "*are not designed to criticise [Dr Hope] or seek adverse findings to be made against her, but rather to illustrate her alignment with the clinical actions of Dr Khan*". On the other hand, it was submitted on behalf of Dr Khan that "*the mistakes made in this case and the burden of this tragic loss, should not be borne exclusively*".

12.43 First, to the extent that the submissions suggest that the functions and purpose of coronial proceedings is to determine who, or what sufficiently interested party, should bear the "*burden*" or responsibility for an adverse outcome is to mischaracterise and misunderstand the nature of such proceedings and the coronial jurisdiction generally.

12.44 Second, as noted above, the submissions on behalf of Dr Khan focus heavily on the purported involvement of Dr Hope in Baylen's care and clinical reasoning exercised by Dr Hope in this regard. It was submitted that Dr Hope's only ongoing concern as at the time of handover to Dr Kshatriya on 22 November 2013 was whether Baylen had a "*brain injury*" and whether it was inconsistent with the mechanism of injury described by Ms Merlin. From here, it was submitted that Dr Hope's concern therefore aligned with the clinical opinion of Dr Khan and characterisation of the Addendum Report as "*normal*".

12.45 However, these submissions disproportionately assign a degree of involvement by Dr Hope in Baylen's care that is not supported by the evidence. Dr Hope had no involvement in reviewing or interpreting the Addendum Report. Further, her report to the Helpline on 29 November 2019 reflected her understanding of Baylen's clinical course during his admission after she handed over

to Dr Kshatriya. Dr Hope was not directly involved in these matters but later learned about them and reported to the Helpline.

12.46 Third, it was submitted on behalf of Dr Khan that he acted consistently with the views held by his more junior staff, namely Dr Hope and Dr Conallin. Again, it should be remembered that Dr Conallin was only 19 days into his paediatric rotation and Dr Hope had nine months of paediatric training.

12.47 Fourth, Dr Hope expressly rejected the proposition that she sought to reassure Dr Khan that there were no concerns about non-accidental head injury for Baylen:

> No. When I spoke to Dr Khan, although I don't remember the conversation with words or anything like that, what I knew was that I had enough concern about suspicion of there being an injury that was more serious than a skin injury. I told him about the information I had collected. I did not say that "Oh, I don't think that, or from my interactions I don't think there's any reason to not suspect". I didn't have any of that dialogue with him because I did not feel that that was in my place to tell him that. I just told him what I saw, what the information was, that the mechanism was this, this is what I see in front of me, these are my concerns, and that I think a CT would be helpful and from there I don't recall the rest of the conversation, but at no point did I say, "I'm really reassured by this, Doctor".

12.48 Fifth, by virtue of his seniority and experience and his greater degree of involvement in Baylen's management, Dr Khan had information to inform his clinical decision-making which was not available to Dr Hope. Dr Khan had contact with Ms Merlin during the morning ward rounds on 23 and 24 November 2013 and supervised Dr Conallin. Dr Hope acknowledged that Dr Khan relied on her clinical judgement but described the nature of their working relationship in this way:

> He's relying on me being able to examine and take a history, but to a certain extent, as an SMRO, I am an information gatherer. It's my impression that there would be some things that he would take from me as a clinical judgment and others where he would reserve that until he saw the patient.

12.49 **Conclusions:** Dr Khan recognised that Baylen's presentation might be suspicious for non-accidental injury. He also recognised that the purported mechanism of injury was an unwitnessed fall. Dr Khan reasoned that this would only have been of concern if there was some serious injury associated with it. A CT scan was therefore warranted. Dr Khan considered that the CT scan excluded the possibility of serious injury because no subdural haematoma was identified. Had such pathology been identified this would have resulted in a change in Baylen's management.

12.50 However, Dr Khan considered that even if a fracture had been identified it would have been managed conservatively without neurosurgical intervention. Whilst Dr Khan agreed that it was still important to rule out the possibility of a fracture, he acknowledged that this was not possible based on the information that he had been provided with.

12.51 This information came from the discussion between Dr Dhillon and Dr Conallin. Dr Dhillon gave evidence that he had observed an occipital bone fracture by the time of his discussion with Dr Conallin. This account was based on Dr Dhillon's notes, which are no longer available, and an undated statement. However, this does not accord with Dr Conallin's contemporaneous progress note entry which refers only to the possibility of a fracture being present. Whilst the evidence indicates that Dr Dhillon and Dr Conallin did discuss that any undisplaced occipital bone fracture would be managed conservatively without any surgical intervention, there is no clear evidence that Dr Dhillon informed Dr Conallin that he had seen an occipital bone fracture on the imaging.

12.52 Similarly, Dr Dhillon's evidence regarding advice given about performing an MRI, venogram or neurological examination is not reflected in Dr Conallin's progress note entry. Dr Conallin himself acknowledged that there was ambiguity regarding performance of any of these further investigations. Again, there is no clear evidence that Dr Dhillon advised Dr Conallin that these investigations should be considered. However, what is clear is that no plan was formulated for an MRI to be performed.

12.53 Correlation with Baylen's clinical history might have influenced any decision regarding performance of an MRI. Whilst correlation with Baylen's clinical history was performed, it was done with certain limitations. The delay in Baylen's presentation affected the reliability of any examination for injury such as a subgaleal haematoma. Further, reports of Baylen vomiting in the absence of any symptoms of diarrhoea might suggest another cause for the vomiting besides a gastrointestinal illness. Finally, any observations of the interactions between Baylen and Ms Merlin on the ward were not fully informed by the actual living arrangements at Baylen's home, although this was not clear to clinical staff at the time.

12.54 Ultimately, the combination of the above factors led Dr Khan to conclude that the possible fracture identified on the CT scan was likely an accessory suture which did not require an MRI or any further investigations to be performed.

**13. Did clinical staff take appropriate steps to escalate their possible concerns about the cause of Baylen's injuries including to the Department of Family and Community Services (as it then was)?**

13.1 The *Child Wellbeing and Child Protection Policies and Procedures for NSW Health* Policy Directive (**Child Protection Policy Directive**), published on 15 April 2013 and in force as at November 2013, informed Local Health Districts, Speciality Health Networks, other health services and health workers about the tools and resources available and the interagency arrangements in place to assist them to meet their responsibilities and provide a consistent NSW Health response to child protection and wellbeing. The policy directive included a fact sheet for NSW Health workers which identified a number of child wellbeing and child protection resources including the Mandatory Reporter Guide (**MRG**).

13.2 Section 7 of the Child Protection Policy Directive identifies indicators of child abuse and neglect, including potential indicators of physical abuse including, relevantly, bruising on the face, head or neck; bone fractures or dislocations, especially in children under two years of age; explanation inconsistent with injury; and head injuries where the child may be drowsy or vomiting.

13.3 Section 7.2.3 of the Child Protection Policy Directive provides that if a health worker has a concern that a child, young person or class of children or young people is at risk of significant harm, they should use the MRG and to determine the next steps. The MRG will assist Health mandatory reporters in making a decision about the level of risk and deciding whether to report their concerns. Relevantly, the following is noted:

> The MRG does not replace critical thinking or prohibit a mandatory reporter from the course of action he/she believes is appropriate.
> […]
> The MRG encourages the reporter to focus on critical information to inform their decision-making. The MRG is intended to support professional judgement and facilitates consistent decision-making.

13.4 This is in circumstances where the *Paediatric Emergency Department Observation Chart 1-4 Years* contained an Injury Risk Assessment Screen checklist featuring eight identified areas of risk. In Baylen's case, one of these areas - inappropriate delay in presentation - was ticked, "*Yes*". This in turn required the local child protection procedure to be activated. However, as at November 2013, there was no local child protection procedure in place at Tamworth Hospital.

13.5 Similarly, the HNELHD *Child's Health Questionnaire* was not completed in Baylen's case. The questionnaire contained questions relating to who may stay with a child in hospital (and their relationship to the child) as well as who the child lives with. If these questions had been asked, they might have elicited information regarding the nature of Ms Merlin's relationships, and family dynamics within the home where Baylen lived. Equally, it is possible that even if the questions had been asked this information may not have been elicited, noting Dr Hope's attempts to obtain a social history.

13.6 Also in force at the relevant time was the NSW Health *Children & Infants – Acute Management of Head Injury* Policy Directive which requires all health services to have local guidelines/protocols

based on the *Infants and Children: Acute Management of Head Injury Clinical Practice Guidelines* (**Head Injury Guidelines**). The Head Injury Guidelines provide for the following:

> Each patient should be individually evaluated and a decision made as to appropriate management in order to achieve the best clinical outcome.

13.7 The Head Injury Guidelines recognise that the patterns of head injury and the principles of management in children have some important differences from adults. These relate to a number of matters and include:

> A history of loss of consciousness may be unobtainable or unwitnessed. Children, particularly those aged less than two years, with no history of loss of consciousness can still have a significant risk of intracranial injury.
>
> Parents generally provide the most reliable and trustworthy information, however, if the history is inconsistent and / or does not match the physical findings then an investigation into the possibility of inflicted head injury must be carried out. Children with inflicted head injury (child abuse) present to Emergency Departments. Much of this may go unrecognised unless a high index of suspicion is maintained. The current NSW guidelines stipulate that recognition of inflicted head injury is a duty of care for all practitioners and that notification is mandatory in all suspected cases.

13.8 The Head Injury Guidelines also instructs readers to become suspicious of inflicted head injury when:

(a) inadequate history is provided for a serious head injury;

(b) there is a serious head injury after a reportedly minor fall;

(c) there is significant change in history over time;

(d) another child is being blamed for the findings; and

(e) there seems to have been an unreasonable delay in presentation.

13.9 Further, the Head Injury Guidelines provided for the following:

> Any infant or young child with a suspicious head injury may have been physically assaulted and therefore should be referred immediately to a tertiary centre. Consultation with a tertiary centre is advisable in all cases where there is the slightest suspicion that an infant has been abused.

13.10 In addition, the Head Injury Guidelines noted:

> Practitioners are advised to use the NSW Mandatory Reporter Guide in all cases where there is a reasonable suspicion of inflicted head injury.

13.11 The HNELHD issued *the Infants and Children – Acute Management of Head Injury* Policy Compliance Procedure (**Head Injury Procedure**) for clinicians in emergency departments where infants and children present with head injuries. The Head Injury Procedure identified low, intermediate and high

risk based upon certain features being present associated with history, mechanism and examination. Determination of the level of risk would then guide the management of a patient, including the need for medical review, observation, resuscitation or discharge.

13.12 Relevantly, if suspected non-accidental injury was identified from a patient's history, then management involved notification to the Department of Family and Community Services (**FACS**) if non-accidental injury was present. This can be distinguished from the clinical practice guideline which refer to only a reasonable suspicion of inflicted head injury.

13.13 Dr Hope gave evidence that she gave thought to the mechanism of Baylen falling from the bed and said:

> My view at the time was that if, indeed, there was a brain injury causing his symptoms, that I found it to be suspicious that the mechanism offered was not enough to cause that injury.

13.14 Dr Hope considered it prudent to wait for the outcome of the CT scan to see whether any abnormality was identified. Although a potential abnormality was identified no further investigation by imaging was conducted. Dr Hope was not involved in the interpretation of the CT scan and any clinical decision-making associated with this interpretation. Dr Hope had no further involvement after handing over to Dr Kshatriya until Baylen represented to hospital on 28 November 2013.

13.15 Dr Khan explained his approach to the prospect of referral to the Helpline in this way:

> In the very beginning when we went through the head injury guideline - we have mentioned - you pointed it out to me so that these are guidelines and they have to be used in clinical conjunction. This is something where you have to make a clinical judgment. And in this thing, well, making a notification to FACS also is pretty invasive. I have to be very convinced. I need to have enough evidence to disrupt a family when making a - but again this is part of my job. I have to make - as my role as a paediatrician in the community, anybody, all of us are there to protect children. And - but when I make a notification, I need to have enough evidence. And that's one of the - on that weekend, I did not feel I had enough evidence to make that notification.

13.16 Associate Professor McDonald explained that the MRG "*had been rolled out in about 2011*" and expressed some uncertainty about whether it was "*used widely*". He seemed to suggest that a clinician more experienced than Dr Khan should have used the MRG to guide consideration about whether a report should be made to FACS, but noted that it is typically the supervising consultant that has responsibility for management of a patient in this regard. Notwithstanding, Associate Professor McDonald expressed the following view regarding whether, on balance, there were sufficient red flags for Dr Khan to be thinking about speaking to the Child Wellbeing Unit to guide consideration of further investigation for Baylen:

> I personally would have done that if I had been the treating clinician as an experienced doctor, but I could understand how an equally reasonable doctor would've been reassured by normal parent-child interaction, by absence of brain injury, and normal neurological condition as far as you can assess in a toddler by both his own observations and those of the nursing staff.
>
> But I, I personally would've discussed this, I think, with the Child Wellbeing Unit on the basis of my very extensive clinical experience. I am a consultant, unlike Dr Khan was at the time. And also those holes in

> the Swiss cheese lining up in the way that you've delineated. I think a discussion would have taken place and that could have either been the Child Wellbeing Unit. Of course, these cases such as this have led to the establishment of the CASACAL line, the child abuse et cetera line, and what would happen in 2022 apart from the fact that the rostering would have been a lot better for the doctors would have been an ability of Dr Khan or any doctor in the CASACAL and get that opinion and it arose because of the problems that existed in 2013.

13.17 Dr Tzioumi referred to the Child Abuse and Sexual Assault Clinical Advice Line (**CASACAL**) as a state-wide initiative and described it in this way:

> It's like a helpline, if you like, but for clinicians, and targeting doctors working more in regional, rural, and smaller hospitals, and other clinicians who work with children when there are questions of how they may manage or diagnose child abuse. Any of those, what we say, clinical questions. The State has been divided into three kind of regions, and the three tertiary child protection units are the hubs, if you like, and have a roster of senior clinicians, like myself, where they are available to answer enquiries from across the State. So, so there is the Children's Hospital at Randwick, The Children's Hospital at Westmead, and the John Hunter child protection team.

13.18 Dr Tzioumi also explained the availability of resources beyond CASACAL:

> And in addition to that telephone line, the three child protection teams that I mentioned are also available directly. So some clinicians may choose not to use the line but to ring, you know, my service. Or sometimes they ring me directly because they've worked with me previously and say, "I've got this child. This is the problem. What do you suggest I do next?" And so, and we collate those, that information at State wide level for the CASACAL kind of consultation, trying to support clinicians when they have children like Baylen present with injuries they are not sure about, to, you know, how you investigate what to do next.

13.19 **Conclusions:** As at November 2013 a child protection policy framework existed which provided clinicians at Tamworth Hospital with necessary resources to identify whether a report should be made regarding a child at risk of significant harm, and to assist with determining appropriate next steps in that child's management. Relevantly, the Head Injury Guidelines set a relatively low threshold for consultation with a tertiary centre and use of the MRG. That is, consultation was advisable in all cases where there was the slightest suspicion of child abuse, and use of the MRG was advised in cases where there was a reasonable suspicion of inflicted head injury.

13.20 There is no evidence the clinicians involved in Baylen's case, who were all mandatory reporters, consulted either the head injury guidelines or the head injury procedure. Instead, the evidence indicates that the clinicians instead relied upon their own clinical experience and familiarity with past practices and procedures to determine whether a notification to the FACS helpline was required.

13.21 Dr Hope considered the possibility of Baylen's presenting symptoms to be due to non-accidental injury but considered it prudent to await the findings of the CT scan and whether any abnormality was detected. As a potential abnormality was not confirmed with further investigation, it does not appear that there was a basis for Dr Hope to make a report to the Helpline.

13.22 Dr Conallin also made no report to the Helpline. However, given that he was only 19 days into his paediatrics rotation, and working under the supervision of Dr Khan, this can be attributed to his relative lack of experience.

13.23 Dr Khan's evidence suggests that his approach to the issue of mandatory reporting was premised on being "*very convinced*" about the presence of non-accidental injury. It is acknowledged that a report to the Helpline carries with it serious consequences for the family of a patient the subject of a report, and should be done following careful consideration. However, Dr Khan's approach regarding the need for convincing evidence does not appear to correlate with the relatively low threshold set by the Head Injury Guidelines for consultation with a tertiary centre or use of the MRG.

13.24 As Associate Professor McDonald acknowledged, Dr Khan was not a consultant at the relevant time, and a consultant in the position of Dr Khan likely would have considered consultation with a tertiary centre appropriate to guide Baylen's management. However, Dr Khan was the most senior and experienced clinician directly involved in Baylen's care which suggests that as a matter of good clinical practice, further consideration ought to have been given to consulting the child protection team at John Hunter Hospital.

### *Policy changes relating to child protection*

13.25 Following Baylen's death, a Local Guideline and Procedure entitled *Management of Children and Young People at Risk of Significant Harm who present to Tamworth Hospital (excluding those referred by external agencies*) (**Risk of Significant Harm Guideline**) was issued by Tamworth Hospital. It reiterated the importance of recording all concerns, assessments, investigations, reviews and MRG reports and later conducting a review of the case to ensure it had been appropriately managed.

13.26 In March 2018 the Risk of Significant Harm Guideline was reviewed and ultimately rescinded because it was felt to duplicate information contained in the state-wide Child Protection Policy Directive.

13.27 In early 2018 changes were made to child protection training at Tamworth Hospital, with clinical staff in the Paediatric and Emergency Departments required to complete a three-part online module, together with a targeted, one-day, face-to-face training session provided by child protection trainers. This was in addition to child protection training as part of induction training for new staff during their orientation to the Hospital.

13.28 The evidence regarding completion of such training can be summarised as follows:

(a) as at September 2018, more than 90% of Emergency Department nursing staff, but only 54% of Emergency Department medical staff had completed the online course;

(b) rates of completion of the mandatory one-day, face-to-face session were 29% for the Emergency Department and 23% for paediatric medical staff;

(c) by April 2022, rates of completion of the online course had improved across all staff in both departments; and

(d) completion of the mandatory one-day face-to-face session was at 37% for the Emergency Department and 24% for paediatric medical staff.

13.29 Ms Kylie Whitford, Deputy General Manager, Peel Sector, Hunter New England Health, explained that since early 2020, all face-to-face training across NSW Health had ceased due to the COVID-19 pandemic, and completion of online training had also proved difficult due to ongoing staff shortages.

13.30 **Conclusions:** It is evident that since 2018 significant training opportunities in the area of child protection have been provided to emergency department and paediatric staff at Tamworth Hospital. However, completion rates for such training appear to be relatively low, due in part to restrictions caused by the COVID-19 pandemic and staff shortages. Notwithstanding, higher completion rates for such training will greatly assist with good clinical practice and service delivery to paediatric patients and their families. It is therefore necessary to make the following recommendation.

13.31 **Recommendation:** I recommend to the Chief Executive Officer, Hunter New England Local Health District, that urgent consideration be given to prioritising completion of Child Protection Training for firstly, paediatric medical staff and secondly, for emergency department medical staff at Tamworth Base Hospital.

### *Policy changes relating to the acute management of head injury in children*

13.32 In November 2020, Paediatric Clinical Guidelines were issued state-wide as part of a Paediatric Improvement Collaborative. The Paediatric Clinical Guidelines replaced the previous state-wide Child Protection Policy Directive and Clinical Practice Guideline. This was the result of a tri-state initiative between New South Wales, Victoria and Queensland aimed at reducing variation in the management of paediatric patients. The Paediatric Clinical Practice Guidelines are now hosted on the Royal Children's Hospital Melbourne website. Dr Tzioumi considered the Paediatric Clinical Guidelines to be an improvement on the previous Child Protection Policy Directive for their ease of use, with links embedded through the narrative of the guidelines.

13.33 Relevantly, the Paediatric Clinical Guidelines provide for an initial assessment of a child patient based on the modified Glasgow Coma Scale, which then assists in the classification of patients into different categories depending on the severity of the head injury. Clinicians are directed to consider various risk factors when differentiating between types of head injuries, including suspected child abuse as a risk factor. This highlights that the Paediatric Clinical Guidelines on "*head injury*" are not limited to suspected inflicted head injuries or non-accidental head injuries.

13.34 Since Baylen's death, there has been further research into a correlation between where a bruise is located on a young child and the likelihood that the child has been exposed to physical abuse.

13.35 Earlier research had resulted in the clinical decision "rule" called *TEN-4*, where T stands for trunk or torso, E stands for ears, N stands for neck and 4 stands for under four years or four months. The rule operated so that if a child under four years had bruising in any of those areas a clinician should have

a heightened suspicion for child abuse. The same applied if an infant under four months had any bruising at all.

13.36 Further research added an additional mnemonic, *FACESp*, where F stands for frenulum (the piece of skin inside the upper lip), A stands for angle of the jaw, C stands for cheeks, E stands for eyelid, S stands for subconjunctivae (little haemorrhages on the white part of the eye) and P stands for patterned bruising. The research found such a clinical decision rule had both high sensitivity (a low number of false negatives) and high specificity (a low number of false positives) in successfully identifying cases of child abuse and is reflected in the new guidelines. TEN-4 FACESp is incorporated into the Paediatric Clinical Guidelines under the heading "*Child Abuse*".

13.37 Dr Tzoumi explained the application of the TEN-4-FACESp, which is described as a clinical decision rule in this way:

> It's what we called in lay terms a red flag. So if you have a child present to the emergency department and has one of these types of bruises, that's one of what's called, in med decision, differential diagnosis. You've got to think of that possibility.

13.38 Dr Tzioumi went on to explain that whilst the Child Protection Policy Directive was quite emphatic in its terms providing that an infant or young child with a suspicious head injury should be referred immediately to a tertiary centre, the Paediatric Clinical Guidelines are less definitive. That is, the terms of the Paediatric Clinical Guidelines invite consideration of consultation with a local paediatric or paediatric neurosurgical team, and consideration of transfer to a tertiary paediatric hospital.

13.39 Dr Tzioumi was understandably unable to measure the impact of such a change but expressed concern that the change would result in children not being as readily transferred to a tertiary centre. Dr Tzioumi described the importance of a tertiary centre in this way:

> The tertiary centre, because they've got the child protection teams, they can do a more thorough forensic assessment of the injury and produce a medical legal report, like we have in this case, where general paediatricians in smaller country based services don't have that level of expertise, and that has caused some difficulties in the legal system. As far as I'm aware, prior to the rescinded policy practice guideline being replaced, so the reason it was put in, in this is to get, to reduce variation in the forensic approach, or the forensic opinions I should say.

13.40 Dr Tzioumi also gave evidence about current proposals to introduce a state-wide document:

> Yes, we're in the process of developing local clinical guidelines for the management of physical abuse and neglect cases. It will be sitting on the intranet of Sydney Children's Hospital network, but it's not there yet. But that's part - and we need to address this specific question.

13.41 **Conclusions:** Having regard to the evidence given by Dr Tzioumi regarding the differences in approach between policies, the importance of referral to a tertiary paediatric centre for child patients with a suspicious head injury and initiatives to develop local clinical guidelines to assist with the management of such patients, it is necessary to make the following recommendations.

13.42 **Recommendation:** I recommend that a copy of the findings in the *Inquest into the death of Baylen Pendergast* be forwarded to NSW Health for consideration by the Child Protection and Wellbeing Unit in the development of any NSW specific guidelines regarding management of physical abuse and neglect cases involving children and young people.

13.43 As at November 2022, some formalised training regarding the Paediatric Clinical Guidelines was due to take place at Tamworth Hospital that month. However, this too was affected by delays associated with the COVID-19 pandemic. Ms Whitford gave evidence expressing uncertainty regarding the current status of the Head Injury Procedure related to the now rescinded state-wide Policy Directive.

13.44 The Head Injury Procedure usefully included access to a fact sheet available online containing information for parents and caregivers of a child with a head injury. Ms Whitford was unable to confirm whether similar information sheets referenced on the Royal Children's Hospital Melbourne website, or the fact sheets referred to in the Head Injury Procedure were currently being used at Tamworth Hospital. Ms Whitford expressed hope that such a parent information sheet would be provided to all parents and caregivers but expressed a belief that this was only done on a "*case by case basis*".

13.45 **Conclusion:** Providing parents and caregivers of a child with a head injury with information regarding how to recognise symptoms that may require further medical management provides an additional layer of protection upon the discharge of a child from hospital. It is therefore necessary to make the following recommendations.

13.46 **Recommendation:** I recommend to the Chief Executive Officer, Hunter New England Local Health District, that appropriate steps are taken to confirm or ensure that parents and caregivers of children presenting with head injury are being provided with appropriate fact sheets or handouts explaining what symptoms they should be particularly alert for upon discharge and what to do if such symptoms arise.

13.47 **Recommendation:** I recommend to the Chief Executive Officer, Hunter New England Local Health District, that urgent consideration be given to prioritising the completion of Paediatric Clinical Guidelines training for paediatric medical staff, if same has not already completed.

## 14. Was the decision to allow Baylen to leave the hospital on a gate pass appropriate?

14.1 Graeme Kershaw, Manager of Medical Services, Tamworth Hospital, confirmed that there was no formal process, policy or written procedural guidance for the allocation or management of gate passes in November 2013. Dr Khan explained the concept of a gate pass in this way:

> Gate pass is a practice which has been there for - in part of paediatrics for many years, and I realise that - when I look back now there has not been - there has never been a policy, I think Tamworth Hospital may have been one of the first one to develop the policy in 2015 June, and note there is a policy in Sydney Children's Hospital in November 2015, but it's been there to help the families. It is - it does not mean that we are clinically worried.
>
> If just - it's an option given to the parents, because when we have sent children home for - medically well, and I have no concerns about the medical condition, it is just one of the things, it lowers the threshold for the parents to come back directly to the ward. One of the things - it's a convenience to the parents.

14.2 Professor Besser gave evidence that he is not critical of the decision to release Baylen on a gate pass provided that "*an MRI scan was going to be organised*".

14.3 Dr Tzioumi expressed her view about the gate pass in this way:

> Again, if we take it in isolation and say clinically was a gate pass reasonable, yes. However, if you, if you add to the clinical context the concern that this might be abusive injuries, then no. So you can see it depends how the clinicians at Tamworth were thinking at the time or whether or not they were reassured enough that they didn't have any concerns about child abuse. If that question had sort of been cleared from their minds, if you like, then I think it's, you know, just as a clinician it's reasonable. But if you have that suspicion or concern of worry, then it's not a safe thing to do. So it depends again how their team, the paediatric team, felt at that point. It's hard for me to say.

14.4 **Conclusions:** On one view, given Baylen's apparent improvement during the course of his admission, his clinical presentation at the time he left hospital, and the view formulated regarding whether his presentation was suspicious for non-accidental injury, it was appropriate to allow him to leave hospital on a gate pass. However, it should be emphasised that the view formulated by Dr Khan was premised on information that was unclear. As noted above, the neurosurgical consult with John Hunter Hospital did not result in clear advice regarding confirmation of a right occipital fracture, or advice which could inform a definitive decision regarding performance of an MRI or other investigations.

14.5 Instead, the decision to allow Baylen to leave hospital on a gate pass was premised on Dr Khan's conclusion about the likelihood of an accessory suture being seen on the CT scan. The relatively low threshold set by the Head Injury Guidelines for suspicion of non-accidental injury and the evidence of Dr Tzioumi suggests that sufficient concern should have existed for at least a consultation to occur with a tertiary paediatric centre before Baylen was allowed to leave on a gate pass. However, it is acknowledged that Dr Tzioumi expressed difficulty reaching a definite view, even with the benefit of hindsight, as to whether there was a sufficient level of reassurance against the possibility of non-accidental injury for Baylen to leave hospital on a gate pass.

### *Policy changes relating to provisional discharge*

14.6 Ms Whitford gave evidence that in conjunction with the HNE *Health Policy Compliance Procedure Approved Leave of Absence for Patients* (released in March 2016) (**Approved Leave Procedure**), the use of the *Paediatric Admitted Patient Leave and Provisional Discharge Patient Information and Leave* form has been adopted as standard procedure. Ms Whitford explained that the provisional discharge or leave of an admitted patient from the paediatric ward occurs only in specific circumstances which are clinically determined by the treating team. The provisional discharge is usually indicated for children and young people who are candidates for Hospital in the Home services.

14.7 Ms Whitford explained the difference between the two services in this way:

> So, sometimes if a patient needs to leave for a particular reason, there might be a family event or something that they might need to go to that - or an appointment or something else, we might have their plan that they leave for a short period of time or a period of time and then come back. And other times, it might be that they're trialling possible discharge, so there might be some things that they're putting in place in the home that we'll see whether or not that works for, for the child to be able to return home.

14.8 Relevantly, the provisional discharge form requires consent from a parent or guardian that if their child becomes more unwell they are to be returned to hospital for review. However if the child remains well, the parent/guardian is instructed to call the children's ward to receive any further discharge instructions within 24 hours.

14.9 The Approved Leave Procedure contains a number of additional safeguards:

(a) all patient leave from a HNELHD facility needs to be approved by a Medical Officer prior to discharge, with this approval to be documented;

(b) medical officers are also required to separately document in the patient's health care record evidence that a discussion regarding the potential risks to both patient and carer that may arise from temporary leave has taken place; and

(c) the person responsible for a child on approved leave must be actively followed-up if a child does not return following the agreed period of leave and HNELHD staff are concerned about any risk to the child's health, safety or welfare.

14.10 Further, Ms Whitford gave evidence that nurses at each handover should check whether contact has been made with a child's parents when the child is on provisional leave. If the child has not returned at the time required, it should be picked up at the handover most proximate to the child's scheduled return time. Failing this, it should be picked up the next morning in the context of morning rounds with the broader medical team.

14.11 Ms Whitford gave evidence that she could not advise how the parent or carer of a patient on provisional discharge would know that their child's discharge summary would be provided to their general practitioner. However, Ms Whitford gave evidence that some follow up is conducted:

> I understand that there's regular checking by the person that oversees the junior team to make sure that those discharge summaries are sent out and is - yeah.

14.12 **Conclusion:** Relevant improvements have been made to the process by which child patients are discharged from hospitals within the HNELHD. Procedures now exist to ensure that advice and instructions provided to parents and carers are appropriately documented and that patients are appropriately followed up after being provisionally discharged.

14.13 Provision of discharge summaries to a patient's general practitioner ensures that healthcare providers within the community are accurately informed of the circumstances surrounding a child's presentation to hospital. This information informs ongoing management of the child within the community. As the evidence is unclear as to the extent to which such discharge summaries are provided, the following recommendation is necessary.

14.14 **Recommendation:** I recommend to the Chief Executive Officer, Hunter New England Local Health District that an audit be conducted of the completion of discharge summaries, and the provision of discharge summaries to general practitioners, to ensure that such summaries are being completed and provided in a timely manner following discharge of a paediatric patient.

## 15. Was there appropriate follow-up by clinical staff after Baylen's release from the hospital on a gate pass?

15.1 Dr Khan explained the process in this way:

> The process with the gate pass is that the parents elect to either come back at the time that has been designated, they call, or if they don't call the nursing - one of the nursing staff will call them, and then that discharge process is completed.

15.2 Dr Hope also described the follow-up process:

> The gate pass is - documentation of the gate pass is actually part of the clinical notes and forms that sticker that was referred to earlier with terms and conditions, but as part of the handover, it's important that because the patient is still admitted under the treating team, that we are aware of them should they need to return or phone with a question […]
> […]
> I don't think I've ever seen anything written down about what handover or the expectations are of the handover sheet as such. So I'm speaking from experience and my understanding of what is safe practice, but I'm not sure if there is a document that determines what happens with gate pass patients on handover.

15.3 Ms Merlin describes speaking with someone from Tamworth Hospital on 25 November 2013 after Baylen was allowed to leave on a gate pass. However, this reported contact was not documented and no contemporaneous record of this reported contact exists.

15.4 However, what is known is that Dr Khan contacted Ms Merlin on 28 November 2013 because he considered that there had been no follow-up after Baylen had left hospital on a gate pass. Dr Khan was reportedly informed that Baylen had been reviewed by his general practitioner and was not displaying any symptoms that warranted a return to hospital.

15.5 **Conclusions:** There is no documented evidence to confirm that any contact took place between Ms Merlin and a Tamworth Hospital staff member on 25 November 2013. Therefore, it is not known whether any such contact occurred. Further, even if this contact occurred it is not known what was discussed and, relevantly, whether any information was disclosed by Ms Merlin which suggested that Baylen should return to hospital.

15.6 The only confirmed follow-up occurred on 28 November 2013 when Dr Khan called Ms Merlin. This occurred because Dr Khan was either not informed or not aware of the reported contact on 25 November 2013. Either way, it occurred five days after follow-up was due.

15.7 Therefore, the evidence establishes that no appropriate follow-up with Baylen was conducted after he left hospital on a gate pass because any purported follow-up was not documented, Dr Khan was not aware or not informed of any such earlier follow-up, or because there was an explained delay in recognising that no follow-up had occurred.

## 16. Were Baylen's carers given appropriate advice about his condition and possible precautions when Baylen left the Hospital?

16.1 A Discharge Checklist was not completed for Baylen at any time. This Checklist contained important information such as whether:

(a) discharge precautions were given to Baylen's parents/carers;

(b) follow up referrals/appointments had been organised;

(c) notification of discharge had been given to relevant community health professionals where consent was given by Baylen's parents; and

(d) education was provided to Baylen's parents/carers in relation to matters such as "*specific precautions*" and whether they were "*able to state signs and symptoms requiring follow up*" as nominated on the Checklist.

16.2 As the Checklist was not completed, it is not clear what advice was provided to Ms Merlin. However it seems evident that advice about Baylen's condition and possible precautions regarding his care were either not made clear to Ms Merlin, or she did not appreciate the significance of symptoms such as vomiting which ought to have prompted follow-up at hospital. It also seems evident that Mr Pendergast was not provided with any such advice or guidance directly from the hospital and that his awareness of such matters came from what he was told by Ms Merlin.

16.3 **Conclusions:** As a Discharge Checklist for Baylen was not completed, his parents and carers were not given appropriate advice about his condition and possible precautions to be taken after leaving hospital. In the absence of a completed Checklist it is unclear whether Ms Merlin was provided with adequate advice about recognising symptoms in Baylen that might require medical follow up or a return to hospital. It is also unclear whether steps were taken to ensure that Ms Merlin understood and appreciated the significance of any advice given to her. No such advice was provided to Mr Pendergast and so he was even less informed of the circumstances in which Baylen might require follow up or a return to hospital.

## 17. Other changes and improvements following Baylen's death

### *Handover of care of injured children and communication of the history of injuries*

17.1 Both nursing and medical staff in the Emergency Department at Tamworth Hospital are now required to fully complete the Emergency Department Observation Chart (**EDOC**). The EDOC includes a risk assessment section for injury/neglect with affirmative answers to a series of questions prompting a staff member completing the EDOC to activate local child protection procedures, including by reference to the MRG. Audits carried out to monitor compliance with the EDOC show a high completion rate for nursing staff with a need for similarly high completion rates for medical staff, particularly those that work in paediatrics.

17.2 Ms Whitford also stated that since April 2022 morning and afternoon handovers have utilised a *Paediatric Ward Handover Sheet*, which contains key information relating to child patients, including any risks identified for such patients.

### *Interpretation of imaging*

17.3 At the time she gave her evidence, Ms Whitford expressed her belief that overseas-based radiologists are no longer used at Tamworth Hospital to interpret CT results but was unable to provide specific details of any such arrangements. A subsequent enquiry with the HNELHD has revealed that radiology services at Tamworth Hospital are now provided by a company called LUMUS, which provides onsite radiologists and remote reporting of images both in and out of hours. While LUMUS provides the majority of coverage throughout the 24-hour day, it has a sub-contract with Everlight Radiology, which provides services primarily between 10:00pm and 8:00am. Radiologists employed by Everlight Radiology may be based overseas, although are required to be Accredited Radiologists by the Royal Australian and New Zealand College of Radiologists.

17.4 Whilst is apparent that remote reporting arrangements still exist at Tamworth Hospital in some circumstances, increased local reporting suggests that any communication between the reporting radiologist and treating teams can be more easily and readily facilitated.

17.5 Dr Tzioumi gave evidence as to the current significant shortage of paediatric radiologists in New South Wales and the difference between a tertiary hospital in Sydney and a regional hospital:

> I, in my work - where I work in the tertiary hospital who is well resourced, when I get consulted about children in other localities, to find a radiologist, one of our own paediatric radiologists, that has the time to sit down with me and go through the scan to say, you know, I review the scan but I'm not a radiologist, and I may see something or somebody else has raised a question, I say, "Can you tell me?", and they do it from their goodness of their heart, literally. Because they are really, extremely busy, and they won't officially report on scans done elsewhere. They say they don't have capacity.
> […]
> So it's, it's a very tricky State wide problem.
> […]
> I know for New South Wales it is. We've been aware for some time this is a critical workforce issue.

17.6 Separately, an MRI machine has been installed at Tamworth Hospital and has been operational since 1 February 2018. While planned MRIs are performed during business hours on a weekday, Tamworth Hospital does have 24-hour anaesthetist coverage together with radiographers on site or able to be called in such that an MRI can be conducted as a matter of urgency if required.

### *Additional staffing*

17.7 Since April 2018, a social worker has been appointed to the Tamworth Hospital Emergency Department, working 8:30am to 5:00pm on weekdays. This represents a significant development, noting there were no social workers dedicated to the Emergency Department at the time of Baylen's death.

17.8 Dr Tzioumi highlighted the importance of this improvement:

> The paediatricians, like myself, we are all trained right from when we are students to take a social history. So we can ask about the family constellation; who is in the family, how many children, all those issues. But a social worker, that's what they are trained to do. They go more in-depth and obviously can sometimes be able to discover more vulnerable families, to say, you know, that, just other than this is a family with two or three children, two parents, there are these extra stressors on this family. So they've got that expertise. And I've worked with social workers in the multi-disciplinary team for over 20 years and I'm still amazed how, when they ask the question, the way they asked it and they frame their perspective elicits different answers to the way a doctor asks the questions. So it's not impossible for a doctor to take a good social history, that's what I'm saying, you, you can and you're trained, but the social worker brings that expertise and in-depth understanding.

17.9 The following improvements in staffing have also occurred:

(a) the introduction of a weekend social work service;

(b) as at November 2022, a full time senior social worker for the Emergency Department was being recruited to work with the current social worker and provide an extension to the hours of cover during the week and on weekends;

(c) a key accountability of the social worker position is to assist in the delivery of child protection training to staff; and

(d) an additional full-time social worker had also been retained by the Paediatrics and Maternity Department to complement the existing full-time social worker in that area.

17.10 On 1 November 2022, a trial of the psychosocial crisis support service, Violence Abuse and Neglect, was commenced at Tamworth Hospital Emergency Department to complement the existing day-time support already in place. This service is staffed by social workers, psychologists and others with counselling qualifications who run a 24-hour a day call-in service, and can come in to the Emergency Department if required.

17.11 Ms Whitford also highlighted the development of “Safety Action Meetings” and “Safe Start Meetings” which focus on child protection issues associated with domestic violence, and the early identification of risk factors in pregnant women. Nurses are also required to complete a “Paediatric Risk Assessment” form upon a child’s admission to a ward from the Emergency Department, which prompts consideration of child protection issues. Completion of such forms are then subject to an audit.

## 18. Findings pursuant to section 81(1) of the Act

18.1 Before turning to the findings that I am required to make, I would like to acknowledge, and express my gratitude to Ms Donna Ward SC and Ms Amber Richards, Counsel Assisting, and their instructing solicitors, Mr James Herrington and Ms Taylor Bird of the Crown Solicitor's Office. I am also grateful to previous Counsel Assisting in this matter, the Honourable Justice Dhanji and Mr Nick Kelly.

18.2 The entire Assisting Team has provided enormous assistance and shown remarkable dedication during the entire coronial investigation and inquest process. They have shown dedication, meticulousness, sensitivity and empathy at all times.

18.3 I also acknowledge the assistance of Detective Senior Graham Goodwin for his similar dedication throughout the course of the investigation and for his efforts in preparing the initial comprehensive brief of evidence.

18.4 The findings I make under section 81(1) of the Act are:

*Identity*

The person who died was Baylen Pendergast.

*Date of death*

Baylen died on 30 November 2013.

*Place of death*

Baylen died at the Sydney Children's Hospital, Randwick NSW 2031.

*Cause of death*

The cause of Baylen's death was complications of blunt head injury resulting from at least two separate acts of trauma. It is most likely that these acts of trauma occurred on 17 and 28 November 2013. Any contribution to death arising from the injuries sustained on 17 November 2013 cannot be entirely excluded. However the traumatic event on 28 November 2013 alone was sufficient to cause death. This latter incident involved the application of significant non-accidental force that was sufficient to cause the left-sided subdural haematoma, the laceration of the dorsal splenium and retinal haemorrhages.

*Manner of death*

The expert medical evidence establishes that it is most likely that Baylen's injuries were not the result of accident or misadventure. Rather, the injuries were the result of the application of significant force by another person or persons. However, the mechanism by which this force was applied cannot be established on the available evidence.

## 19. Epilogue

19.1 Baylen had enormous love for his family and those closest to him. Equally, their love for Baylen cannot be measured, nor can the depth of the loss that they continue to experience be described.

19.2 It is truly heartbreaking to know that Baylen's life ended at such a young age. But all of Baylen's family know of the joy that this special, little boy brought to their lives. In the words of Baylen's father, Baylen is forever in their hearts and souls.

19.3 On behalf of the Coroners Court of New South Wales and the Assisting Team, I offer my deepest sympathies and respectful condolences to Baylen's family and all those who have personally felt the joy that Baylen brought to their lives.

19.4 I close this inquest.

Magistrate Derek Lee
Deputy State Coroner
23 June 2023
Coroners Court of New South Wales

**Inquest into the death of Baylen Pendergast**

**Appendix A**

**Recommendations made pursuant to section 82, *Coroners Act 2009***

*To the Chief Executive Officer, Hunter New England Local Health District*,

I recommend that:

1. urgent consideration be given to prioritising completion of Child Protection Training for firstly, paediatric medical staff and secondly, for emergency department medical staff at Tamworth Base Hospital;

2. appropriate steps are taken to confirm or ensure that parents and caregivers of children presenting with head injury are being provided with appropriate fact sheets or handouts explaining what symptoms they should be particularly alert for upon discharge and what to do if such symptoms arise;

3. urgent consideration be given to prioritising the completion of Paediatric Clinical Guidelines training for paediatric medical staff, if same has not already completed; and

4. an audit be conducted of the completion of discharge summaries, and the provision of discharge summaries to general practitioners, to ensure that such summaries are being completed and provided in a timely manner following discharge of a paediatric patient.

I also recommend that a copy of the findings in the *Inquest into the death of Baylen Pendergast* be forwarded to NSW Health for consideration by the Child Protection and Wellbeing Unit in the development of any NSW specific guidelines regarding management of physical abuse and neglect cases involving children and young people.

Magistrate Derek Lee
Deputy State Coroner
23 June 2023
Coroners Court of New South Wales