



IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2016 1599

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)

Section 67 of the Coroners Act 2008

Findings of:	CAITLIN ENGLISH, ACTING STATE CORONER
Deceased:	SANAYA SAHIB
Date of birth:	20 January 2015
Date of death:	9 April 2016
Cause of death:	Suffocation
Place of death:	Olympic Park, Heidelberg West, Victoria, 3081

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HER HONOUR:

BACKGROUND

1. Sanaya Sahib (**Sanaya**) was 14 months old at the time of her death. Sanaya was the only child born to Sofina Nikat (**Ms Nikat**) and Abdul Sahib (**Mr Sahib**). Ms Nikat was born and raised in Lautoka, Fiji and was engaged to Mr Sahib when she was approximately 19 years old, in April 2012.
2. In September 2012, Ms Nikat married Mr Sahib in Fiji and on 19 May 2013, Ms Nikat relocated from Fiji to Melbourne to live with Mr Sahib.¹
3. In mid-2013, Ms Nikat discovered that she was pregnant but by December 2013, she miscarried the pregnancy.² The available evidence suggests that Ms Nikat's in-laws blamed her for the miscarriage and that they were emotionally and verbally abusive towards her because of this.³
4. In March 2014, Ms Nikat went on holiday to Fiji so that she could see her parents. Whilst Ms Nikat was on holiday in Fiji, Mr Sahib's father contacted Ms Nikat's family requesting that Ms Nikat not return to Australia and advised that the marriage would not continue.⁴ Following negotiations between Ms Nikat's and Mr Sahib's family, it was agreed that Ms Nikat would return to Australia.⁵
5. In April 2014, Ms Nikat returned to Australia and resided with her husband and parent's in-law. She advised police that following her return to Australia, she had been receiving medical treatment for an unknown ailment and had been advised by her doctor not to fall pregnant.⁶ In spite of this, Ms Nikat advised that Mr Sahib had refused to use contraception and that Ms Nikat had become pregnant again.⁷
6. In November 2014, Ms Nikat's family were told that Mr Sahib's family wished to send her back to Fiji again. Ms Nikat later confirmed with police that her husband and in-laws were very controlling of her during this period.⁸ It was reported that during this time Ms Nikat's cousin, Ms Husan Afsana Habib (**Ms Habib**) had received information that "*the Sahib family*

¹ *Coronial Brief*, Statement of Susan Jane San Juan dated 3 June 2016, 406

² *Coronial Brief*, Statement of Zureen Sahib dated 10 May 2016, 163

³ Statement of Dr Yvonne Skinner dated 7 March 2017, 4

⁴ *Coronial Brief*, Statement of Zureen Sahib dated 10 May 2016, 163

⁵ *ibid*

⁶ Statement of Dr Yvonne Skinner dated 7 March 2017, 4

⁷ *ibid*

⁸ *ibid*; *Coronial Brief*, Transcript of police interview with Sofina Nikat held on 12 April 2016, 844-845

*were not taking good care of Sofina. Sofina was apparently not in a good condition. She was not allowed to go out without them; if they went out she was often left at home alone; they prevented her from answering the door or phone”.*⁹

7. Ms Habib then proceeded to contact Ms Nikat, who informed her that she wished to leave the residence.¹⁰ When Ms Habib attended Ms Nikat’s residence for a scheduled meeting on 13 November 2014 and requested to speak with her, Ms Habib was reportedly told that Ms Nikat was not home.¹¹ Ms Habib then contacted police who assisted Ms Nikat in exiting the residence and Ms Nikat relocated to Ms Habib’s parent’s house.¹²
8. On 19 November 2014, Ms Nikat made an application for a Family Violence Intervention Order (**FVIO**) against Mr Sahib and his family, citing physical, emotional and sexual violence.¹³ On 9 January 2015, Ms Nikat was granted a FVIO preventing Mr Sahib and his parents from contacting Ms Nikat or committing family violence towards her.¹⁴
9. On 18 December 2014, Ms Nikat met with a social worker whilst attending an antenatal appointment at Northern Health.¹⁵ A statement from the hospital indicates that during this appointment, treating staff developed concerns for Ms Nikat’s wellbeing and safety and were advised that she had recently left a difficult relationship.¹⁶
10. During the birth of Sanaya in January 2015, medical records from Northern Health indicate that Ms Nikat “*was happy for husband to be present*” and was “*encouraged to notify [staff] if any issues*”.¹⁷ On 23 January 2015, Ms Nikat was spoken to by a social worker given the hospital’s prior noted concerns for Ms Nikat’s safety. During this conversation, Ms Nikat confirmed that she had reconciled with Mr Sahib.¹⁸
11. On 13 January 2015, Ms Nikat made an application to have the FVIO withdrawn, and on 19 February 2015, the FVIO was revoked.¹⁹
12. Following their discharge from hospital, Ms Nikat and Sanaya moved in with her cousin in-law and Mr Sahib moved into a rental property nearby.²⁰ Reports regarding Ms Nikat’s

⁹ *Coronial Brief*, Statement of Husan Habib dated 6 May 2016, 173; Northern Health Report dated 3 December 2016, 1

¹⁰ *ibid*

¹¹ *ibid*

¹² *Coronial Brief*, Statement of Husan Habib dated 6 May 2016, 174

¹³ *Coronial Brief*, Summary of Circumstances, 3; *Coronial Brief*, Appendix U.

¹⁴ *ibid*

¹⁵ Northern Health Report dated 3 December 2016, 1

¹⁶ *ibid*

¹⁷ Northern Health Records for Safina Nikat generated on 12 July 2018, 2

¹⁸ *ibid*

¹⁹ *Coronial Brief*, Appendix U

behaviour towards her daughter during this time are conflicting. In a statement to police, Ms Habib advised that she was told by Ms Nikat's in-law's that Ms Nikat was not "*looking after Sanaya well. Dirty nappies were left unattended in the house. She wasn't doing any of the house work. She was always on Facebook and not attending to Sanaya*".²¹ However, Ms Habib advised that she had not held concerns for Sanaya or Ms Nikat's parenting capacity during this period.²²

13. Sometime between July 2015 and August 2015, Mr Sahib took Ms Nikat to her cousin, Ms Habib's, home.²³ After dropping Ms Nikat off, Mr Sahib called Ms Nikat's family, stating that he "*didn't want to see [Ms Nikat] anymore and didn't want [Ms Nikat] or Sanaya back*".²⁴ Following this, Ms Nikat resided with Ms Habib and her family.
14. On 6 November 2015, Ms Nikat contacted family violence agency, Safe Futures, and advised workers that she was too scared to return home because she alleged that her relatives were abusive towards her.²⁵ Ms Nikat further advised that she was mistreated²⁶ and that the relatives that she had been living with would regularly take Sanaya from her whilst she did housework and that they "*do not look after the baby*".²⁷ It is unclear from the records provided which relatives Ms Nikat was referring to during this conversation as records identify both Mr Sahib and Ms Nikat's cousin's as perpetrators.
15. Following this contact, Safe Futures arranged for crisis accommodation for Ms Nikat and Sanaya and they were subsequently transferred to transitional housing on 10 November 2015. Ms Nikat and Sanaya both continued to be case managed by Safe Futures up to the time of the fatal incident.²⁸
16. During her engagement with Safe Futures, Ms Nikat advised staff that she was having difficulty managing Sanaya's behaviour and that Sanaya was not sleeping well.²⁹ As these difficulties continued, Ms Nikat sought the assistance of her parents and advised them that Sanaya was not acting normally³⁰ and would cry all the time. In response to these concerns,

²⁰ *Coronial Brief*, Statement of Husan Habib dated 6 May 2016, 175

²¹ *ibid*

²² *ibid*

²³ *ibid*

²⁴ *ibid*

²⁵ Records provided by Safe Futures Foundation dated 25 July 2018, 2

²⁶ *ibid*, 3

²⁷ *ibid*

²⁸ Records provided by Safe Futures Foundation dated 25 July 2018

²⁹ *ibid*, 14, 15, 22, 27, 127 & 128

³⁰ *Coronial Brief*, Statement of Shaireen Sofia dated 19 May 2016, 119

Ms Nikat's parents spoke with an Imam in Fiji who advised that Sanaya "*had been experiencing the evil spirit*"³¹ and that Ms Nikat was, in turn, affected by the '*evil eye*'.³²

17. To assist with these concerns, the Imam advised that Sanaya should drink holy water to cure any evil spirits and Ms Nikat was given a locket for Sanaya to wear in the hope that it would "*warn away any further evil spirits*".³³
18. Between March 2016 and April 2016, Ms Nikat was staying between two residences, a refuge organised by Safe Futures in Mitcham, and Ms Ali's home in Heidelberg West.³⁴
19. Whilst Ms Nikat was staying with her cousin, Ms Rabiya Ali (**Ms Ali**), in Heidelberg West, on 3 April 2016, Sanaya had a seizure and was taken to Austin Hospital. Sanaya was diagnosed with convulsions and an afebrile seizure and a referral was made for a follow-up appointment with a paediatric specialist.³⁵
20. On 4 April 2016, Ms Nikat complained to her Safe Futures case manager that "*Sanaya was playing up*" and "*crying a lot, not eating properly and not sleeping properly*".³⁶ On 5 April 2016, Ms Nikat spoke to her case manager again regarding Sanaya and advised that she "*wouldn't sleep for more than 15 minutes at a time during the day and maybe an hour or two at night*".³⁷

THE PURPOSE OF A CORONIAL INVESTIGATION

21. Sanaya's death constituted a '*reportable death*' under the *Coroners Act 2008* (Vic) (**the Act**), as the death occurred in Victoria and was violent, unexpected and not from natural causes.³⁸
22. The jurisdiction of the Coroners Court of Victoria is inquisitorial.³⁹ The Act provides for a system whereby reportable deaths are independently investigated to ascertain, if possible, the

³¹ *Coronial Brief*, Statement of Sohail Haqani dated 18 May 2016, 122-123

³² *ibid*

³³ *ibid*

³⁴ *Coronial Brief*, Statement of Rabiya Ali dated 10 April 2016, 183.

³⁵ Austin Health, Medical Records of Sanaya Sahib, 6

³⁶ Records provided by Safe Futures Foundation dated 25 July 2018, 15

³⁷ *ibid*, 14

³⁸ Section 4 *Coroners Act 2008*

³⁹ Section 89(4) *Coroners Act 2008*

identity of the deceased person, the cause of death and the circumstances in which the death occurred.⁴⁰

23. It is not the role of the coroner to lay or apportion blame, but to establish the facts.⁴¹ It is not the coroner's role to determine criminal or civil liability arising from the death under investigation,⁴² or to determine disciplinary matters.
24. The expression "*cause of death*" refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.
25. For coronial purposes, the phrase "*circumstances in which death occurred*,"⁴³ refers to the context or background and surrounding circumstances of the death. Rather than being a consideration of all circumstances which might form part of a narrative culminating in the death, it is confined to those circumstances which are sufficiently proximate and causally relevant to the death.
26. The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through the observations made in the investigation findings and by the making of recommendations by coroners. This is generally referred to as the Court's "*prevention*" role.
27. Coroners are also empowered:
 - (a) to report to the Attorney-General on a death;⁴⁴
 - (b) to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice;⁴⁵ and
 - (c) to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice.⁴⁶ These powers are the vehicles by which the prevention role may be advanced.
28. All coronial findings must be made based on proof of relevant facts on the balance of probabilities.⁴⁷ In determining these matters, I am guided by the principles enunciated in

⁴⁰ See Preamble and s 67, *Coroners Act 2008*

⁴¹ *Keown v Khan* (1999) 1 VR 69

⁴² Section 69 (1)

⁴³ Section 67(1)(c)

⁴⁴ Section 72(1)

⁴⁵ Section 67(3)

⁴⁶ Section 72(2)

Briginshaw v Briginshaw.⁴⁸ 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 that they caused or contributed to the death.

29. In conducting this investigation, I have made a thorough forensic examination of the evidence including reading and considering the witness statements and other documents in the coronial brief.

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

Identity of the Deceased, pursuant to section 67(1)(a) of the Act

30. On 12 April 2016, Ms Nikat visually identified the deceased to be her daughter, Sanaya Sahib, born 20 January 2015.

31. Identity is not in dispute in this matter and requires no further investigation.

Medical cause of death, pursuant to section 67(1)(b) of the Act

32. On 10 April 2016, Dr Victoria Francis (**Dr Francis**), a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an autopsy upon Sanaya's body. On 14 April 2016, Dr Linda Iles (**Dr Iles**), a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted a brain examination on Sanaya's body. Dr Francis provided a written report, dated 25 August 2016, which concluded that Sanaya died from unascertained causes.

33. Dr Francis confirmed the following in her report:

(a) there was evidence of injuries in the form of lacerations and bruising to Sanaya's mouth region which indicated recent blunt force trauma. These injuries can be caused by medical resuscitation measures, accidental trauma, such as a fall, or as a result of inflicted injury.

(b) that another potential cause of the mouth injuries is external airway compression (smothering), which may cause no obvious injuries but which may cause minor abrasions and bruising to the oral mucosa⁴⁹ and skin surrounding the mouth.

⁴⁷ *Re State Coroner; ex parte Minister for Health* (2009) 261 ALR 152

⁴⁸ (1938) 60 CLR 336

⁴⁹ Oral mucosa is term for the "skin" inside the mouth that covers most of the oral cavity apart from the teeth.

- (c) that post-mortem radiology was performed at the Royal Children's Hospital and reviewed by Dr Timothy Cain, a Paediatric Radiologist. Dr Cain's examination showed no evidence of skeletal trauma;
 - (d) there was a small amount of clear frothy liquid within her lungs and drowning could not be excluded as a potential mechanism of death; and
 - (e) the neuropathological findings of Dr Iles confirmed no significant neuropathological abnormality of Sanaya's brain.
34. Dr Francis also noted that there was no evidence of significant natural disease to account for Sanaya's death.
35. Toxicological analysis of post mortem blood specimens taken from Sanaya were negative for common drugs or poisons. However, post mortem hair specimens taken from Sanaya were positive for methamphetamine.⁵⁰ Dr Francis commented that this is likely due to environmental exposure to methamphetamines, but possible ingestion of the drug at some point cannot be excluded.
36. There is no evidence identified during the post mortem examination that any other person was involved in Sanaya's death.

Circumstances in which the death occurred, pursuant to section 67(1)(c) of the Act

37. On 9 April 2016 at approximately 9.40am, Ms Nikat took Sanaya out for a walk in a stroller from Ms Ali's residence on Perth street in Heidelberg West.⁵¹ Ms Ali offered to accompany Ms Nikat but she insisted on going for a walk alone.
38. CCTV footage contained within the coronial brief shows Ms Nikat walking and pushing a stroller along Liberty Parade and then sometime later crossing that street and heading towards Darebin Creek trail. Shortly after 10.00am, CCTV footage shows Ms Nikat on the eastern side of Darebin Creek.⁵²
39. Sometime between 10.00am to 10.20am, Ms Nikat suffocated Sanaya and left her body at the creek.⁵³ Ms Nikat then left the area, pushing an empty stroller back to Ms Ali's residence.

⁵⁰ Methamphetamine, also known as a central nervous system stimulant, was detected in hair samples at a concentration of between 0.38 to 0.47 ng/mg.

⁵¹ *Coronial Brief*, Statement of Rabiya Ali dated 9 April 2016, 180

⁵² *Coronial Brief*, CCTV footage contained in exhibits 4, 7, 9, 10 and 11

⁵³ *ibid*

When she arrived back at Ms Ali's residence, Ms Nikat said that Sanaya had been kidnapped by a stranger.

40. Ms Ali contacted the police at approximately 10.39am.⁵⁴ Police arrived shortly after and commenced a search of the area. In the early hours of the following morning, on 10 April 2016, a family assisting with the search located Sanaya's body in Darebin Creek.
41. During the initial emergency services call and subsequently at the Heidelberg Police Station on 9 April 2016, Ms Nikat claimed that a man had kidnapped Sanaya and that she had chased this man but had twisted her ankle.⁵⁵
42. On 12 April 2016, however, Ms Nikat made full admissions to police during a formal interview and admitted to killing Sanaya. Ms Nikat described Sanaya as being possessed and also thought that what she had done to Sanaya would be better for her and she was in a better place now.⁵⁶ Ms Nikat confirmed that she had suffocated Sanaya by covering her mouth and nose and rolled her into the creek before leaving the area on 9 April 2016.⁵⁷

COMMENTS PURSUANT TO SECTION 67(3) OF THE ACT

43. The unexpected, unnatural and violent death of a young child is a devastating event. Violence perpetrated by a family member is particularly shocking, given the family unit is expected to be a place of trust, safety and protection.
44. For the purposes of the *Family Violence Protection Act 2008*, the relationship between Sanaya and Ms Nikat was one that fell within the definition of family member⁵⁸ under that Act. Moreover, the actions of Ms Nikat causing her death constitutes family violence.⁵⁹
45. In light of Sanaya's death occurring under circumstances of family violence, I requested that the Coroners' Prevention Unit (CPU)⁶⁰ examine the circumstances of Sanaya's death as part of the Victorian Systemic Review of Family Violence Deaths (VSRFVD). The VSRFVD assists Victorian Coroners to examine the circumstances in which family violence deaths

⁵⁴ *Coronial Brief*, Transcript of emergency services call from Rabiya Ali and Sofina Nikat to Victoria Police dated 9 April 2016, 451

⁵⁵ *ibid*, 455-462

⁵⁶ *Coronial Brief*, Transcript of police interview with Sofina Nikat held on 12 April 2016, 844-845

⁵⁷ *ibid*, 848

⁵⁸ *Family Violence Protection Act 2008*, section 8.

⁵⁹ *Family Violence Protection Act 2008*, section 5(1)(a)(i)

⁶⁰ The Coroners Prevention Unit is a specialist service for Coroners established to strengthen their prevention role and provide them with professional assistance on issues pertaining to public health and safety

occur. In addition, the VSRFVD collects and analyses information on family violence-related deaths. Together, this information assists with the identification of systemic prevention-focused recommendations aimed at reducing the incidence of family violence in the Victorian Community.

46. I confirm that research has identified characteristics specific to women who have committed filicide and which may place a child at greater risk of being killed.⁶¹ Moreover, studies have found that a sense of social isolation and lack of social support, as well as heightened levels of stress, have been identified as factors associated with greater risk of maternal filicide.⁶²
47. Material within the coronial brief indicates that Ms Nikat was experiencing significant social isolation at the time of the fatal incident. Ms Nikat did not have close family or friends in Australia and had reported that her husband and in-laws were abusive towards her. Ms Nikat also reported that the people around her would often criticize her parenting and Sanaya's behaviour, complaining to her that Sanaya was '*not a normal baby*'.⁶³ Ms Nikat further disclosed during her interview with police that everyone was '*blaming her and everything...and I didn't have anyone by my side to tell me what to do and what to not*'.⁶⁴ Ms Nikat was also residing alone at the time of the fatal incident and only appeared to have sporadic contact with Ms Ali and her family at the time of Sanaya's death.
48. Ms Nikat's circumstances at the time of Sanaya's death also indicate that she was experiencing a heightened level of stress. Ms Nikat was living in temporary accommodation, had allegedly experienced an extended period of abuse from her husband's family, was having difficulty parenting Sanaya, and was concerned that her in-laws would send her back to Fiji.
49. Dr Danny Sullivan, a forensic psychiatrist, was engaged on behalf of Ms Nikat's legal defence representative to produce a forensic psychological report that noted in the lead up to the fatal incident, Ms Nikat '*felt very bad emotionally and began having restless sleep*'.⁶⁵
50. I note that research has also found that mothers are at greater risk of perpetrating filicide if they are the primary caregiver of at least one child, are experiencing financial problems (such as unemployment), and are involved in abusive adult relationships.⁶⁶

⁶¹ *ibid*

⁶² McKee, G. R., & Shea, S. J. (1998). Maternal filicide: a cross-national comparison. *Journal of clinical psychology*, 54(5), 679-687

⁶³ *Coronial Brief*, Transcript of police interview with Sofina Nikat held on 12 April 2016, 844

⁶⁴ *ibid*, 845

⁶⁵ Statement of Dr Danny Sullivan dated 4 September 2017, 4

51. Ms Nikat was the primary caregiver for Sanaya and forensic psychiatrist, Dr Yvonne Skinner, further noted that Sanaya was very ‘clingy’, giving Ms Nikat little time to herself.⁶⁷ Additionally, Ms Nikat did not have a job at the time of the fatal incident, was only receiving Centrelink benefits and was residing in transitional accommodation.⁶⁸ Ms Nikat had also reported having been abused by her husband and family in-law, causing her to leave their residence.⁶⁹
52. I confirm that mental illness is a significant contributing risk factor for maternal filicide, with mothers who have committed filicide being found to have commonly experienced depression or psychosis prior to or during the fatal incident.⁷⁰ In a study undertaken by Resnick, it was found that 67 per cent of mothers who had committed filicide were psychotic at the time of the fatal incident, and that depression and schizophrenia/psychosis were diagnosed commonly among filicidal mothers.⁷¹ Women with psychiatric disturbances or depression, were also found to be more likely to suicide after killing their child.
53. Whilst Ms Nikat did not report suffering from psychosis at the time of Sanaya’s death, Ms Nikat’s cousin advised that she believed that Ms Nikat was depressed following the birth of Sanaya and that Ms Nikat had spoken about experiencing suicidal thoughts in the past.⁷² Following her arrest, Ms Nikat was also diagnosed with having had major depressive disorder and disclosed that she had thought of killing herself at the time of Sanaya’s death but had been too afraid to follow through on her plan.⁷³

Maternal child health screens for post-natal depression

54. In the course of the coronial investigation, the contact between Ms Nikat, Sanaya and Maternal and Child Health Nurses (MCHN) was reviewed.
55. It appears that Ms Nikat and Sanaya were first seen by a Maternal and Child Health nurse (MCHN) from the City of Casey on 27 January 2015 at one week of age and continued to be seen by this service regularly until four months of age. According to records available to the

⁶⁶ Krischer, M. K., Stone, M. H., Sevecke, K., & Steinmeyer, E. M. (2007). Motives for maternal filicide: Results from a study with female forensic patients. *International journal of law and psychiatry*, 30(3), 191-200

⁶⁷ Statement of Dr Yvonne Skinner dated 7 March 2017, 6

⁶⁸ *Coronial Brief*, Transcript of police interview with Sofina Nikat held on 12 April 2016, 615

⁶⁹ Records provided by Safe Futures Foundation dated 25 July 2018

⁷⁰ Krischer, M. K., Stone, M. H., Sevecke, K., & Steinmeyer, E. M. (2007). Motives for maternal filicide: Results from a study with female forensic patients. *International journal of law and psychiatry*, 30(3), 191-200

⁷¹ Resnick, P. J. (1969). Child murder by parents: a psychiatric review of filicide. *American Journal of Psychiatry*, 126(3), 325-334

⁷² *Coronial Brief*, Statement of Robiya Ali dated 10 April 2016, 187; Statement of Dr Danny Sullivan dated 4 September 2017, 6

⁷³ *Coronial Brief*, Transcript of police interview with Sofina Nikat held on 12 April 2016

Court, Sanaya was then seen at Manningham Maternal and Child Health Centre (**Manningham MCH**) on 15 December 2015 for an eighth month check-up.⁷⁴ I confirm that notes from these services are minimal and do not appear to indicate that any concerns were raised during the appointment.⁷⁵

56. During an appointment on 24 February 2015, the attending MCHN undertook the Edinburgh Postnatal Depression Scale (**EPDS**) with Ms Nikat. Notes indicate that Ms Nikat was assessed as having an EPDS score of 5, indicating a low likelihood of developing post-natal depression, and that MCHN proceeded to discuss the signs and symptoms of post-natal depression with Ms Nikat.
57. On 11 March 2016, Ms Nikat and Sanaya attended an appointment at Whitehorse Maternal and Child Health Centre (**Whitehorse MCH**) for the 12 months check up with the support of Safe Futures.⁷⁶ During this appointment, a Key Ages and Stages assessment was completed which included a discussion regarding 'family health and wellbeing'.⁷⁷ There is no indication that any further assessments for post-natal depression were undertaken with Ms Nikat following the 24 February 2015, despite significant changes to her relationship and living circumstances.
58. MCHNs follow the Key Ages and Stages guidelines when meeting with women and their children throughout the postnatal period.⁷⁸ These guidelines indicate various physical and social developmental and wellbeing factors for nurses to assess at different stages of a child's development.⁷⁹ A statement from the Manager of Health and Family Services in Whitehorse indicates that Sanaya presented well during the appointment on 11 March 2016 and that the MCHN did not hold concerns for her welfare.⁸⁰
59. This appears to be in line with MCHN guidelines which indicate that at the four-week consultation, the MCHN is guided to ask direct questions regarding the physical and mental wellbeing of the mother, undertake a family violence risk assessment and, if necessary,

⁷⁴ Maternal Child Health Records of Sanaya Sahib provided by City of Whitehorse dated 10 August 2018, 2-3

⁷⁵ *ibid*

⁷⁶ *ibid*

⁷⁷ *ibid*; Statement of Mr T Johnson, Manager of Health and Family Services Whitehorse City Council

⁷⁸ Department of Education and Early Childhood Development, Victorian Government (2009) *Maternal and Child Health Service: Practice Guidelines 2009*; Department of Education and Early Childhood Development, Victorian Government (March 2009) *Maternal and Child Health Service: Key Ages and Stages Framework*

⁷⁹ *ibid*

⁸⁰ Statement of Mr T Johnson, Manager of Health and Family Services Whitehorse City Council

complete the Edinburgh Postnatal Depression Scale.⁸¹ These assessments are aimed at detecting postnatal depression early, thus allowing for early intervention. Following the four-week assessment, MCHN's are encouraged "*to monitor maternal health and wellbeing throughout all the KAS [Key Ages and Stages] visits*"⁸² but are not directed to ask direct questions or undertake any further assessments of maternal wellbeing.

60. I confirm that the Australian Clinical Practice Guidelines for Mental Health Care in the Perinatal Period recommends that psychosocial assessments should be completed between six to 12 weeks following the birth of a child.⁸³ Under the current MCH Key Ages and Stages Guidelines, the maternal emotional health and wellbeing check, which includes screening for postnatal depression, occurs when the child is four weeks old and there is no clear direction for staff to rescreen at a later date.⁸⁴
61. I note that in instances where a mother's circumstances change or where she is unable to, or does not attend, the four-week MCH appointment, the MCH guidelines and practice manuals do not appear to stipulate whether staff are required to administer the emotional health and wellbeing check at the woman's next appointment.⁸⁵
62. In the Australian Clinical Practice Guidelines for Mental Health Care in the Perinatal Period it is suggested that mothers should complete the Edinburgh Postnatal Depression Scale in the six to twelve weeks following the birth of their child, and that, ideally, the assessment should be completed twice throughout the postnatal period.⁸⁶
63. Consensus-based recommendations from the Centre of Perinatal Excellence suggest that following the first antenatal screening, a repeat screening should be completed "*at least once*

⁸¹ Department of Education and Early Childhood Development, Victorian Government (2009) *Maternal and Child Health Service: Practice Guidelines 2009*; Department of Education and Early Childhood Development, Victorian Government (March 2009) *Maternal and Child Health Service: Key Ages and Stages Framework*

⁸² Department of Education and Early Childhood Development, Victorian Government (2013) *Perinatal Mental Health and Psychosocial Assessment*, 2

⁸³ Centre of Perinatal Excellence, (October 2017) *Mental Health Care in Perinatal Period- Australian Clinical Guideline*, 28; Department of Education and Early Childhood Development, Victorian Government (2013) *Perinatal Mental Health and Psychosocial Assessment*, 2

⁸⁴ Department of Education and Early Childhood Development, Victorian Government (2009) *Maternal and Child Health Service: Practice Guidelines 2009*; Department of Education and Early Childhood Development, Victorian Government (March 2009) *Maternal and Child Health Service: Key Ages and Stages Framework*

⁸⁵ Department of Education and Early Childhood Development, Victorian Government (2013) *Perinatal Mental Health and Psychosocial Assessment*, 2; Department of Education and Early Childhood Development, Victorian Government (2009) *Maternal and Child Health Service: Practice Guidelines 2009*; Department of Education and Early Childhood Development, Victorian Government (March 2009) *Maternal and Child Health Service: Key Ages and Stages Framework*

⁸⁶ Centre of Perinatal Excellence, (October 2017) *Mental Health Care in Perinatal Period- Australian Clinical Guideline*, 28; Centre of Perinatal Excellence

later in the pregnancy”⁸⁷ and that the screening should be repeated “at 6–12 weeks after the birth and at least once in the first year following birth”.⁸⁸ In light of this research and the available evidence in the coronial brief, the lack of further post-natal depression screening for Ms Nikat was a missed opportunity for intervention.

Criminal justice outcome

64. On 22 September 2017, in the Supreme Court of Victoria, Ms Nikat pleaded guilty to infanticide in relation to Sanaya’s death. On 23 November 2017, Ms Nikat was sentenced to a Community Corrections Order for 12 months due to her pre-sentence custody of 529 days.⁸⁹
65. I am satisfied, having considered all of the available evidence, that no further investigation is required.

RECOMMENDATIONS PURSUANT TO SECTION 72(2) OF THE ACT

Increased frequency of post-natal depression screens by Maternal Child Health Nurses

66. In reflection of this, in 2005, the offence of Infanticide was amended in the *Crimes Act 1958* (Vic) to include the killing of a child by its mother, due to a disturbance of the mind caused by the effects of either childbirth or lactation, within the two year period after giving birth.⁹⁰ Prior to this, infanticide had only covered offences in which a mother had killed their child within a 12 month period of giving birth.⁹¹ This amendment was introduced by the Victorian Government given that “the vast majority of deaths in these circumstances occur in the first two years”⁹² of a child’s life.
67. In Victoria, infanticide describes a particular kind of child killing that is both an offence and an alternative verdict to murder. I confirm that research indicates that mothers who commit filicide most commonly kill children aged between zero to five.⁹³ The Law Reform Commission of Victoria identified that statistics of child killings by mothers who are mentally

⁸⁷ Centre of Perinatal Excellence, (October 2017) *Mental Health Care in Perinatal Period- Australian Clinical Guideline*, 28

⁸⁸ Centre of Perinatal Excellence, *Perinatal Mental Health Guideline: Summary for mental health nurses* <<https://www.cope.org.au/perinatal-mental-health-guideline-summary-for-mental-health-nurses/>>.

⁸⁹ *R v Nikat* [2017] VSC 713, 9

⁹⁰ Victoria, *Parliamentary Debates*, Legislative Assembly, 6 October 2005

⁹¹ *ibid*

⁹² *ibid*, 1352

⁹³ Debowska, A., Boduszek, D., & Dhingra, K. (2015). *Victim, perpetrator, and offense characteristics in filicide and filicide-suicide. Aggression and violent behavior*, 21, 113-124; Thea Brown, Samantha Bricknell, Willow Bryant, Samantha Lyneham, Danielle Tyson and Paula Fernandez Arias, ‘Trends & Issues in crime and criminal justice- Filicide Offenders’ (2019) 568 *Australian Institute of Criminology*

disturbed due to the birth of the child generally take place within the first two years after birth.⁹⁴

68. In support of this recommendation, the University Health Network Women's Health Program in Toronto found that "*postpartum depression usually begins within 1–12 months after delivery*",⁹⁵ thus suggesting that wellbeing support offered throughout this period would be most appropriate.
69. As such, **I RECOMMEND** that the Victorian Department of Health and Human Services update the frequency of the maternal health and wellbeing check, as outlined by the *Maternal Child Health Service: Practice Guidelines 2009* and *Perinatal Mental Health and Psychosocial Assessment: Practice Resource Manual for Victorian Maternal and Child Health Nurses*, to occur at regular intervals throughout a mother's engagement with Maternal and Child Health service at least once a year for the first two years of the birth of a child.
70. **I also RECOMMEND** that the Victorian Department of Health and Human Services issue updated guidelines to include steps to contact mother's in instances where their personal circumstances have significantly changed to administer post-natal depression screening at the earliest available opportunity.

FINDINGS AND CONCLUSION

71. Having investigated the death, without holding an inquest, I make the following findings pursuant to section 67(1) of the Act:
- (a) the identity of the deceased was Sanaya Sahib, born 20 January 2015;
 - (b) the death occurred on 9 April 2016 at Olympic Park, Heidelberg West, Victoria, 3081, from suffocation; and
 - (c) the death occurred in the circumstances described above.
72. I convey my sincerest sympathy to Sanaya's family.

⁹⁴ Victorian Law Reform Commission, *Defences to Homicide – Final Report* (October 2004), xxiii

⁹⁵ Donna Stewart, E. Robertson, Cindy-Lee Dennis, Sherry Grace, Tamara Wallington, '*Postpartum Depression: Literature Review of Risk Factors and Interventions*' (2003) University Health Network Women's Health Program, 19

73. Pursuant to section 73(1A) of the Act, I direct that a copy of this finding be published on the Coroners Court website.
74. I direct that a copy of this finding be provided to the following:
- (a) Mr Abdul Sahib, senior next of kin;
 - (b) Ms Sofina Nikat, senior next of kin;
 - (c) Ms Colleen Carey, Principal Solicitor, Department of Health and Human Services;
 - (d) The Honourable Mr Daniel Andrews MP, Premier of Victoria;
 - (e) Ms Liana Buchanan, Principal Commissioner, Victorian Commission for Children and Young People; and
 - (f) Detective Acting Inspector Stuart Bailey, Victoria Police, Coroner's Investigator.

Signature:



CAITLIN ENGLISH
ACTING STATE CORONER

Date: 30 October 2019

