IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2020 004720

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

*Section 67 of the **Coroners Act 2008***

Amended pursuant to section 76(a) of the ***Coroners Act 2008***, as at 16 September 2022

Findings of:	Coroner David Ryan
Deceased:	Child C
Date of birth:	10 March 2018
Date of death:	27 August 2020
Cause of death:	1(a) Drowning
Place of death:	Regional Victoria

INTRODUCTION

1. On 27 August 2020, Child C was two years old when he drowned in a dam on the rural property where he lived in Regional Victoria. At the time of his passing, Child C lived with his parents, JQ (who is Indigenous)[1] and AT, and his half-sibling Child M. AT's father also lived in a separate house on the property. Up until shortly prior to his passing, when they went to live with their father and his partner, Child C's other half-siblings, Child K and Child F, also lived at Regional Victoria.

BACKGROUND

2. Child C was born on 10 March 2018. He was the subject of six reports to Child Protection relating to ongoing concerns involving neglect, alleged exposure to parental substance abuse, mental health issues and cumulative harm. The first five reports were closed at the intake stage with four community referrals. The last report to Child Protection was received on 17 June 2020 and was open in the protective intervention phase at the time of Child C's passing.

3. Between 2011 and 2017, Child Protection had also received several reports about Child C's half-siblings, including a report in relation to Child M who nearly drowned in a dam on a neighbour's property when he was 3 years old.

4. Child C's parents had a poor history of engagement with Child Protection and community organisations which made service delivery very challenging.

THE CORONIAL INVESTIGATION

5. Child C's passing was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Passings that are unexpected, unnatural or violent, or result from accident or injury are reportable to the coroner.

6. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

[1] The word 'Indigenous' has been capitalised to reflect the appropriate and respectful manner of referring to First Nations People.

7. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

8. Section 7 of the Act provides that a coroner should liaise with other investigative authorities, official bodies or statutory officers to avoid unnecessary duplication of inquiries and investigations and to expedite the investigation of deaths. The Commission for Children and Young People (**the Commission**) conducted an investigation into Child C's passing and prepared a Child Investigation Report (**CDI Report**) dated 9 December 2021 which contained a number of findings and recommendations.

9. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Child C's passing. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians, investigating officers and practitioners from the Department of Fairness, Families & Housing (**DFFH**) – and submitted a coronial brief of evidence.

10. On 16 March 2022, I conducted a mention hearing in Court to discuss the findings and recommendations of the CDI report with representatives of DFFH. The DFFH subsequently provided a further statement to the Court on 27 April 2022.

11. This finding draws on the totality of the coronial investigation into Child C's passing including evidence contained in the coronial brief, the CDI Report and the further statement from DFFH. While I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[1]

[1] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Circumstances in which the death occurred

12. At around 2.00pm on 27 August 2020, Child C fell asleep on the couch at home with his mother.[2] When she later woke at about 5.00pm,[3] Child C was no longer with her and she noted that *"the front door of our house was open and it was closed before I had fallen asleep."*[4] AT alerted JQ and Child M, who had also been asleep, and together they searched the house and the surrounding property. They were joined by AT's father.[5]

13. A short time later, Child C was found in a dam on the property by Child M. He was unresponsive and Child M carried him toward the house where he was met by his mother and then his grandfather. His grandfather commenced cardiopulmonary resuscitation (**CPR**) while AT contacted emergency services.[6] Victoria Police and Ambulance Victoria paramedics were despatched at about 5.30pm and subsequently arrived at about 5.41pm with an ambulance helicopter also arriving at 6.03pm.[7] Paramedics took over the performance of CPR and despite their best efforts, Child C was not able to be revived and resuscitation was ceased at 6.23pm.[8]

Identity of the deceased

14. On 27 August 2020, Child C, born 10 March 2018, was visually identified by his mother, AT.

15. Identity is not in dispute and requires no further investigation.

Medical cause of death

16. Forensic Pathologist Dr Brian Beer from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an examination on 28 August 2020 and provided a written report of his findings dated 1 September 2020.

17. Dr Beer reviewed a post-mortem computed tomography (**CT**) scan, which did not reveal any fractures of any evidence of skeletal injury.

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2 Statement of AT dated 14 December 2020.
3 Statement of JQ dated 14 December 2020; Statement of Detective Senior Constable Bianca Cola dated 7 January 2021.
4 Statement of AT dated 14 December 2020.
5 Statement of AT dated 14 December 2020.
6 Statement of AT dated 14 December 2020; Statement of AT's father dated 12 December 2020.
7 Statement of Senior Constable Michael Balazs dated 14 December 2020; Statement of Michaela Malcolm dated 21 February 2021.
8 Statement of Michaela Malcolm dated 21 February 2021.

18. Toxicological analysis of post-mortem samples did not identify the presence of any alcohol or any commons drugs or poisons.

19. Dr Beer provided an opinion that the medical cause of death was 1 (a) Drowning.

20. I accept Dr Beer's opinion.

INVOLVEMENT OF CHILD PROTECTION

21. Statements were obtained from the Director of Child Protection, a manager of Child & Family Services with Anglicare Victoria, and a Family Support Worker at the Bendigo and District Aboriginal Co-operative (**BDAC**), which summarised Child C's involvement with Child Protection and family services.[9]

The First Report

22. On 8 February 2018, Child Protection received an "*unborn report*" in relation to Child C and the three half-siblings who were living with his parents at the time. The report raised concerns that Child C's half-siblings were not being provided with adequate food and water and that their hygiene was poor. Further, the report alleged ice[10] had been used at the property.

23. Child Protection contacted the school where Child C's half-siblings attended and were informed that, although there had been a couple of occasions where the school had provided breakfast, it had no concerns that the children were being neglected. On 20 February 2018, Child Protection considered that the concerns would be best managed in the community and referred the matter to ChildFIRST[11] for follow up and support before closing the report.

24. ChildFIRST closed the referral after noting that Child Protection had investigated the same issues in October 2017 and had found no concerns. They forwarded a letter to Child C's mother advising of the support available should it be required.

[9] Statement of Damian Worley dated 20 January 2021; Statement from BDAC staff member dated 16 March 2021; Statement of Paula West dated 11 April 2022.
[10] Crystal methamphetamine.
[11] ChildFIRST is a community based intake program that receives referrals where there may have been a concern relating to a child and/or families' welfare or wellbeing. Referrals are received from Child Protection and other community based services. Such referrals in the Loddon region are now received through The Orange Door (see para 51).

The Second Report

25. On 7 June 2018, Child Protection received a report in relation to Child C and the three half-siblings who were living with his parents at the time. The report raised concerns regarding environmental neglect and that Child C's parents were using drugs.

26. Child Protection again contacted the school where Child C's half-siblings attended and were informed that the children presented in a clean uniform, were not "*malodorous*" and that their mother had never been observed by staff to be substance affected. The school reported no significant concerns for the children. On 12 June 2018, Victoria Police advised that Child C's parents were not known to police and no substance related matters were recorded on its system. On 13 June 2018, although the school having to provide food was an ongoing issue, Child Protection closed the report as the children were not assessed to be at significant risk.

The Third Report

27. On 6 May 2019, Child Protection received a report in relation to Child C and the three half-siblings who were living with his parents at the time. The report raised concerns regarding environmental and medical neglect, specifically that the children were not being regularly bathed or provided with regular meals and their mother had not followed up with medical appointments in relation to some of Child C's half-siblings. Further, it was reported that the house was a mess and littered with rubbish piled high.

28. On 7 May 2019, Child Protection contacted the school where Child C's half-siblings attended and were informed that they had not been recently attending and the principal had visited the home to speak with their mother but there had been nobody home. The school advised that although there were some academic concerns, there were no significant concerns in relation to the children's appearance or hygiene. Child Protection also contacted the local Maternal and Child Health Nurses who advised that Child C was not connected with their services. On 17 May 2019, Child Protection considered that the concerns would be best managed in the community and referred the matter to ChildFIRST for follow up and support before closing the report.

The Fourth Report

29. On 17 January 2020, Child Protection received a report in relation to Child C and the three half-siblings who were living with his parents at the time. The report raised concerns regarding environmental neglect alleging that the children had untreated head lice, that there were wasps and mice around the family home, and that the children were not showering frequently or provided with sufficient meals.

30. Child Protection contacted the local Maternal and Child Health Nurses who advised that Child C was still not connected with their services. On 21 January 2020, Child Protection obtained an update from ChildFIRST, who advised that their last involvement with the family was in May 2019 (after the third report) where they had been unsuccessful in contacting the family despite a number of attempts including a home visit. After consulting with a Community Based Senior Child Protection Practitioner (**CBSCPP**),[12] ChildFIRST closed the referral. They were also contacted by the children's school in June 2019 who advised that the children had returned to school, were presenting as neat and tidy and had been bringing their lunch to school. The school advised that they would continue to support the family and refer the matter back to ChildFIRST if required. On 28 January 2020, Child Protection closed the report after making an enhanced referral to ChildFIRST to support a longer period of community involvement.

The Fifth Report

31. On 28 February 2020, Child Protection received a report that raised concerns regarding a lack of appropriate supervision and parenting capacity. Child C was located by his half-siblings walking along the highway, unsupervised, with the family dog, and wearing only a nappy. They then took him on the school bus to their school, where he was fed by staff and then returned home.

32. Later on 28 February 2020, Child Protection followed up with ChildFIRST who advised that they had conducted a home visit on 4 February 2020, but the family had not been home. They subsequently arranged a welfare check by Victoria Police, who sighted the children and no concerns were raised. ChildFIRST consulted with a CBSCPP, who advised that the concerns did not warrant a Child Protection investigation. They then closed the enhanced referral that

[12] Section 38 of the *Children, Youth and Families Act 2005* permits ChildFIRST practitioners and family services to consult with senior Child Protection practitioners about children and family referred to their services and these consultations are recorded on the Child Protection (**CRIS**) file.

had been made in response to the fourth report. ChildFIRST noted in their file at that time that should a further report be made to Child Protection, investigation was recommended.

33. Also on 28 February 2020, Child Protection requested a further welfare check by Victoria Police who subsequently spoke with Child C's mother about the incident. Her explanation was that she had been asleep and had no idea that the other children had taken Child C. Police noted that the house was very messy with junk piled up at the door and ants crawling around everywhere.

34. On 10 March 2020, after consultation with Community Based Child Protection, Child Protection determined that it was appropriate to make a further enhanced referral to ChildFIRST given that Child C's mother had not been aware of his whereabouts for a significant period of time. On 17 March 2020, a CBSCPP and ChildFIRST visited the home and spoke with Child C's mother who disclosed that Child C and his father identified as Indigenous[2] and agreed to engage with family services. Child Protection then closed the report and on 27 March 2020, the family was referred to BDAC.

35. BDAC had difficulty engaging with the family throughout April and May 2020 and arranged to consult with a CBSCPP to discuss their concerns. The consultation was completed after BDAC staff visited the home on 1 June 2020. Although they were unable to enter the home due to COVID-19 restrictions, the children were observed through the front door and windows and the parents agreed to engage with BDAC. In response to inquiries as to why Child C's mother was not answering BDAC's calls, she advised that she was having issues with her mobile phone. BDAC offered to purchase her a new phone but she declined and provided an email address her preferred method of contact.

The Sixth Report

36. On 17 June 2020, Child Protection received a report in relation to Child C and the three half-siblings who were living with his parents at the time. The report raised concerns about the children's poor school attendance, home environment and parenting capacity. On 2 July 2020, Child Protection obtained an update from BDAC who advised that Child C's parents had not been engaging with the service. BDAC conducted an unannounced home visit on 29 June 2020 at 10.30am and it had taken some time before they could speak with Child C's mother as she had been asleep. She confirmed that she had not responded to any of BDAC's emails and provided JQ's mobile number when asked if there was any other way for them to be contacted.

[2] The word 'Indigenous' has been capitalised to reflect the appropriate and respectful manner of referring to First Nations People.

37. BDAC advised Child C's mother that she needed to engage with the service or they would close the referral due to lack of engagement and advise Child Protection. They did not sight any children during the visit. BDAC noted their concern that the children were not being supervised and that a dam next to the house was not fenced. Child C's mother advised that the children would go in the dam in summer and they would be supervised "*sometimes*".

38. On 10 July 2020, Child Protection conducted an unannounced visit at the property. Child C's mother denied the allegations that the children were not attending school. Staff were unable to inspect the home as Child C's mother stated that it was being treated for a mouse infestation and in the meantime they were staying in her father's house on the property. Child Protection inspected her father's home which revealed no concerns. Child C's mother advised that Child C had not had any immunisations since he was 6 months old as he did not have a Medicare Card and that she had not taken him to his two-year appointment at the Maternity Child Health Nurse.

39. On 10 July 2020, following the home visit, Child Protection had a consultation with BDAC and assessed that further investigation was required with planned follow-up with BDAC, the school and the Maternity Child Health Nurse and a further home visit to sight the home environment and interview the children.

40. On 16 July 2020, Child Protection completed a risk analysis and noted the history of poor parenting capacity, neglect and the likelihood of cumulative harm to the children. It was noted that two of the half-siblings were now living with their father and that Child C was in a particularly vulnerable position because of his age.

41. On 7 August 2020, Child Protection conducted a further visit at the home where they encouraged Child C's mother to engage with family services and to arrange for Child C to be registered with Medicare. Child Protection were advised that Child C had recently attended the Maternal Child and Health Nurse for a check-up. They observed that Child C presented as happy and appropriately dressed and that his interactions with his parents appeared appropriate.

42. On 17 August 2020, BDAC advised Child Protection that Child C's family had failed to engage with the service despite multiple attempts to contact them.

43. On 28 August 2020, Child Protection was advised that Child C had passed.

REPORT OF THE CHILD AND YOUNG PERSONS COMMISSION

44. The CDI Report made the following findings after investigating Child C's passing:

> "*1. Child Protection closed reports two to five prematurely. Child Protection had a history of involvement with the family and there was sufficient additional concerning information regarding Child C as an infant to proceed to investigation. Despite several indications of significant risk of neglect and cumulative harm, it was not until the sixth report that Child Protection decided to investigate. As a result of Child Protection closing the intake reports, Child C remained at risk of ongoing significant harm as he continued to be exposed to parental risk factors that detrimentally impacted on his safety and wellbeing.*
>
> *2. Child Protection did not sufficiently acknowledge or respond promptly to physical and environmental risks to Child C at his family home, including lack of parental supervision. Despite the information that Child Protection had about Child C's parents not supervising Child C and leaving him in dangerous circumstances, Child Protection did not take the immediate and necessary action required to ameliorate the risk to Child C. Consequently, Child C was left at significant risk of harm in the absence of effective parental supervision.*
>
> *3. Child Protection did not consistently follow up unsuccessful referrals to ChildFIRST and engagement with the Maternal and Child Health Service following each report. In the absence of child health monitoring and effective family support, protective risks for Child C remained significant and unchanged.*"

45. As a preface to the Commission's recommendations, the CDI Report noted as follows:

> "*This inquiry raises issues relating to poor information sharing and a lack of coordination between Child Protection and ChildFIRST, absence of timely escalation and barriers that prevent ChildFIRST engaging with families.*
>
> *In particular, it raises the practice whereby Child Protection repeatedly closes reports with a referral to ChildFIRST without checking or appearing to consider whether past referrals have been effective.*"

46. The Commission reiterated the following recommendations from past inquires:

> "***Lost, not forgotten: Inquiry into children who died by suicide and were known to Child Protection***
>
> *Recommendation 2*
>
> *That the Department develop, resource and implement a set of standard analytical data sets for ChildFIRST/The Orange Door and IFS to monitor and report on the timelines and effectiveness of their engagement with children and families, including:*
>
> - *time between initial assessment and commencement of case management*
> - *rates of unsuccessful engagement*
> - *referral outcomes*
> - *re-reports.*
>
> ***Inquiry into issues of cumulative harm and suicide in child deaths***
>
> *Recommendation 3.3*
>
> *That the Department amend its procedural requirements for referral and consultation: ChildFIRST/Integrated Family Service (September 2017) to include guidance outlining when cases should be escalated and risk of cumulative harm reviewed, following closure of an enhanced referral to ChildFIRST/Integrated Family Services based on unsuccessful engagement with the family.*"

47. The Commission also made the following recommendation directly as a result of its investigation:

> "*That the Department and ChildFIRST utilise this inquiry to further strengthen practitioners assertively responding to infants particularly in the context of multiple family reports, where neglect and cumulative harm has been an ongoing and entrenched issue.*"

DEPARTMENT'S RESPONSE TO THE CDI REPORT

48. DFFH provided a statement from the Acting Director of the Office of Professional Practice and the Acting Chief Practitioner dated 27 April 2022 which details its response to the CDI Report.

49. The Department stated that it broadly accepts the findings recorded in the CDI Report. It acknowledges, with the benefit of hindsight, that various aspects of Child Protection's practice in relation to Child C's case could have been improved.

50. The Department further acknowledges that the Fifth Report should have been subject to a cumulative harm review with consideration to pattern and history, and lack of meaningful engagement by the family with community services. It noted that a comprehensive file review may have resulted in the report being assessed as requiring an earlier elevation and escalation to investigation to assess the risk posed to Child C.[13] The Department stated that the decision not to conduct a cumulative harm review at the Firth Report was due to the competing needs in managing high levels of demand for Child Protection service, and case reviews were prioritised based upon the level of risks posed to children.

51. The Department set out the changes made in Child Protection practice, policy, training and procedure since Child C's passing, including its response to the recommendations contained in the CDI Report. The improvements and developments identified by the Department include The Orange Door and the SAFER Children Framework.

52. The Orange Door provides an area-based intake, assessment, immediate intervention and connection to other services for individuals and families impacted by family violence, as well as families needing extra support with wellbeing for their children. The Orange Door receives child wellbeing referrals from professionals, as well as people self-referring. The services provided by ChildFIRST are currently being transitioned on a regional basis to The Orange Door.

[13] A protective investigation requires Child Protection to see the child and family and conduct a comprehensive investigation to determine the actual circumstances of the child and whether these circumstances meet the legislative requirements that the child is in need of protection as defined in section 162 of the *Children Youth and Families Act 2005*.

53. The SAFER Children framework became operational on 20 November 2021. It includes a new risk assessment framework designed to strengthen Child Protection practice by supporting and guiding practitioners in the identification and assessment of risk, and planning for the safety, development, needs and wellbeing of individual children within their family culture and community.

Steps taken in relation to Recommendation 2 in Lost, not forgotten: Inquiry into children who died by suicide and were known to Child Protection (2019)

54. The Department advises that it is currently developing an operational data report on family services and family violence which includes ChildFIRST. The report is expected to be completed by June 2022 and will be used to improve oversight and management of services, including referrals to ChildFIRST. The Department is also working to include data from The Orange Door, which is expected to be completed by December 2022.

Steps taken in relation to Recommendation 3.3 onto Inquiry into issues of cumulative harm and suicide in child deaths (2018)

55. The Department advised that the relevant procedural requirements were updated in January 2020 to reflect contemporary practice guidance, including changes which respond to this recommendation. Specifically, they require that, at a minimum, the CBSCPP must be consulted if ChildFIRST is unable to engage the family, and that no enhanced referral can be closed due to non-engagement without prior consultation (section 38 consultation).

56. In the event that there continue to be protective concerns following the section 38 consultation and the family decline support or other services, the CBSCPP may decide to open a report and transfer the child and family to Child Protection services for an investigation.

57. It is noted that these changes to the relevant procedural requirements were in place at the time of the Fifth Report and appear to have been complied with in terms of consultation with the CBSCPP. However, as conceded by the Department, with the benefit of hindsight, this process ought to have resulted in earlier escalation of Child C's case to Child Protection for investigation.

Response to the CDI Report Recommendation

58. The Department's initial response to the CDI recommendation is contained in the CDI Report and included a two-part Child Protection Practice Leadership-Chief Practitioner webinar series, the implementation of the SAFER children framework and two information sessions delivered to the North West Child Protection Intake Practice Leaders by Lakidjeka Aboriginal Child Specialist Advice and Support Service.

59. Since it provided its initial response to the CDI Report, the Department advises that it has updated its risk assessment practice advice contained in the Child Protection Manual which includes a response tool designed to assist practitioners with their infant practice. Also, the second part of the Child Protection Practice Leadership-Chief Practitioner webinar series on Recognising and Responding to Child neglect was held on 14 December 2021, which included a case study addressing themes identified in the Commission's investigation into Child C's passing. The webinar remains available for reference to Child Protection practitioners.

FINDINGS AND CONCLUSION

60. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

    a) the identity of the deceased was Child C, born 10 March 2018;

    b) the death occurred on 27 August 2020 in Regional Victoria , from drowning; and

    c) the death occurred in the circumstances described above.

61. In this investigation, I have avoided duplicating the thorough investigation conducted by the Commission into Child C's passing, which led to recommendations that have been considered and responded to by DFFH and findings which have been broadly accepted.

62. I find that Child C's passing was clearly preventable, with the principal cause being a lack of parental supervision. There was also a failure by Child Protection to adequately assess and appreciate the significant risk associated with Child C's exposure to neglect and cumulative harm and a failure to escalate Child C's case to the investigation phase at an earlier stage of its involvement with him.

63. I am satisfied that the Department has adequately responded to the recommendations in the CDI Report and I do not propose to make any further recommendations as part of this investigation. The effectiveness of the implementation of many of the changes that have occurred in practice and policy since Child C's passing will need to be monitored and assessed by the Department to determine whether they are sufficient to adequately address the risks identified in this case.

COMMENTS

Pursuant to section 67(3) of the Act, I make the following comments connected with the death.

64. This case has highlighted a number of missed opportunities that were available to Child Protection to provide more effective care to a very vulnerable child who was living in an environment of ongoing parental neglect. However, I acknowledge that Child Protection practitioners are engaged in an extremely challenging task on a daily basis and with limited resources. This case demonstrates that they can be required to operate in remote locations while subject to pandemic restrictions and with families who struggle to engage with them.

65. As outlined in the second statement of the Department, the Child Protection program has finite resourcing. It is noted that there are approximately 130,000 intake reports every year, with approximately 25,000 open cases that Child Protection is managing with a workforce of approximately 2,193 staff. This resourcing capacity impacts the delivery of Child Protection services across the State and the limitation is generally greater in rural areas, where it is particularly difficult to recruit and retain practitioners.

I convey my sincere condolences to Child C's family for their loss.

Pursuant to section 73(1B) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

I direct that a copy of this finding be provided to the following:

AT and JQ, Senior Next of Kin

Liana Buchanan, Commissioner for Children and Young People

Secretary to the Department of Families, Fairness & Housing

Senior Constable Samuel Fary, Coroner's Investigator

Signature:

Coroner David Ryan

Date : 01 August 2022

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.