FORM 37

Rule 60(1)

REDACTED FINDING INTO DEATH WITH INQUEST

Section 67 of the Coroners Act 2008

Court reference: 3753/09

Inquest into the Death of HAYLEY

Delivered On:	19th October, 2011
Delivered At:	Ballarat Magistrates' Court 100 Grenville Street South, Ballarat 3350
Hearing Dates:	27th June to 6th July, 2011 inclusive 8th July, 2011
Findings of:	JOHN OLLE, CORONER
Representation:	Ms J. Benson appeared on behalf of DHS Mr M. McLay appeared on behalf of Wimmera Uniting Care Mr M. Simon appeared on behalf of St Arnaud Childcare Mr J. Hannebery appeared on behalf of K. Wheeler and J. Bongiorno Mr T. Burns appeared on behalf of G. Paterson and J. Bruce Mr R. Gipp appeared on behalf of the Chief Commissioner of Police Mr T. Lavery appeared on behalf of SR
Place of death:	Royal Children's Hospital, 50 Flemington Road, Parkville 3052

Counsel Assisting the Coroner: Mr C. Winneke of Counsel in the Coroners Court of Victoria at Ballarat

FORM 37

Rule 60(1)

REDACTED FINDING INTO DEATH WITH INQUEST

Section 67 of the Coroners Act 2008

Court reference: 3753/09

In the Coroners Court of Victoria at Ballarat

I, JOHN OLLE, Coroner

having investigated the death of:

Details of deceased:
Surname:
First name: HAYLEY
Address: Arnard, Victoria 3478

AND having held an inquest in relation to this death on 27th June, 2011 to 6th July, 2011 and 8th July, 2011
at Ballarat Magistrates' Court
find that the identity of the deceased was HAYLEY
and death occurred on 2nd August, 2009

at Royal Childrens Hospital, 50 Flemington Road, Parkville 3052

from
1a. HEAD INJURY

in the following circumstances:

PURPOSES OF A CORONIAL INVESTIGATION

1. The primary purpose of the coronial investigation of a *reportable death*[19] is to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which the death occurred.[20] The practice is to refer to the *medical* cause of death incorporating where appropriate the *mode* or *mechanism* of death, and to limit investigation to circumstances sufficiently proximate and causally relevant to the death.

2. Coroners are also empowered to report to the Attorney-General on a death they have investigated; the power to comment on any matter connected with the death, including matters relating to public health and safety or the administration of justice; and the power to make

[19] Section 4 of the Act requires certain deaths to be reported to the coroner for investigation. Apart from a jurisdiction nexus with the State of Victoria, the definition of a reportable death includes all deaths that appear "to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from accident or injury."
[20] Section 67 of the Act.

recommendations to any Minister, public statutory or entity on any matter connected with the death, including recommendations relating to public health and safety or the administration of justice.[21]

3. The focus of a coronial investigation is to determine what happened, not to ascribe guilt, attribute blame or apportion liability and, by ascertaining the circumstances of a death, a coroner can identify opportunities to help reduce the likelihood of similar occurrences in future.

BACKGROUND

- Hayley was born on 30 May 2007. She was the second child of Robert and CG. She had an older sister, JG, and two brothers SM and AG
- In November 2008, the family relocated to a rental property at St Arnaud ("the home"). Shortly afterward, the parents separated. CG was pregnant with their third child. The couple had separated on prior occasions. The relationship featured complexities of family violence, accommodation instability, financial strain, drug and alcohol misuse, and other social difficulties.
- Following separation, Hayley and SM remained at the home with their father.
- In February 2009, Robert commenced a new relationship with a neighbour, SR. SR and her 6-year-old daughter, TW moved into the home.
- On 7 April 2009, Hayley and SM commenced childcare at the St Arnaud Children's Precinct ("childcare").

4. The family had a long-standing involvement with the Department of Human Service Child Protection Service (DHS) dating back to 2004. The full extent of this contact, spanning many years, was beyond the scope of my investigation. DHS also had a history of involvement with SR dating back to 2004.

5. From early May 2009, it was apparent that Robert's personal circumstances were becoming increasingly problematic. In particular, Robert:

- had fallen behind his rent and childcare fees;
- had minimal contact with his parents;
- was finding the demands of caring for two young children increasingly difficult;
- was drinking heavily;
- was regularly involved in loud arguments at home;
- he looked vague, avoiding eye contact and communication;
- displayed confusion; and
- was late collecting the children from childcare.

[21] Sections 72(1), 72(2) and 67(3) of the Act regarding reports, recommendations and comments respectively.

6. My investigation has primarily focussed on the months leading up to Hayley's death. A chronology prepared by the parties has accurately set out all relevant events and will remain on the coronial file.

7. Concerns were raised with authorities in relation to Hayley (and SM) in the month leading up to her death, including presentations of injuries at childcare on: 17 June 2009 (Hayley presented with scratches and bruises on her cheeks), 22 June 2009 (Hayley has 'purple looking lip .... face has come up with bruises around scratch marks on the right hand side.') and 29 June 2009 (Hayley presented with two black eyes and a raised lump on her forehead).

CIRCUMSTANCES OF DEATH

8. On 7 and possibly 8 July 2009 Hayley, aged two, sustained serious injuries at her home. In the early hours of 8 July 2009, her father, Robert, conveyed Hayley to the St Arnaud Hospital. On admission, Hayley was assessed as being in a critical condition. Within hours of admission, she was airlifted to the Royal Children's Hospital. She subsequently died on 2 August 2009.

9. There is uncertainty as to the manner in which Hayley suffered the injuries which led to her death. It was however clear that Hayley suffered those injuries at her home in the company of her primary carer and father, Robert, his partner, SR and her brother, ShR. The injuries Hayley suffered appear to have occurred in an aggressive and violent atmosphere fuelled by the excessive consumption of alcohol by the adults present.

10. Dr Andrea Smith of the Victoria Forensic Paediatric Medical Service noted that Hayley had suffered a constellation of injuries, including head injuries which resulted in severe brain injury. The post mortem examination conducted by Dr David Ranson, Deputy Director of the Victorian Institute of Forensic Medicine, on 3 August 2009 determined that the medical cause of Hayley's death was head injury.

11. Of relevance to this investigation, I also conducted a contemporaneous investigation into the death of Robert. I determined in that matter that Robert died as a result of hanging on 13 July 2009 in circumstances where he intended to take his own life.

UNCONTENTIOUS MATTERS

12. At the completion of the police investigation and prior to the commencement of the inquest, it was apparent that a number of the facts about Hayley's death are known and were uncontentious. These include the deceased's identity, the medical cause of her death and aspects of the circumstances, including the place and date of her death.

13. Given this, I formally find that the deceased was Hayley, born on the 30 May 2007, late of St Arnaud; that she died on the 2 August 2009 at the Royal Children's Hospital located at 50 Flemington Road, Parkville; and that the medical cause of her death is "head injuries".

THE FOCUS OF THE INVESTIGATION

Introduction

14. The Inquest Brief prepared for this investigation is comprehensive. Investigative shortcomings following Hayley's death have been identified.

15. All interested parties, in particular, Victoria Police and DHS fully co-operated with my investigation. Witnesses provided frank and forthright evidence at the inquest. Individual shortcomings were acknowledged. The witnesses displayed a collective determination to ensure identified deficiencies are never repeated.

16. DHS and Victoria Police have acknowledged a host of serious deficiencies in their investigative roles in the weeks leading to Hayley's death. To the credit of each organisation, wide ranging systemic improvements have been instigated across Victoria.

17. The professionals involved in Hayley's case could not have reasonably foreseen her imminent risk of death. Having considered all the evidence I am unable to conclude that any individual failing contributed to Hayley's death. Further, I am not satisfied that the absence of the identified systemic failings would have necessarily averted the tragic outcome. A conclusion such as this would be based on speculation only. I am however able to say that the system designed to support the protection of children in Victoria did not serve Hayley well and the tragic and distressing circumstances of her death must be a catalyst for change.

How did Hayley sustain the injuries which lead to her death?

18. Hayley suffered injuries during 7 July 2009 and possibly on 8 July 2009 prior to being taken to hospital. After considering all the available evidence uncertainty remains as to the manner in which Hayley suffered the injuries.

19. It is probable that Robert caused some of the injuries to Hayley. It may also be the case that SR caused some injury to Hayley. The extent of those injuries is unclear. It is also not clear which injury or injuries ultimately caused Hayley's death, and on the state of the evidence, it is difficult to conclude which of the two was responsible.

20. There is no suggestion from either Robert or SR that SR's brother ShR caused any injuries to Hayley. His role is restricted to that of an individual who witnessed and did nothing to stop the abuse suffered by Hayley over a prolonged period.

21. In order to conclude that one or other of those persons (namely Robert or SR) inflicted the injuries that ultimately were the cause of death, I would need to be satisfied by clear and cogent evidence.[22] The fact that Robert is deceased does not lessen that standard.

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[22] *Briginshaw v Briginshaw*

22. Upon the applications of SR and ShR, I excused both individuals from giving evidence,[23] I accept that the absence of their evidence cannot be used to fill evidentiary gaps, or strengthen available evidence which suggests SR's involvement. As none of the three adults at the house have given evidence on oath, no version has been tested by cross examination. An examination of each version of events as outlined in their written statements fails to explain how Hayley sustained her injuries with any certainty. On the basis of this exercise it is difficult to elevate one version over another.

23. It is clear that each adult was drinking heavily over the hours of Hayley's ordeal. Sometime around 8.00pm that evening, SM and TW were put to bed but Robert kept Hayley up as punishment for being naughty. It appears that Hayley was required to stand in a corner for an extended period, possibly hours. It is apparent that Robert was unable to cope with a two-year-old and that he demonstrated extremely poor parenting skills. These factors in combination with excessive alcohol provided the setting for the tragic events. The evidence does not however allow me to conclude that any adult present intended to cause fatal injuries to Hayley.

Was Hayley's death preventable?

24. A child protection system which relies on notifications of alleged child abuse, is not the optimal system to protect children - irrespective of the motivation, skill and dedication of staff or systemic efficiency of a system which responds to alleged abuse. Prior to Hayley's death her family was not considered in the highest of risk categories, despite the multitude of issues faced by the family. It is likely that a child protection system designed to prevent abuse before it occurs was Hayley's best chance of survival - this is the single biggest learning from this investigation. At inquest, dedicated and experienced staff urged a mind-shift from reaction to early intervention.

25. The prevention of child abuse and neglect is not achieved solely through statutory involvement with child protection agencies and police criminal investigations. For the most part, these responses occur in the wake of harm to a child having already occurred. It is essential that investment therefore be made in programs designed to engage and assist families prior to serious problems emerging and before particular patterns of behaviour become entrenched.[24]

INVESTIGATION OF CHILD ABUSE IN VICTORIA

26. Both Victoria Police and DHS Child Protection have a responsibility to investigate cases of suspected abuse of a child.

VICTORIA POLICE

27. During the inquest, a series of concessions were made by Victoria Police in regard to the limitations and deficiencies of the investigation into the injuries sustained by Hayley.[25]

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23 As permitted by section 57 of the Coroners Act 2008.
24 See Comments
25 Submission on behalf of the Chief Commissioner of Police dated 8 July 2011

28. In relation to the attendance at the St Arnaud Children's Precinct on 30 June 2009, Victoria Police acknowledged that a more thorough investigation was required to identify the cause of Hayley's injuries. Further, it was conceded that the significance of certain pieces of evidence were not fully appreciated; that photographs of her injuries and a forensic medical investigation should have been arranged; childcare staff should have been interviewed; and that police attendance at the family home to speak to Hayley's carers was necessary. It was also acknowledged that relevant Victoria Police family violence policy and procedural directions (including completion of the Family Violence Risk Assessment and Risk Management Report - VP Form L17) were not adhered to.

29. I note that the SOCAU member in attendance at the St Arnaud Children's Precinct on 30 June 2009 was a relatively junior officer with limited experience carrying out investigations with young children. Under normal circumstances, attendance would have occurred in the company of a supervising officer. Victoria Police identified that the supervision provided to the SOCAU member on the day was below standard. It was also noted that further direction should have been given, mainly in respect to completing the various investigative requirements outlined above. It was also acknowledged that further inquiries with the DHS Child Protection service as to the availability of any other evidence was needed, prior to withdrawing police involvement.

30. Victoria Police conceded that the response following notification of Hayley's presentation to St Arnaud Hospital on 8 July 2009 similarly involved a number of shortcomings. It was accepted that police did not attend the hospital nor the family residence at the earliest opportunity, thus delaying the collection of information and evidence; that the three adults present on the evening Hayley was injured were not interviewed at the first available opportunity; that there was no consideration given as to whether other children were at risk when notification of Hayley's condition was first received; and that the DHS Child Protection service was not notified or contacted in order to obtain a relevant family history.

31. Within Victoria Police, immediate liaison between the Victoria Police CIU and SOCAU did not occur; contact was not made with police in Melbourne following Hayley's transfer to the Royal Children's Hospital; and once again, internal family violence policies and procedures were not followed. It was acknowledge that all of these actions should have taken place.

32. The investigation that commenced on the morning of 8 July 2009 at Hayley's home in St Arnaud, was also found to be lacking in a number of ways. Here, Victoria Police acknowledged there was a failure for information to be communicated between CIU from SOCAU that possibly implicated SR as having contributed to Hayley's injuries; that a VATE interview with SR's daughter should have been arranged at the earliest opportunity; that there was a failure to ascertain from SOCAU or the DHS Child Protection Service that Hayley had presented to childcare with injuries the previous week; and that a far greater level of scrutiny should have been applied to the accounts of Hayley's injuries provided by SR on the day.

33. Nevertheless, Victoria Police maintain that sufficient evidence existed that implicated Robert in regard to Hayley's assault and warranted the charges that were made. Prior to those charges being laid however, a more thorough investigation that gave consideration to a far greater range of available evidence might have taken place. At the very least, police should have spoken with workers at the St Arnaud Children's Precinct regarding their observations about Hayley and SM, as well as obtaining a family history from the DHS Child Protection service as to the Department's previous involvement with both Robert and SR. Flaws with the record of interview completed with Robert have also been identified and accepted by Victoria Police.

Remedial Activities in response by Victoria Police

34. Since Hayley's death, Victoria Police have introduced a range of reforms to address the identified inadequacies both at the regional level and across the entire organisation. Some of these occurred in direct response to this event, while others were the result of long-term planned reforms.

35. An example of the latter category has involved the transition of the Victoria Police SOCAU to what in now referred to as the Sexual Offence Child-Abuse Investigation Team (SOCIT). Members of SOCIT are required to have completed a qualification known as the Field Investigation Course. This is a competency based training program, which requires police to initiate, conduct and finalise routine investigations. Members are also required to complete the Advanced Diploma of Public Safety (Police Investigations), formerly referred to as Detective Training School.

36. In addition, the Sexual Offence and Child Abuse Course must be completed, which involves a focus on interview techniques with children, vulnerable witnesses and suspects. The inquest heard that the introduction of the SOCIT has also meant an increase in the numbers of specialist investigators state-wide.

37. In respect to the problems with the police investigation occurring on 30 June 2009, I note that the following steps have been taken in the Horsham region:

- modifications to staffing arrangements to ensure two members work together wherever possible and to enable supervision from an Officer in Charge of SOCIT;
- changes to the leave policy to improve staffing levels; increased liaison with the DHS and the introduction of three monthly meetings between the Department and the Officer in Charge of the SOCIT;
- completion of a compliance audit of what was then the Horsham SOCAU to ensure compliance with policy and legislation; updating the Horsham Standard Operating Procedures in order to improve the responses to child abuse, with the requirement that photographs of injuries be taken even where it has been established that no crime is committed;
- stricter requirements regarding arrangements for forensic medical investigations whether or not these injuries are thought to be attributable to child abuse; additional training in the area of interview techniques and family violence; and

- circulation of the Memorandum of Understanding between the DHS and Victoria Police to all members in the Northern Grampians Police Service area, in conjunction with an email to all members of the area regarding the critical importance of Victoria Police adhering to family violence policies and procedures, including the appropriate use of the Victoria Police Form L17.

38. In respect to the investigation conducted by Stawell CIU on 8 July 2009, I note initiatives to address the identified deficits have included:

- a review of the after-hours call out policy at the Northern Grampians CIU;
- a review of staff-rostering at the Stawell/Ararat CIU;
- additional training packages regarding police responsibilities at crime scenes, with an emphasis on the responsibilities of supervisors;
- further training regarding the collection of evidence and interview techniques;
- the development and distribution of the Frontline Supervisors' Guide including reference to crime scene management and responses to family violence matters; and
- increased levels of supervision at the commencement of investigations.

39. I note that Victoria Police as an organisation remains committed to addressing family violence and child abuse, and that it recognises the need for police involvement in efforts aimed at identification of vulnerable children and early intervention.

40. I was advised that police are participants in the Grampians Family Violence Prevention Network and the Protecting Vulnerable Families initiative in the Northern Grampians Shire; the appointment of Family Violence Liaison Officers across the state and including the Northern Grampians Police Service Area which is aimed at engaging recidivist households in an attempt to address family violence. Additionally, there has been an increased allocation of police resources in the St Arnaud area, and strategic work done to develop strategies that address family violence.

41. I was told that since 2002, considerable efforts have been made by Victoria Police to ensure that the organisation responds to reports of family violence and child abuse as serious incidents that warrant immediate police attention and a professional, well co-ordinated response. This commitment is reflected in documents such as the *Code of Practice for the Investigation of Family Violence and Living Free from Violence - Upholding the Right: Victoria Police Strategy to Reduce Violence Against Women and Children 2009 - 2014*. Publicly available crime statistics reflect that over the past five years, the number of family violence incidents police have attended has increased considerably, and that there has been an associated rise in the number of charges laid in connection to these matters.[26]

42. The evidence presented at inquest however revealed that at the time of Hayley's death, the expectations and cultural attitudes embodied in this reform had not been absorbed by the entire organisation. On more than one occasion and across a range of police units featuring both

[26] Victoria Police, *Family Incident Reports 2006/07 - 2010/11*, 2011, http://www.police.vic.gov.au/content.asp?a=internetBridgingPage&Media_ID=72311

junior and long-standing members, it was demonstrated that a lack of clarity existed as to the appropriate course of action to be pursued by Victoria Police in respect to a complaint of serious child abuse.

43. I acknowledge the significant range of measures that have since occurred to address this issue, but emphasise that an ongoing and strategic approach is necessary in order that the requisite level of awareness and procedural compliance take place both in the long term. I have therefore made two recommendations to address this matter (Recommendations 1 and 2).

Family violence and criminal offence

44. The police investigation regarding the presentation of Hayley's injuries and identification of those responsible was impeded in a number of ways. Evident was a premature focus by police on the admissibility of evidence that might later be used in criminal proceedings.

45. The inquest heard that on at least two occasions, early judgements regarding the type of information that may, or may not have been, admissible in court, unnecessarily curtailed the investigative process. A thorough criminal investigation clearly requires that information from a wide range of sources be collected and examined in the initial stages of this process, regardless of whether or not it can later be used in any court proceedings that may arise.

46. Victoria Police submitted that this is, and was, their policy, and that this approach underlies the training and instruction of its members. To this end, and for the purpose of placing this commitment on the public record, I note the stated intention on behalf of the Victoria Police to endeavour to ensure that the need to keep an open mind and perform any criminal investigation in a thorough and objective manner will be reinforced through continued professional development and training.

DEPARTMENT OF HUMAN SERVICES

47. The investigation of Hayley's injuries conducted by the DHS Child Protection service on 30 June 2009 was found to be lacking in a number of ways. On this day, the significance of some of the issues initially flagged to the DHS Child Protection service in early February 2009 might have assumed greater significant. In addition, SM's disclosure relating to the cause of injuries to Hayley's face was inadequately investigated.

48. Appropriate concessions were made by the DHS in respect to their involvement in the investigation that was conducted on 30 June 2009.[27] Primarily, it was acknowledged that relevant case-notes were not recorded on the electronic Client Relationship Information System (CRIS) within the prescribed timeframes; and that a more thorough investigation of Hayley's injuries should have occurred.

[27] Submission on behalf of the Secretary to the Department of Human Services dated 8 July 2011

49. This might have involved a thorough visual examination at the very least, and most likely, a forensic medical examination. The Department stated that it would be usual practice for a thorough visual examination of Hayley to be undertaken. It is not the purpose of the inquest to assess this claim, but I do draw attention to fact the that on this occasion, a very experienced practitioner with access to information about the family's extensive involvement with the DHS Child Protection service did not take this course of action. Nevertheless, further inquiries were made with Robert about Hayley's injuries in a prompt manner by child protection workers on that day. It was agreed at the inquest that it would have also been beneficial for additional enquiries to be made with individual staff members of the St Arnaud's Children's Precinct as well as SR.

50. I note that following Hayley's death, the Office of the Child Safety Commissioner prepared a report that identified system-wide issues relevant to her death. In a publicly released summary of some of the findings from this investigation, staff vacancies and increased workloads for employees in the Grampians region were identified as being problematic at the time.[28]

51. This point was also raised at the inquest, although it did not form a specific focus of the investigation. Nevertheless, it was stated that the child protection worker who had responsibility for Hayley and her family had a case-load of between 50 and 70 cases throughout May and June 2009. Whilst this was not provided by DHS as a justification for the events that occurred, it is nonetheless significant in terms of understanding some of the pressures faced by child protections workers during this period. It was reported that additional government funding was directed to the DHS Child Protection service to address this situation, which resulted in eight new positions in the Grampians child protection program and the introduction of additional senior roles across the organisation to focus on supervision and skill development.[29]

52. A suite of training measures were also introduced by the DHS, both in the Grampians region and across the organisation at large. These included specialist training for supervisory staff and reflective practice sessions led by a senior Child Protection worker. Advanced practice in child protection training was also delivered in various regions in 2010 and 2011.

53. Hayley's death also initiated some revision to the DHS Child Protection Practice Manual, particularly in regard to advice regarding 'Conducting the first visit.' This update included practice standards and procedural considerations for planning and commencing an investigation, interviews with relevant parties, visual examination of the child and managing parental resistance when it occurs.

54. I make one final observation. On the occasion of the joint visit between the DHS Child Protection service and Victoria Police on 30 June 2009, there was an apparent lack of clarity in regard to the expectations and requirements of protective interveners in response to the identification of Hayley's injuries.

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28 Department of Human Services, *Government response to the review of the statewide implications of the death of Hayley undertaken by the Office of the Child safety Commissioner*, 2009, Victorian Government, Department of Human Services, http://www.dhs.vic.gov.au/about-the-department/news-archive/?a=434594

29 Statement of Melissa McInerney, DHS Grampians Region, dated 25 November 2009

55. During the inquest, reference was made to a protocol first developed in 1998 between the DHS and Victoria Police, that relates to improved provision and delivery of services to children and young people who have suffered, or likely to suffer, significant harm due to physical, sexual, emotional or psychological abuse and/or neglect. It was noted that this protocol is under review, however I would like to impress that particular consideration be given to the need for improved clarity regarding the roles, responsibilities and required actions of both Victoria Police and the DHS Child Protection within this document. I have therefore made a recommendation to address this issue (Recommendation 3).

COMMENTS

Pursuant to section 67(3) of the **Coroners Act 2008**, I make the following comment(s) connected with the death:

Early Identification and Intervention with vulnerable families

1. The inquest identified two main areas with respect to early identification and intervention that were relevant to the circumstances surrounding Hayley's death. Firstly, there appears to have been a lack of clarity as to whether the issues pertaining the care of Hayley and Sean, prior to their injuries emerging from May 2009, were best managed within a child protection framework or under a family support model.

2. While it was appropriate that the DHS Child Protection service investigated concerns raised from early February 2009, from this time onward, and up until the Department became aware of the possibility of child abuse having occurred, it would have been prudent for the Department to discuss family support options with Robert and give consideration to referring him to Child FIRST.

3. The court heard that the roles and responsibilities of DHS Child Protection and Child FIRST are governed by the Child Protection and Integrated Family Services State-Wide Agreement ('Shell Agreement') 2010. It is important that effective communication and information sharing between the two organisations occur, as intended by this agreement, so that instances of child abuse requiring investigation take place promptly, and instances in which vulnerable families requiring intervention and support receive this assistance.

4. Following Hayley's death, further funding for Child FIRST was made available to Child FIRST by the Victorian Government.[30] The court heard however, that these funds were easily absorbed and that service demand currently exceeds capacity. This has reportedly resulted in prioritisation of cases and resultant waiting lists for services, as well as impacting upon the quality of services that can feasibly be delivered. These are real and important considerations.

[30] Department of Human Services, *Government response to the review of the statewide implications of the death of Hayley undertaken by the Office of the Child safety Commissioner*, 2009, Victorian Government, Department of Human Services, http://www.dhs.vic.gov.au/about-the-department/news-archive/?a=434594

5. It is beyond the role of the coroner to argue for allocation of funding and resources for particular government and non-government initiatives. Nevertheless, it would appear necessary for a thorough analysis of existing service demand and unmet need to be conducted in order to fully comprehend the extent of the requirements for family support and early intervention services in the Grampians region. I have therefore made a recommendation which addresses this issue (Recommendation 4).

Complex social problems and the ability to parent

6. My investigation revealed a range of social problems that undoubtedly impacted on the degree to which parental responsibilities were met. These included a history of family violence; drug and alcohol use sustained over many years; parental learning difficulties and low levels of literacy; unemployment, financial hardship and socio-economic disadvantage; generational involvement with the DHS Child Protection service; limited social and informal support networks; and, a lack of connection to the local community.

7. Against these complexities, it is clear that Robert required specific assistance with respect to his ability to provide a stable and nurturing environment for his children. Evidence was presented to indicate that developmental milestones, age appropriate behaviours and suitable behaviour management techniques for young children were concepts not well understood by Robert. Both in his parental role and in respect to his personal difficulties, Robert undoubtedly required a far greater level of practical assistance, guidance, education and support, than he was receiving in the months preceding Hayley's death.

8. There is some evidence to indicate that parental education and home visiting programs can play a role in a comprehensive approach to child maltreatment prevention.[31] Two examples of parenting support programs operational in the Grampians region were discussed at the inquest. These are the in-home family support service offered by Wimmera Uniting Care and the Parent-Child Mother Goose Program.[32]

Significance of injuries detected on children

9. Hayley's death was subject to examination by the Victorian Child Death Review Committee (VCDRC).[33] In May 2010, several recommendations were made by the VCDRC to the DHS arising from this analysis. These were summarised and tendered at the inquest by the DHS. Two of these recommendations addressed issues pertaining to clarity around program guidance concerning physical abuse and the conditions for arranging a medical examination in

[31] See for example, P.J Holzer et al, 'The effectiveness of parent education and home visiting child maltreatment prevention programs', *Child Abuse Prevention Issues no. 24, Australian Institute of Family Studies National Child Protection Clearinghouse*, Melbourne Australia 2006.

[32] The Parent-Child Mother Goose Program aims to strengthen the bond between parent child through the use of rhymes, songs and stories.

[33] The Victorian Child Death Review Committee (VCDRC) reviews the deaths of children and young people who were clients of the Victorian Child Protection service at time of their death or within 12 months of their death. The aim of the VCDRC is to identify common themes and comment on service responses to vulnerable children and their families.

cases of alleged physical abuse of young children. The DHS states that it has responded to these recommendations.

10. Many children who die as a result of fatal assault have a documented history of prior injuries, including bruising and fractures.[34] While bruising is a relatively common childhood injury, research indicates that bruising detected on certain regions of the body should be treated with particular caution and prompt further investigation. For example, bruising observed on a child's head, neck, ears, trunk, buttocks and genital region has been shown to be more indicative of inflicted injuries.[35] Recognition of the significance of bruising and other injuries in these areas is important in order to better identify cases of suspected child abuse.

11. A number of professionals who had contact with Hayley and SM from mid-May 2009 did not appear to fully appreciate the significance of the location of the bruising and other injuries observed on the children in the weeks preceding her severe assault.

12. Both Victoria Police and the DHS Child Protection service have since taken further steps in an effort to ensure that a thorough visual examination or forensic medical investigation occurs. However, it is equally important that the significance of the location of particular injuries upon children be realised, particularly by protective interveners, so that sighting such injuries prompts and even closer analysis, and adds more weight for the need for a thorough visual examination or forensic medical investigation as required.[36] I have therefore made a recommendation to address this issue (Recommendation 5).

Information sharing

13. In the weeks preceding Hayley's death, professional persons held important information about the welfare and living circumstances of Hayley and her brother. This included both historical and contemporary knowledge, collected from a variety of sources. The inquest heard that on a number of occasions, this information was not communicated to the appropriate person in a timely and complete manner. This issue occurred both within and between organisations.

14. It is recognised that for the most part, there was no deliberate attempt for this situation to arise. Rather, certain observations and knowledge held by a range of parties appears to have been either incorrectly assessed or assigned a lesser level of significance than it required. As a result, the apparent deterioration in the care provided to Hayley and the increased risks both she and her brother faced do not appear to have been fully appreciated by those in a position to take action.

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34 NSW Commission for Children and Young People, Fatal Assault of Children and Young People, (2002) 66.

35 F.D. Dunstan et al, 'A scoring system for bruise patterns; a tool for identifying abuse' (2002) 86 *Archives of Diseases in Childhood* 330-333; Tomika Harris, 'Bruises in children: Normal or child abuse?' (2010) 24 (4) *Journal of Pediatric Health Care* 216-221; S Maguire et al, 'Are there patterns of bruising in childhood which are diagnostic or suggestive of abuse? A systematic review' (2004) 90 *Archives of Disease in Childhood* 182-186; M. Clyde Pierce et al, 'Bruising characteristics discriminating physical child abuse from accidental trauma', (2010) 125 (67) *Pediatrics* 67-74.

36 This is not to underestimate the importance of other sites of injury detected upon children, but rather to draw attention to the literature highlighting the significance of particular locations as more indicative of abuse.

15. Several examples of this kind were identified and discussed during the course of the coronial investigation. These are briefly listed here, not for the purpose of attributing blame, but to demonstrate that fatal assaults of young children rarely occur 'out of the blue.' Rather, it is often the case that significant information regarding parental risk factors and/or a deterioration in the child's living circumstances has not been fully integrated.

- As outlined above, Robert would have benefited from early referral to Child FIRST by the DHS Child Protection service. Both Robert and CG were well known to the Department, and consideration of their histories would suggest that ongoing assistance was likely to have been necessary throughout the early years of their children's lives. However, an early referral was not forthcoming by the DHS.
- From mid-May 2009, childcare workers had documented their observations and concerns for Hayley and SM. Within the childcare centre itself, there appears to have been some level of disagreement as to the causation and significance of these injuries on at least one occasion. While the St Arnaud Children's centre acted appropriately in notifying the DHS Child Protection of their concerns, the detail that was subsequently communicated at this time remains in dispute.
- It is the position of the DHS Child Protection service and Victoria Police that on the occasion of their visit to the centre on 30 June 2009, all records pertaining to problems identified with the children were not revealed. Importantly however, this information was not requested, and the onus is upon protective interveners to make inquiries about such information.
- Furthermore, during the course of the investigation into Hayley's assault from 8 July 2009, communication of information already in possession by Victoria Police between CIU and SOCAU did not take place. Further, communication between Victoria Police and the DHS Child Protection service at the time Hayley's life threatening injuries were reported did not happen at the first opportunity. As outlined, this had implications for the investigation that followed.

16. Provisions currently exist for concerns regarding the welfare and safety of a child to be shared between, and with, protective interveners. A lack of legislative or governance arrangements was not at fault here. Rather, the problem rested with a failure among individuals and organisations to fully disclose both the presence and detail of information that was held, and to confidently state a position as to the perceived significant of this information. In turn, this resulted in the absence of a complete picture having been available, and perhaps, for more decisive protective action to be implemented.

17. A range of initiatives have been introduced following Hayley's death to help improve communication and information sharing among organisations working with children at risk and vulnerable families in the Grampians region. The court heard that for the most part, these share the common objective of building relationships between organisations; enhancing understanding of the roles and responsibilities of respective service providers; and improving understanding of regional issues impacting upon vulnerable children and their families.

18. Efforts in this regard have included introduction of formal meetings on a three monthly basis between Victoria Police SOCIT and DHS Child Protection service in Horsham; and the

development of the Northern Grampians Vulnerable Children Network comprised of the DHS Manager of Community Care and Housing, the Department of Education and Early Child Development (DEECD) Early Years Manager, the Manager of Wimmera Uniting Care, the Northern Grampians Shire Council and Victoria Police.

19. Further, in June 2010, Victoria Police and the DHS signed an overarching Memorandum of Understanding (MOU) with regard to general principles of cooperation on a range of issues. Accompanying the MOU was the introduction of a governance process whereby the Secretary of DHS, the Chief Commissioner of Victoria Police and their relevant Executive Directors and Deputies meet biannually to discuss issues emerging from cooperation between the two organisations. This group has also given consideration to how the principles of cooperation in any agreement can be implemented and managed at a regional level.

20. My final observation here is that the success of these initiatives in meeting the underlying objective of improved cooperation and communication among organisations involved in the prevention, identification and response to child maltreatment, will require an ongoing commitment across all levels of the respective organisations.

Community participation in the protection of children

21. The safety and protection of children is an activity that must be shared by the entire community. The circumstances surrounding Hayley's death indicate the need for persons who hold concerns for children and young people to communicate their observations in a clear and complete manner as soon as possible, and particularly, to those who are in a position to intervene.

22. Community awareness and involvement are important aspects of initiatives aimed at preventing child maltreatment and abuse. Indeed, the extent to which these efforts are effective and sustainable often depends on the level of community participation. During this investigation, a number of those who gave evidence attested to the widely held view that the prevention of child abuse and neglect is a shared responsibility that involves co-operation among services providers, professionals, local organisations and individual community members. It was further demonstrated that those from the local area held valuable knowledge about the particular issues encountered by families in the region. Many were cognisant of the obstacles faced by Robert and the extent to which they impacted upon his ability to care for his children.

23. There is a clear role for professionals to work actively in their local areas to raise awareness and develop understanding around the factors that pose risks to children as well as child abuse itself. Conceivably, this should involve activities designed to increase knowledge of how assistance can be obtained for families experiencing difficulty, as well as the roles and responsibilities of relevant organisations in the local area. Importantly, this should promote a degree of visibility and strengthen the relationship between services and local community members. I have therefore made a recommendation to address this issue (Recommendation 6).

Protecting Victoria's Vulnerable Children Inquiry

24. On 31 January 2011, the Victorian Government announced the 'Protecting Victoria's Vulnerable Children' Inquiry. The purpose of the Inquiry is to investigate systemic problems in Victoria's child protection system and make recommendations to strengthen the protection of Victorian children who are at risk of, or who have experienced, neglect and/or abuse. The terms of reference that apply to the Inquiry are broad, but include consideration being given to the factors that increase the risk of abuse or neglect occurring; and the interaction of departments and service providers in their work with at-risk families and children.

25. Many of the issues touched upon as part of the inquest are pertinent to this Inquiry. These issues are complex and not easily addressed through a coronial investigation alone. Nevertheless, they are highly relevant in respect to a broader investigation into child welfare and safety in this state.

I therefore direct that a de-identified copy of this finding be provided to the Protecting Victoria's Vulnerable Children Inquiry for information purposes only.

Previous reviews of Victoria's child protection system

26. The Victorian child protection jurisdiction has been reviewed many times. Prior to the current review noted above, the Victorian Law Reform Commission released its Final Report into Protection Applications in the Children's Court (the VLRC Report) in June 2010. The VLRC Report noted that there had been nine major reviews in the past 33 years and concluded that a major review occurred every four to five years, supplemented by a smaller review approximately every second year. In addition, it noted that the 'prevalence of reviews demonstrates both the complexity of child protection issues and the difficulty in gaining widespread support for reform.'

27. Options proposed in the VLRC Report included the establishment of an Office of the Children and Youth Advocate as multi-disciplinary body to advance the interests of children and young persons as well as an option to broaden the role of the Child Safety Commissioner. At inquest, I heard evidence from an experienced child protection worker who strongly advocated for the establishment of a ministry for children in Victoria - 'where there are free and universal services ... for every child'. Whilst a recommendation of this kind is outside the scope of this investigation, there is no doubt that an independent body to the protect the interests of children would be a worthwhile and much needed advancement.

The Victorian Systemic Review of Family Violence Deaths

28. The deaths of Hayley and Robert were examined as part of the Victoria Systemic Review of Family Violence Deaths (VSRFVD). The VSRFVD, based with the Coroners Court of Victoria, provides analysis of family violence-related deaths investigated by Victorian coroners to inform future interventions aimed at protecting children and adults from violence. I am grateful for the assistance provided to me by the VSRFVD throughout the course of this coronial investigation.

RECOMMENDATIONS

Pursuant to section 72(2) of the **Coroners Act 2008**, I make the following recommendations connected with the death:

1. That Victoria Police give consideration to developing a program of regular training and information dissemination for operational members across all regions of the organisation to ensure familiarity and compliance with the Code of Practice for the Investigation of Family Violence, the Victoria Police Manual pertaining to the investigation and response to family violence, and completion of the Victoria Police Form L17, in order to ensure that requirements of members are well understood, and that appropriate action is taken when police receive reports of, and respond to, instances of family violence and child abuse.

2. That all Victoria Police officers be provided with the contact details of DHS Child Protection services in each region and the Child Protection After Hours Emergency Service, and be reminded that, pursuant to section 181 of the *Children, Youth and Families Act 2005* (Vic), all members, not only SOCIT officers, are protective interveners and mandatory reporters.

3. That the 1998 protocol between Victoria Police and DHS, *Protecting Children: Protocol Between the Department of Human Services and Victoria Police*, be revised and updated to reflect the current legislative requirements of both organisations, and clarify the roles and responsibilities of both the Department of Human Services and Victoria Police, in respect to investigations of child abuse.

4. That DHS give consideration to conducting a thorough analysis of early intervention and family support requirements in the Grampians region. This should include consideration of unmet need, client waiting lists and proportional staff ratios to client populations, in order to determine the capacity of the region to effectively respond to these requirements, and enable a timely and planned approach to the delivery of early intervention and family support services in this area.

5. That DHS Child Protection service and Victoria Police consider providing specific training and/or information to staff members involved in the investigation of child abuse, regarding the significance of bruising and injury patterns that may be indicative of inflicted injuries upon children, in order to afford particular significance to these injuries both at the time of notification and when conducting further investigation.

6. That DHS Child Protection, Child FIRST and Victoria Police SOCIT in the Grampians region give consideration to engaging in a systematic program of community education (targeting childcare centres, schools and other community groups), regarding the risk factors for, and identification of, possible child abuse and neglect, including an educative component as to when a notification to the DHS Child protection is warranted, in order to facilitate greater community

awareness of these issues and promote the visibility of services that are able to assist children either at risk of, exposed to, such violence and abuse.

Signature:

John Olle
Coroner
Date: 19th October, 2011