IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2013 3373

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1) of the Coroners Act 2008

Deceased:	HB
Delivered on:	14 January 2020
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Findings of:	Coroner Paresa Antoniadis SPANOS
Hearing dates:	Directions Hearings: 7 July 2017, 29 March 2018 Inquest: 19, 23 and 24 April 2018
Counsel assisting the Coroner:	Leading Senior Constable King TAYLOR from the Police Coronial Support Unit
Representation:	Ms J. BENSON appeared on behalf of the Department of Health and Human Services Ms M. FITZGERALD appeared on behalf of the Royal Children's Hospital Ms R. ELLYARD appeared on behalf of Anglicare/Child FIRST
Catchwords:	Child with complex medical needs, malnourished child, total parenteral nutrition, PEG feeding, seizure disorder, epilepsy, Lennox Gastaut syndrome, DHHS, Child Protection, ChildFIRST, Disability Client Services

TABLE OF CONTENTS

I, PARESA ANTONIADIS SPANOS, Coroner, having investigated the death of

HB and having held an inquest in relation to this death

at Melbourne on 19, 23 and 24 April 2018:

find that the identity of the deceased was HB

born on 11 September 2004, aged 8 years and 10 months

and that the death occurred on 1 August 2013

at Hoppers Crossing, Victoria 3029

from:

I (a) ASPIRATION PNEUMONIA IN A CHILD WITH AN EPILEPTIC ENCEPHAOLOPATHY[1] AND EXTREME CACHEXIA[2]

in the following circumstances:

INTRODUCTION[3]

1. HB, referred to in this finding as HB, was the third child and daughter born to EG and DB. HB was six weeks short of her ninth birthday when she died on 1 August 2013 at the home she shared with her mother and three sisters in Hoppers Crossing. HB is survived by her parents, grandparents and three sisters; BB who was 12 years and 11 months old when HB died, JB who was 11 years and eight months and LB who was almost two years old.

2. HB was born on 11 September 2004 at the Royal Women's Hospital by caesarean section. She was in good condition at birth weighing 3.29kg with good Apgar scores of 9/9. HB experienced no major adverse medical events since birth and appeared to be developing normally until about five months of age. At this time, her parents noticed her development was slower than expected - HB was their third child - and observed her to be making jerking movements. They reported their concerns to the family doctor who referred HB to a consultant paediatrician. After investigations, HB was diagnosed with infantile spasms and commenced on antiepileptic medications. HB underwent regular medical review thereafter and a raft of investigations in an effort to ascertain the underlying cause of her condition.[4]

3. While the raising of four children can be expected to have its challenges, particularly for a single parent or carer, HB had very special care needs arising from her frequent seizures,

[1] Any degenerative disease of the brain.
[2] A profound and marked state of constitutional disorder; general ill health and malnutrition.
[3] This section is a summary of background and personal circumstances and uncontentious matters that provide a context for those circumstances in which the death occurred.
[4] See paragraphs 54 and following below for a fuller medical history.

severe developmental delay and cerebral palsy and required time consuming round the clock care.

4. HB could not speak but she could make sounds that her family were able to interpret as 'yes', 'no' or an indication of pain for example. HB could not move independently and would spend her time either lying down or in a wheelchair. She needed to be manually lifted or hoisted from bed to wheelchair, and vice versa, and needed all activities of daily living performed for her including bathing and toileting

5. Relevantly, HB could not swallow safely and was fed special formula and administered her prescription medications through a percutaneous endoscopic gastrostomy (PEG) tube.[5] In the period leading to her death, HB was meant to be fed 250mls special formula five times a day commencing between 9.00-10.00am and two-hourly thereafter. The formula was delivered via syringe bolus with a 60ml water flush following each feed. This feeding regime was overseen by a dietician and was designed to meet all HB's nutritional requirements.[6]

6. Also delivered via PEG tube were HB's prescription medications. In the period preceding her death, her medication regime comprised levetiracetam 500mg twice daily, phenytoin 24mg three times a day, clonazepam 0.1mg four times a day and lamotrigine 75mg twice daily. Even with all these medications, HB was not expected to be seizure-free. Rather, the medication regime was expected to decrease the number and duration of her seizures.[7]

CIRCUMSTANCES PROXIMATE TO HB'S DEATH

7. EG and DB separated on Boxing Day 2011. From then until HB's death some 20 months later there was a period of instability for the whole family, with HB and her sisters moving between their parents, at other times moving premises, at times not seeing their father for weeks at a time and their care being shared between their parents with whatever supports they could muster or chose to engage.

8. Immediately following their parents' separation, HB and her sisters remained in their father's care in the family home at Skipton for about three weeks. By mid-January 2012, EG wanted the girls returned to her care and struck an informal arrangement with DB for each of them to have the children four days at a time. When that arrangement fell apart, EG

[5] Percutaneous endoscopic gastrostomy is an endoscopic medical procedure in which a tube (PEG tube) is passed into a patient's stomach through the abdominal wall, most commonly to provide a means of feeding when oral intake is not adequate, for example, because of dysphagia (difficulty swallowing) or sedation.
[6] Statement of paediatric dietician, RCH, Ms Sarah Clarke dated 1 October 2013 at page 39 of the coronial brief.
[7] Report of Dr Jeremy Freeman, staff specialist in neurology, RCH, dated 10 September 2013, page 33 of the coronial brief.

and DB wrote up a parenting agreement whereby JB and LB would live with EG, BB and HB would live with DB, and on alternative weekends one parent would look after all four girls, ensuring they also spent time together and their parents had some respite.[8]

9. When this arrangement also broke down, application was made to the Family Court, which resolved with consent orders made on 30 November 2012. Pursuant to those orders, during school term the children would live with their mother in Tarneit where she had set up residence and spend time with their father in their former family home in Skipton each weekend from 4.30pm Friday to 4.30pm Sunday. On alternative weeks, HB would remain with her father until 4.30pm on the Wednesday afternoon, after her sisters returned to their mother's care. Again, this arrangement seems to have recognised HB's high care needs and allowed each parent some respite.[9]

10. After the Family Court orders were made, arrangements between the parents did not go as smoothly as they might. According to DB, he did not see the girls in March 2013 as he developed an eye condition which made it difficult for him to drive and EG was not prepared to drive the girls to him. Consequently, he only saw them occasionally from mid-April and was denied school holiday contact in July. At his request, in early July 2013[10], EG brought the girls to DB's parents' home on one occasion so he could see them. However, EG did not bring HB on this occasion as DB had hoped, saying that she wanted to spend some time alone with HB.[11]

11. When DB eventually saw HB on Wednesday 17 July 2013, he noticed how thin she was and commented to EG that she felt like she only weighed about 14kg. According to DB, this annoyed EG and she denied it was the case and said HB was a lot heavier than that. DB asked when HB had last been weighed and EG said it had been some time as she was busy and had missed the last appointments with the dietician and paediatrician.[12]

12. As far as has been ascertained from medical records and statements included in the coronial brief, HB's last recorded weight was 19.50kg measured in the Royal Children's Hospital General Medicine clinic on 19 September 2012. At her last appointment with a dietician from at the RCH on 19 December 2012, HB's weight was estimated at 20kg.

---

[8] Statement of DB dated 29 August 2013, pages 76-81 of the coronial brief.
[9] The orders made by the court also made provision for school holidays, telephone contact and other incidental matters. A copy of the orders made by Federal Magistrate Riethmuller on 30 November 2012 is at pages 639-642 of the coronial brief.
[10] DB was unsure but thought this occurred on either 7 or 14 July 2013. Page 84 of the coronial brief.
[11] Pages 84-85 of the coronial brief.
[12] Page 85 of the coronial brief.

13. The last time HB was seen by any healthcare professional was on 9 January 2013 when she was seen by neurologist Dr Freeman, at the RCH. At that appointment, he estimated her weight at 20kg, essentially unchanged from her last appointment.[13]

14. At the time, HB had appointments pending at RCH between March and July 2013 with General Medicine, Paediatric Dentistry, Gastroenterology and with the Dietician. Subsequent investigation indicates that HB was not taken to any of those appointments.[14] As a result, HB was not seen by any healthcare professional between 9 January 2013 and her death, or by anyone else beyond her family and those closely associated with her family.

15. The response of the Department of Health and Human Services (DHHS), in its Child Protection and Disability Client Services iterations to HB's family will also be discussed detail below. Suffice for present purposes to note that Child Protection had received a report on 7 April 2013 (the fifth involving the children of EG and DB) expressing concerns for the four children in their mother's care, including *inter alia,* a report that the mother was using "ice" and leaving the children unsupervised for long periods; that HB was left in the same nappy all day and missed her medication and has not been bathed for weeks; that the home was a "pig sty"; that the children were not attending school regularly and the mother was not providing adequate care for them.[15]

16. This report was closed by Child Protection at intake and treated as a wellbeing report (a term of art) with a referral to ChildFIRST on 16 April 2013.[16] As a result of the referral, there were two reasonably lengthy telephone calls between ChildFIRST staff and EG on 6 May and 12 June 2013, and some other brief telephone calls to confirm or re-arrange assessment appointments. However, the referral did not result in any substantive assistance being provided to EG before it was overtaken by events.[17]

---

[13] Statement of Dr Jeremy Freeman dated 10 September 2013 at page 33 of the coronial brief.
[14] The missed appointments are most accessible at pages 8-9 of the summary at the front of the coronial brief: 13 March 2013, general dentistry appointment missed, letter sent to EG; 2 April 2014, gastroenterology appointment missed, letter sent to EG; 24 April 2013, general medical appointment cancelled by EG via SMS; 6 June 2013, failed to attend dietician, letter sent to EG re-booking appointment for 3 July 2014; 3 July 2013, failed to attend Dietician appointment; 3 July 2013, general neurology, cancelled by EG and re-booked for 2 October 2013
[15] The Case Note documenting this report appears at pages 490-491 of the coronial brief. The report included concerns that the mother leaves home for hours at a time in order to go to Melton to obtain drugs and that she is using ice and that she brings male friends to the home indiscriminately.
[16] See Case Note at pages 490-491 and Intake Record commencing at page 468 of the coronial brief respectively.
[17] See Child FIRST/Anglicare case notes at pages 1439-1443 of the coronial brief. It appears that Child Protection's decision to move the sixth report to investigation caused Child FIRST to cease their involvement with the family pursuant to the fifth report/well-being referral. See Mr Clout's evidence to the effect that this should not be a unilateral decision by Child FIRST but should involve a consultation between Child FIRST and Child Protection before any such decision to close or end the referral is taken and his evidence that he could find no evidence that any such conversation had taken place on this occasion - transcript pages 94-95.

17. Child Protection received another (the sixth) report about the children on 15 July 2013. That report was still extant when HB died. It was reported that DB left the girls with his parents on the weekend of 13-14 July 2013 for an unspecified period and returned intoxicated to his parents' home. The report alleged that he grabbed his eldest daughter by the throat causing his father to intervene by punching him to make him desist. This report was assessed as requiring Child Protection involvement by way of a Planned Investigation.[18]

18. The following day, 16 July 2013, the Child Protection Intake Deputy Area Manager endorsed the case for transfer to Western Melbourne Investigation and Response for investigation given the cumulative emotional and physical harm the children were subjected to in the care of their parents and the consistent nature of the reported concerns over the preceding 12 to 18 months. It was recommended that EG's parenting capacity and the children's contact with their father be further assessed and the case was transferred on 19 July 2013.[19]

19. On 23 July 2013, an Advanced Child Protection Practitioner (ACPP) attempted to conduct an unannounced visit to EG's home in Tarneit only to find the premises unoccupied and a "For Sale" sign and "Sold" sticker affixed to the front of the property. The ACPP telephoned the relevant real estate agent that day and EG on 30 July 2013 to advise that she had been allocated the case and was seeking a face-to-face meeting. EG indicated she was aware of the report and happy to meet but said that next week was better for her. Matters were left on the basis that the ACPP would visit EG and her two youngest daughters (including HB) on 7 August 2013 at the Hoppers Crossing home where they had moved ahead of their previous rental home being sold.[20]

20. Due to her close friendship with EG, one of the people in contact with HB in the months preceding her death was Rebecca Fountain, who visited almost daily. Ms Fountain last saw HB at the beginning of the school holidays in July 2013 when she and EG took their children to the Werribee Zoo. According to Ms Fountain, on this outing HB was wrapped in blankets, slept most of the day, looked sick and was snuffly. HB and EG spent the second week of the school holidays at EG's mother's house.

21. Despite visiting the house regularly thereafter, Ms Fountain did not *see* HB, who was in the bedroom she shared with her mother and younger sister when she visited. However, Ms Fountain stated that she *heard* HB call out to her mother on the evening of 30 July 2013 and,

[18] See Case Notes from pages 393-426 and statement of Eddy De Nardis dated 1 November 2011 at pages 42.12-42.15 of the coronial brief respectively.
[19] See paragraphs 101 and following below.
[20] Ibid.

when she heard her struggling to breathe on the following evening 31 July 2013, told EG that she should take HB to hospital. Ms Fountain left EG's home at around 5.30-6.00pm on 31 July 2013.[21]

HB'S DEATH ON 1 AUGUST 2013

22. The following morning, 1 August 2013, all the family were at home, except JB who was at school. According to JB's account, HB was verbalising that morning and she last heard her do so when she left for school at 8.00am or 8.30am. Other than EG and her daughter, the only other person at the home was her mother's friend Lincoln who had stayed the night.[22]

23. BB's recollection is that she woke at about 7.00-7.30am, told her mother she did not want to go to school and went back to bed. At about 10.30am BB got out of bed and, a short time later when LB woke, went into the bedroom LB shared with HB and their mother, to get her up. BB did not notice anything amiss with HB at the time and set about making chicken nuggets for breakfast for her and LB. According to BB, EG's best friend Lincoln had stayed the night and her mother left to drive him home at about 10.00am. BB was left baby-sitting her sisters until her mother returned at about 11.00am. A little after 1.00pm, BB and her mother were cleaning up and singing along to music when her mother went in to start HB's feeds and found her deceased.[23]

24. EG was formally interviewed by police and gave a different account of the morning of 1 August 2013. According to her account, HB was up until about 3.00am and she was allowing her to sleep in. When EG woke at around 8.00am to get JB off to school, she heard HB make a noise. According to EG, BB and LB were both up by about 8.30am. She could not recall what BB and LB had for breakfast and said that BB cooked chicken nuggets for lunch. Around midday, when EG left to go to the supermarket and drive Lincoln Westcott to Hoppers Crossing railway station, HB was okay, and she was only gone for 20 minutes or less.[24]

25. At about 1.00pm, when HB had had about ten hours sleep, EG thought it was time to get her up and get her day started. She pulled the blanket back and thought it was strange when HB did not react by 'sort of jumping and wriggling a bit' as usual. EG then touched HB and,

[21] Statement of Rebecca Fountain dated 23 October 2013 at pages 129-141 of the coronial brief, esp. at pages134-135.
[22] Transcript of JB's V.A.R.E. interview conducted 17 September 2013, at pages 188-219 of the coronial brief.
[23] Transcript of BB's V.A.R.E. interview conducted 17 September 2013, at pages 142-187 of the coronial brief.
[24] Transcript of EG's Recorded Interview conducted 17 September 2013, at pages 1517-1745 of the coronial brief, especially at pages 1679 onwards dealing with events on 31 July 2013 and the morning of 1 August 2013.

realising she was cold, shook her, called her name and was in a daze for a couple of minutes before taking her phone from BB and calling 000.[25]

26. Records obtained in the course of this investigation indicate that the call to 000 was time-stamped 13:04:54 hours on 1 August 2013. EG attempted cardiopulmonary resuscitation (CPR) under instruction from the 000 call-taker until Ambulance Victoria (AV) paramedics arrived at 1.16pm.[26]

27. On approaching the home, paramedics observed boxes of PEG feeding formula on the front porch. They were directed to a bedroom at the back of the home and found HB lying on the floor on her right side in a curled up foetal position. They noted a strong stench of stale faecal matter in the bedroom. HB was emaciated and wearing a soiled nappy but no pants. The bed had a red/brown stain. There were no physical signs of injury or trauma and "some reddy/brown stuff on her face". [27]

28. Paramedics checked HB for a pulse and found none; a cardiac monitor showed asystole (no electrical activity in the heart); no heart sounds were heard for two minutes; HB was not breathing; and she had a tympanic temperature of 29.1° C on a "coolish sort of day".

29. AV paramedic King made no notation of *rigor mortis* and hazarded a guess that HB had been deceased for at least half an hour and up to three to four hours. He recorded HB's weight at 18 kg but added in his statement that "she wouldn't have been that heavy" and was unsure if this weight was his own estimate or information provided by the mother. [28]

30. AV paramedic King described the house as dirty and untidy with toys and clothes strewn everywhere and stated that it "seemed like the mother was not equipped to be looking after the children". In his career of 17 years as a paramedic, he had "never seen a kid who looked that unwell at home.[29]

---

[25] Ibid at pages 1680-1681.

[26] Statement of AV paramedic Bruce King dated 17 December 2013 at page 45 of the coronial brief. Also, see Appendix I, VACIS electronic Patient Care Report at pages 599 to 603 of the coronial brief. MICA Unit 23 comprised AV paramedics Bruce King (attendant) and Lavinia Cannon (driver) and was dispatched at 1:06 hours and "at patient" or by the patient's side at 1:16 hours.

[27] Ibid. I note the following excerpt from AV paramedic King's statement *"The mother told me that HB's routine would be going to bed at midnight to 2am and sleeping to midday. She told me that she had been in to check HB at about midday and thought she was still asleep. She said that when she hadn't woken by one she went to check her again and found her non responsive and called the Ambulance."*

[28] Ibid.

[29] *"The case stuck in my mind as I don't see that many dead children. I have seen maybe a dozen in my career of 17 years. I have never seen a kid who looked that unwell at home. I have also kept thinking how ill prepared this woman was, she looked ill equipped to take care of HB, she looked like she needed higher care than her mother could give her. The mother didn't look like she could care for herself, she looked unkempt and the environment was untidy. It wasn't like she had just got out of bed."* Statement of AV paramedic King at page 46 of the coronial brief

INVESTIGATION AND SOURCES OF EVIDENCE

31. When first responders from Ambulance Victoria and Victoria Police attended on 1 August 2013 immediately following HB's death, it appeared that she had died of natural causes related to her medical issues and physical condition. Concerns about HB's living circumstances and death were subsequently raised with Victoria Police on 2 August 2013 and in the days following.

32. On 14 August 2013, a joint investigation into the circumstances of the death was commenced by Detective Senior Constable Katie Schroeter from Footscray SOCIT and Detective Senior Constable Chris Hill from the Homicide Squad.[30]

33. The original brief the product of that investigation was ultimately provided to the court under cover of a memorandum dated 29 May 2015. I sought and received additional material through my assistant Leading Senior Constable King Taylor from the Police Coronial Support Unit. This was added to the original brief to form the coronial brief referred to as such during the inquest and throughout this finding.

34. This finding is based on the totality of the material obtained in the coronial investigation of HB's death which will remain on the court file together with the inquest transcript. In writing this finding, I do not purport to summarise all the material and evidence. Rather, I will refer to the evidence only in such detail as is warranted by its forensic significance and the interests of narrative clarity.

35. More specifically (and on the whole), I have chosen not to repeat the detailed chronologies of the family's engagement with the Child Protection and Disability Client Services divisions of the Department of Health and Human Services (the department) and all the detail of the analyses which have been undertaken by the institutions involved with HB's family who were also parties represented at inquest.

36. In part, this arises from the need to confine a coronial investigation to proximate and causally relevant circumstances, and in part, from the need to tread carefully around legislative provisions which protect the identities of children, of those who report child protection concerns to the department and certain litigants or parties to certain types of proceedings.

37. However, in larger part, this reflects my conviction, that more is to be gained from a prevention perspective by looking at HB's death with a focus on the paradigms for delivery

[30] The investigation was initially focused on the possibility of a criminal prosecution and was only provided to the court after that notion was abandoned. This is in accordance with the practice in this jurisdiction which sees coronial investigations in hiatus while any related criminal proceedings are contemplated and/or pursued.

of child protection, family support and disability client services and reflecting on how HB and vulnerable children like her could be better served in the future, perhaps by a shift in those paradigms.

PURPOSE OF A CORONIAL INVESTIGATION

38. The purpose of a coronial investigation of a *reportable death*[31] is to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which the death occurred.[32] HB's death was reported by police as it appeared to have been unexpected and was potentially related to neglectful care.

39. The term "cause of death" refers to the *medical* cause of death, incorporating where possible the mode or mechanism of death.

40. For coronial purposes, the term "circumstances in which the death occurred" refers to the context or background and surrounding circumstances. It is confined to those circumstances which are sufficiently proximate and causally relevant to the death and does not include all circumstances which might form part of a narrative culminating in the death.[33]

41. The broader purpose of any coronial investigations is to contribute to a reduction in the number of preventable deaths, through the findings of the investigation and the making of recommendations by coroners. This is generally referred to as the 'prevention role.'[34]

42. Coroners are empowered to report to the Attorney-General on a death which the coroner has investigated; comment on any matter connected with the death, including matters relating to public health and safety or the administration of justice; and make recommendations to any Minister, public statutory authority or entity on any matter connected with a death which the coroner has investigated, including recommendations relating to public health and safety or the administration of justice.[35] These are effectively the vehicles by which the Coroner's prevention role can be advanced.[36]

---

[31] The term is exhaustively defined in section 4. Apart from a jurisdictional nexus with the State of Victoria (s 4(1)), reportable death includes "a death that appears to have been unexpected, unnatural of violent or to have resulted, directly or indirectly, from an accident or injury". Section 4(2)(a).
[32] Section 67(1).
[33] This is the effect of the authorities – see for example *Harmsworth v The State Coroner* [1989] VR 989; *Clancy v West* (Unreported 17/08/1994, Supreme Court of Victoria, Harper J).
[34] The 'prevention' role is now explicitly articulated in the Preamble and purposes of the Act, compared with the Coroners Act 1985 where this role was generally accepted as 'implicit'.
[35] See sections 72(1), 67(3) and 72(2) regarding reports, comments and recommendations respectively.
[36] See also sections 73(1) and 72(5) which requires publication of coronial findings, comments and recommendations and responses respectively; section 72(3) and (4) which oblige the recipient of a coronial recommendation to respond within three months, specifying a statement of action which has or will be taken in relation to the recommendation.

43. It is important to stress that coroners are not empowered to determine the civil or criminal liability arising from the circumstances in which a reportable death occurred and are explicitly prohibited from including in a finding or comment, any statement that a person is, or may be, guilty of an offence.[37]

IDENTITY

44. Identification of the deceased is the first matter that a coroner is required to ascertain, if possible. HB's identity was confirmed by her mother EG who signed a State of Identification on 1 August 2013 which forms part of the coronial file. As there was no controversy about HB's identity, there was no further investigation of this matter.

MEDICAL CAUSE OF DEATH

45. The second matter that I am required to ascertain is the medical cause of HB's death and there are a number of sources of evidence on which I am able to draw.

46. On the morning of 2 August 2013, forensic pathologist Dr Yeliena Fay Baber from the Victorian Institute of Forensic Medicine (VIFM), reviewed the Police Report of Death to the Coroner (Police Form 83), post-mortem computer tomography scanning of the whole body conducted at VIFM (PMCT) and conducted an external examination of HB's body in the mortuary.

47. Having done so, Dr Baber provided a five page written report of her findings which included the following: the hair is dirty, matted and tied up in a ponytail, the scalp is dirty and head lice are widespread; the nails of the upper limbs (arms) were long and unkempt, the limbs were wasted and generally dirty; the nails of the lower limbs (legs) were long and irregular, the limbs were wasted and generally dirty; the abdomen had a PEG tube in situ which had dried blood around the base and there was dirt embedded in the umbilicus (belly button).[38]

48. Dr Baber also observed that HB weighed 12 kg and was approximately 130 cm in height. Although the external examination revealed an unkempt and cachectic[39] female child who appeared younger than her stated age of eight years[40], Dr Baber observed no sign of injury. Review of the PMCT revealed natural disease in the form of patchy increased lung markings

[37] Section 69(1). However, a coroner may include a statement relating to a notification to the Director of Public Prosecutions if they believe an indictable offence may have been committed in connection with the death. Sections 69(2) and 49(1).
[38] Dr Baber's medical examiner's report (MER) is at pages 27-31 of the coronial brief and includes her formal qualifications and experience.
[39] Pertaining to or characterised by cachexia.
[40] In fact, HB was two months short of her ninth birthday when she died and therefore even smaller for her age.

bilaterally and whiteout of the right middle lobe, consistent with an aspiration pneumonia, but no evidence of traumatic injuries.

49. Routine toxicological analysis of post-mortem specimens taken from HB was performed and revealed the anticonvulsant lamotrigine at a concentration of ~0.8mg/L, but no other prescription medications or commonly encountered drugs or poisons. Dr Baber discussed the level of lamotrigine with a senior forensic toxicologist who advised that this post-mortem concentration is acceptable for the prescribed dose of 50 mg bd (twice daily) as was understood to be the dose prescribed to HB at the time.

50. Being aware of the mother's/EG's objection to an autopsy being performed and based on all the material then available to her, Dr Baber advised that it would be reasonable to attribute HB's death to *aspiration pneumonia in a child with Lennox Gastaut syndrome,* without the need for an autopsy or full post-mortem examination.

51. As Dr Baber was on extended leave and unavailable to attend the inquest, I asked Dr Linda Elizabeth Iles, in her capacity as Head of Pathology at VIFM,[41] to review Dr Baber's report and any other available material ahead of attending the inquest to answer questions about HB's medical cause of death, and to elucidate the circumstances in which she died to the extent possible.[42]

52. Apart from Dr Baber's report, Dr Iles reviewed external photographs of HB taken at VIFM, the PMCT taken at VIFM and reports from the RCH and medical letters/reports from neurologist Dr Jeremy Freeman[43], paediatrician Dr James McLellan[44] and dietician Ms Sarah Clark[45], all from the RCH and all involved in providing clinical management and care to HB.

53. At inquest, Dr Iles made some additional observations to those contained in Dr Baber's report. Dr Iles noted that HB's body weight of 12 kg and height of approximately 130 cm produced a body mass index (BMI) of seven, which was "really quite extreme". While she conceded that a healthy BMI range for an adult is between 20 to 25 and that some modification would need to be made for a child of HB's age, seven was the lowest BMI she

[41] See transcript pages 137-138 where this is discussed.
[42] Dr Iles' evidence commences at transcript page 192.
[43] Dr Freeman's letters/reports dated 10 September 2013 and 11 October 2016 appear at pages 32 and 33.1 respectively of the coronial brief.
[44] Dr McLellan's letters/reports dated 2 October 2013 and 20 October 2016 appear at pages 34 and 3.1 respectively of the coronial brief.
[45] Ms Clarke's letters/reports dated 10 October 2013 and 13 October 0216 appear at pages 40.1 and 41 respectively of the coronial brief.

had ever seen in her professional practice which included 12 years specialisation in forensic pathology.[46]

54. When asked about the significance of a BMI of seven, Dr Iles said that HB would have been in a parlous metabolic and probably immunological state in terms of her vulnerability to infections. Quite apart from calculation of her BMI, Dr Iles expressed the opinion that her appearance post-mortem, with the prominence of her skeleton or bones, and the complete lack of subcutaneous fat, speaks to the extreme state of HB's nutrition.[47]

55. In response to evidence suggesting that HB lost something of the order of eight kilograms, in the period of about seven months immediately preceding her death, Dr Iles testified that the more rapidly and individual loses lose weight, the more metabolically challenged they are.[48] Although HB was reported to have always been a small child, on the third centile in terms of her weight, a weight of 12 kg for her age at the date of death was a significant departure from this and well below the third centile.[49]

56. Based on photographs taken in the mortuary, Dr Iles disagreed with Dr Baber's observation that "post-mortem hypostasis is distributed posteriorly."[50] In her opinion, HB was notably pale and this suggested the possibility that she was anaemic at the time of her death, another potential indicator of insufficient or poor nutritional intake.[51]

57. Also based on a review of mortuary photographs, Dr Iles noted some signs of potential injury, albeit minor, not referred to by Dr Baber in her report – a square shaped area of ulceration on HB's left hip approximately two by one centimetres, which *possibly* represented an unusually shaped pressure sore if HB spent much time lying on her left hip; a crusted lesion on the front of the right knee that looked like a healing abrasion; a bruise on her outer right shoulder; and ill-defined areas of what appear to be parchmented abrasions on HB's face, *possibly* resulting from peri-mortem or even post-mortem injury.

---

[46] Transcript pages 194 and 200-202. Dr Iles added by way of example that in the coronial jurisdiction, a BMI of 13 or less in adults is usually associated with eating disorders or terminal patients with malignancies.
[47] Transcript page 201.
[48] Ibid.
[49] Transcript page 202.
[50] Transcript page 195 – *"So hypostasis is a phenomenon, a post-mortem phenomenon, um, that when blood stops circulating it, um, settles as per gravity, so, um, and as most people, um, after they've been found deceased are put on their back, um, we usually see it, um, on the posterior part of their body. Um, now, circumstances in which you don't often see lividity is when people/s blood volume is reduced or it's – their red cell, um, volume is reduced…they're potentially anaemic…I'm concerned that, ah, she may have been anaemic, based on the fact that she was notably pale…[it is normally] a pink-purple discolouration…"*
[51] I note that the latter is my interpretation of the import of her evidence and not an opinion expressed by Dr Iles.

58. In addition, Dr Iles described an area of excoriation around HB's anus consistent with some sort of rash or irritative phenomenon. As regards the latter, Dr Iles advised that the range of possible causes was large but the most common cause would be irritation from faeces that could arise from being left in soiled nappies.

59. Dr McLellan is a consultant paediatrician who first saw HB at 11 months of age in September 2005.[52] HB's GP's referral had been prompted by the family's concerns that her development was slowing, and that she seemed increasingly tired. The family also reported seeing jerking movements and, on his own observation, Dr McLellan witnessed seizure activity. HB underwent an electro-encephalogram (EEG) which showed a markedly abnormal pattern and several infantile spasms. Dr McLellan diagnosed developmental delay and infantile spasms and commenced HB on vigabatrim, the epileptic medication of choice at the time.[53]

60. According to Dr McLellan's report, infantile spasms are a very serious presentation of childhood epilepsy, which unfortunately lead to more severe epilepsy and severe developmental problems. While there is an underlying brain abnormality or brain chemistry abnormality in most cases, even in 2013, a specific underlying cause for the condition cannot always be ascertained.[54]

61. Dr McLellan saw HB on another 15 occasions over the next three years between 2005 and 2008. While HB was still documented as having a Lennox Gastaut type syndrome, sometimes referred to as West syndrome and more recently severe myoclonic epilepsy of childhood, despite a huge number of investigations carried out by himself and others, the underlying cause of HB's seizures was never elucidated.[55]

62. Dr McLellan had not seen HB during 2013 and concluded his first report by attributing her death to her underlying severe medical problems of severe cerebral palsy, severe epilepsy and undiagnosed underlying metabolic brain condition as the likely main cause of her sudden death, either as nocturnal seizure or aspiration episode, either of them leading to pneumonia. Dr McLellan expressed the opinion that this outcome was not unexpected.

63. When later provided with a copy of Dr Baber's report and invited to comment, *inter alia,* whether he was still of the view that HB's death was the natural progression of her illness or

[52] Interestingly, HB weighed 8.7 kg at her first visit to Dr McLellan at 11 months of age. Dr McLellan's statement dated 2 October 2013, page 34 of the coronial brief.
[53] Ibid.
[54] Ibid, page 35 of the coronial brief.
[55] Ibid.

allowed for the possibility that neglectful care contributed, Dr McLellan found the weight recorded at 12 kg post-mortem was very difficult to understand. He advised that HB's weight was constantly in the 18-20 kg range in 2012, although weighing her was difficult and she was usually fully clothed when attending for review. He thought a terminal weight loss of 10-20 per cent (or 2-4 kg) was *possible* but could not explain a 7-8 kg loss.[56]

64. Dr McLellan reiterated that he had not seen HB since December 2012, could not comment on any other illness that might explain the extent of her weight loss but noted that she "was always a very skinny thin child as a result of her overall condition".[57]

65. HB was referred by Dr McLellan to consultant neurologist Dr Jeremy Freeman who first saw her in September 2008 for ongoing management of her severe epilepsy. Dr Freeman saw her frequently at first and then at roughly six-monthly intervals until January 2013.[58]

66. According to Dr Freeman, HB suffered from a severe and intractable epileptic disorder falling, within the general category of infantile epileptic encephalopathy. Despite an exhaustive search for an underlying cause, none was found. A mitochondrial disorder was suspected but at HB's last review with the metabolic unit at the RCH in 2011, it was felt that she did not have a mitochondrial disorder. Dr Freeman advised in his report that most children with HB's clinical presentation are thought to have *de novo* mutations of genes responsible for brain function.[59]

67. Dr Freeman also advised that HB had severe spastic quadriparetic cerebral palsy,[60] required gastrostomy feeds and was having difficulty with secretions, such that in 2011, her mother asked about oral suctioning. According to Dr Freeman, this lack of development was entirely in keeping with her severe neurological disorder and carries a risk of aspiration pneumonia and reduced life expectancy.[61]

---

[56] Dr McLellan's second report dated 20 October 2016, page 36.2 of the coronial brief.
[57] Ibid. I note that Dr McLellan also said the following about HB's weight loss - *"If the weight measurements at the RCH and at post mortem are both correct then a longer illness like chronic diarrhoea, type 1 diabetes, various rarer metabolic issue [sic] and cancer among others may offer a possible explanation but they would almost always be accompanied by other symptoms and that extreme weight loss would be very obvious to non-professionals."*
[58] HB was seen by Dr Freeman on 15 Sept and 7 Oct 2008; 21 Jan, 17 Feb, 27 May, 20 Aug and 25 Nov 2009; 24 Feb, 16 Jun (and missed a scheduled appointment on 15 Sept) 2010; 18 Mar, 30 Sept 2011; 4 Jul 2012; 9 Jan 2013; and missed a scheduled appointment on 3 July 2013.
[59] Dr Freemans' report dated 10 September 2013, page 32 of the coronial brief.
[60] Spastic quadriplegia/quadriparesis is a specific type of spastic cerebral palsy that refers to difficulty controlling movements in the arms and the legs. Those who experience this form of cerebral palsy will not have paralysis of the muscles, but rather jerking motions that come from stiffness within all four limbs.
[61] Ibid.

68. When last seen by Dr Freeman on 9 January 2013, HB's condition was much the same as it had been and her weight estimated rather than measured at 20 kg. He noted that the last (documented) measured weight was in the General Medical clinic on 19 September 2012 and was 19.50 kg.

69. Dr Freeman was provided with a copy of Dr Baber's report and invited to comment on HB's condition as described. He provided a second report in which he stated that HB's very low weight at the time of her death is a significant finding and would have predisposed her to death during any intercurrent illness. In terms of the appropriate *clinical* response to her condition, Dr Freeman stated that had he been aware of the weight loss, he would have been most concerned to rectify this and would have recommended admission for investigation and close monitoring during refeeding.[62]

70. Dr Freeman was also provided with an extract of records from the Pharmaceutical Benefits Scheme (PBS) which he stated indicated that not all of HB's usual medications were dispensed in April, May and June 2013 and that no clonazepam was dispensed after 4 July 2012. In his second report, Dr Freeman commented about the possibility that HB's antiepileptic medication regime was not being complied with around the time of her death. He said that for children having multiple daily seizures, such as HB, seizure frequency does not always increase when antiepileptic medication is withdrawn and the mother's report that HB had two seizures the night before her death is not unexpected in a child with her condition.[63]

71. However, Dr Freeman concluded by saying that when compared to the significant weight loss and her underlying severe disability, any increase in seizure frequency potentially attributable to medication reduction was a minor factor in the development of aspiration pneumonia.[64]

72. On the basis of all the evidence available to me, and in particular the gloss on Dr Baber's report provided by Dr Iles, I find that the medical cause of HB's death is aspiration pneumonia in a child with an epileptic encephalopathy and extreme cachexia.

FOCUS OF THE CORONIAL INVESTIGATION

[62] Dr Freeman's statement dated 11 October 2016, page 33.1 of the coronial brief.
[63] Ibid, page 33.2 of the coronial brief.
[64] Ibid.

73. Other than the date and place of HB's death which were not contentious, the focus of the coronial investigation and inquest into HB's death was on the circumstances in which the death occurred, namely –

a) the adequacy of the care provided to HB in the family in the seven months or so immediately preceding her death;

b) the adequacy of the response of the Child Protection System to HB and her family, encompassing the Department of Health and Human Services (DHHS) in its Child Protection (CP) and Disability Clients Services (DCS) roles; and

c) the response from Royal Children's Hospital (RCH) staff to HB's failure to attend appointments after 9 January 2013.

ADEQUACY OF CARE PROVIDED TO HB IN THE FAMILY

74. It should be stressed at the outset that EG did not participate in the inquest at all. At my direction she was advised of the listed hearing date but chose not to attend or participate as a party and I chose not to compel her attendance as a witness. Further, while DB attended the inquest and was assisted to the extent possible by my assistance Leading Senior Constable Taylor, he did not have his own legal representation.

75. As described above, HB was entirely dependent on her carers for all activities of daily living and had been dependent to this extent all of her life. Since HB was as well as could be expected when last seen by paediatric dietician Ms Clark at RCH on 19 December 2012 and by Dr Freeman at RCH on 9 January 2013[65], the last time she was sighted by any professional before her death, the primary focus was on the adequacy of care provided to HB in the seven-month period immediately preceding her death when she was in the primary care of her mother and had little contact with her father, especially from March 2013 onwards.

76. The investigation and inquest identified multiple sources of evidence, both direct evidence and indirect from which inferences can be drawn, about the adequacy of the care provided to HB by her mother during this approximate seven-month period.

77. A logical starting point is HB's extreme skeletal appearance when she died and her significant weight loss since January 2013 when she was already a thin child and should have been growing and gaining weight. Since HB was largely immobile there is no evidence of any increase in activity and no suggestion of other illness, apart from something

[65] Pages 33 and 37 of the coronial brief.

like a cold and/or gastric complaint in the days immediately before her death. HB's appearance when she died bespeaks poor nutritional intake and, absent efforts by her mother to seek assistance with feeding or medical attention for weight loss, bespeaks neglect.

78. By way of context, HB weighed 8.7kg when she was 11 months and first seen by Dr McLellan on 1 September 2005. This is about 72% of her weight when she died almost six years later. In the context of stating that HB had significant problems with eating and swallowing and had difficulty putting on weight, Dr McLellan noted that she weighed 12kg on 10 July 2007 (whilst in the care of both parents). Also, HB's weight had "improved a little" to 18.3kg in February to May 2012[66] when she was about seven and a half years of age, and that she was constantly in the 18-20kg weight range in 2012.[67]

79. Medical records from Ballarat Health Services document how difficult it was for HB to gain weight, especially before she was commenced on PEG feeding. Between February 2008 and February 2009, HB weighed between 11 and 12.6 kg.[68] On 26 May 2009, HB weighed 14 kg, up from 13.4 kg one month earlier.[69] HB's weight stabilised at around 14 kg throughout 2009 and during the first quarter of 2010 when she was being fed via a nasogastric tube, pending insertion of a PEG tube. In November 2010, six months after insertion of the PEG tube, HB weighed 14.7 kg. By June 2011 her weight had improved to 17.3 kg and in February 2012 she weighed 18.3 kg with a BMI at 12.7.[70]

80. HB's main medical management was transferred from Ballarat Base Hospital (BBH) to the RCH when the EG and the family moved from Skipton to Melbourne. On 19 December 2012, EG took HB to see a paediatric dietician at RCH. The dietician, Ms Sarah Clark, had received a faxed handover from BBH and plotted HB's height and weight information on growth charts in the RCH electronic health record.[71]

81. HB presented as a child whose nutrition had been appropriately managed, tolerating formula well with no issues with constipation or vomiting. EG advised that HB had been medically well, and her seizures were improving. Ms Clark assessed that HB's weight gains had been appropriate, tracking along the 3rd percentile for age and noted that two heights taken in 2012 placed her around the 25th percentile for height.[72]

---

[66] Statement of Dr McLellan dated 2 October 2013 at pages 34-36 of the coronial brief.
[67] Statement of Dr McLellan dated 20 October 2016 at page 36.2 of the coronial brief
[68] Records from Ballarat Health Services commencing at page 1074 of the coronial brief. See page 1223.
[69] Ibid, page 1208 of the coronial brief.
[70] Ibid, pages 1119 and 1123 of the coronial brief.
[71] RCH records are Appendix R commencing at page 777 of the coronial brief and the growth chart is at page 906.
[72] Statement of Ms Sarah Jane Clark dated 1 October 2013 at pages 37 to 40 of the coronial brief. Ms Clark's notes of this consultation are at pages 864-865.

82. At this initial consultation, Ms Clark changed HB's formula from Pediasure Multifibre (Pediasure) to Nutrison Multifibre (Nutrison) [73] as the latter was available on the RCH Home Enteral Nutrition program (HEN) whereas the former was not. HB had a "nil orally" status and could only be PEG fed with hospital prescribed formula which would meet all her nutritional requirements.

83. According to Ms Clark, given HB's consistent weight gain over the preceding two years, it was expected that with continued good health and appropriate feeding, she would continue to track along the 3rd percentile and weigh about 21-22 kg by her ninth birthday.[74]

84. One of the more concerning observations made by AV paramedics and police members who attended in the immediate aftermath of HB's death was the amount of formula lying about the house.

85. Records from the RCH indicate that Nutrison formula was ordered for HB and delivered to EG's home by courier through the HEN program on 19 December 2012 (32 day supply – 6 cartons); 25 February 2013 (64 day supply – 11 cartons); and 11 July 2013 (64 day supply – 11 cartons).[75] On the crudest analysis, this amounts to five months' supply of formula over an eight-month period. Even accepting EG's explanation that she was feeding HB with some of the remaining old formula (Pediasure), there is a significant shortfall.[76]

86. Looked at another way, a total of 28 cartons were delivered, each containing eight litres of formula, making a total of 224 litres. On 4 September 2013, the police executed a search warrant and seized the formula remaining at EG's home. They seized, among other things, nine complete boxes Nutrison formula (72 litres in total) and two cans and one bottle of Pediasure (the old formula).[77] It follows that only 152 litres of Nutrison were missing and had presumably been given to HB since 19 December 2012, a period of about 224 days.

---

[73] HB's was to be given five feeds of 250 ml Nutrison Multifibre per day (a total of 1250 ml) commencing at 9-10am and two-hourly thereafter, via syringe bolus with a 60 ml water flush after each feed and after each administration of medication (an additional three flushes per day). See pages 39 & 856 of the coronial brief.

[74] Ibid at page 40. This expectation was reiterated in Ms Clark's statement dated 13 October 2016 in reference to the pathologist's reported weight of 12 kg at the time of death – *"The MER showed HB's weight at 12 kg. This is significantly less than the weight recorded during my initial assessment in December 2012 and does not follow a typical growth pattern for an 8 year old. As per my initial statement, based on the CDC growth chart, it would be expected that by her 9th birthday she would have weighed 21-22 kg."* I note that HB's ninth birthday would have been 11 September 2013, some six weeks after her death.

[75] Summary, at page 10 of the coronial brief. I note that the coronial investigators are likely to have made their calculations on page 11 based on six feeds per day rather than the five prescribed by Ms Clarke.

[76] Statement of Ms Clark at page 38 of the coronial brief – *"14 January 2013 – I called EG to see how Hayely was tolerating the new formula. EG told me that HB had not yet started the new formula (Nutrison Multifibre) as she still had Pediasure Multifibre at home. EG estimated the Pediasure would last one more week and she would commence on the Nutrison the week after."* See transcript of EG's Recorded Interview at pages 1625 and following of the coronial brief.

[77] Statement of DSC Christopher Hill at pages 22-23 of the coronial brief. See also, Exhibit 2/Photobook 2 which contains photos take at 2 Christen Court, Hoppers Crossing on 4 September 2013 when the search warrant was

87. At five feeds of 250 ml each per day (1.25 litres in total) HB should have been fed 280 litres formula over this period. If HB was fed only 152 litres of the Nutrison formula, she received only about half of what was prescribed for her and half of her calculated nutritional needs. It follows that this would account for HB's significant weight loss.

88. EG's explanation when interviewed by the police about HB's feeding regime indicates that she is aware of the need to give her five feeds of 250 ml per day and that she was initially alternating Pediasure formula which she still had with the new Nutrison.[78] However, records from Ballarat Health Services who were managing HB's feeding regime until handover to RCH in late 2012 show no orders for Pediasure being placed for HB after February 2012, and without hearing from EG it is not possible to determine the source and quantity of any additional formula that was available to her.[79] When interviewed by the police, EG also admitted but minimised having noted HB's weight loss in the period immediately before her death.[80]

89. As well as the results of toxicological analysis of post-mortem blood noted above, Medicare/Pharmaceutical Benefits Scheme Records obtained by coronial investigators suggest that HB had not been dispensed sufficient quantities of her prescription medications for administration at the prescribed dosages in the eight months immediately preceding her death. While this does not necessarily mean she would have experienced a more seizures or more serious seizures, it suggests that her medical needs were not being attended to assiduously.[81]

90. Similarly, while earlier medical records indicate a tendency on the part of the family to miss or cancel/re-schedule medical and allied health appointments in the past without apparent detriment to HB's overall health, EG's failure to take HB to *any* scheduled medical or allied health appointments for routine review and failure to seek any medical attention for her weight loss in the seven months immediately before her death was critical. The consequence, even if unintended, meant that HB was not seen by anyone outside the family or those closely associated with the family, since her last appointment with Dr Freeman on 9 January 2013.

---

executed and shows cans/bottles of Pediasure formula still in the home, some past its "best before date" – photos 15, 16, 30 and 31.

[78] Transcript of EG's Recorded Interview conducted 17 September 2013, at pages 1625 and following of the coronial brief.

[79] See notes of a review of HB at page 939 of the coronial brief that refers to an order for Pediasure being placed on or about 16 February 2012.

[80] Op cit.

[81] See paragraphs 49 and following above.

91. Moreover, HB's condition when she died, encompassing both her cachexia as well as her dirty, unkempt and head-lice infested state, was consistent with the untidy, unhygienic and chaotic state of the home as observed by first responders on 1 August 2013.[82]

92. Without repeating her various explanations in their totality here, when interviewed by the police, EG essentially said that she was having difficulty coping with the needs of all four children on her own, particularly HB, that she was not receiving any assistance from DB and had sought assistance from Child FIRST recently, that HB had been unwell and difficult to feed of late, that she felt she had fed HB enough and that she felt she had done her best in the circumstances.[83]

93. As EG did not participate in the inquest, the only other evidence that bears on the quality of care she provided to HB in the seven months before she died is in the statements of DB and his parents, who had relatively little contact with EG and HB from March 2013 onwards and in the statement of Ms Fountain who had frequent, almost daily contact at the material time.

94. Even allowing for a partisan perspective, the statements are broadly consistent in conveying the concerns of each witness that EG either could not or simply was not providing adequate care for her daughters and, in particular, that HB's demanding high level care needs were not being met by EG.[84] Similar concerns were reported by DB to DHHS Child Protection and Disability Client Services staff on several occasions between his separation from EG on Boxing Day 2011 and HB's death.

95. There is also a body of other evidence gathered by police and included in the coronial brief from which an inference can be drawn that EG was involved with social media[85] in the months immediately preceding HB's death to an extent that is incompatible with caring adequately for four children, one of whom was severely disabled. While I note the existence of that body of evidence, it is not possible to determine the extent to which EG's engagement with social media in and of itself precluded her also fulfilling the care needs of her daughters.

THE RESPONSE OF THE CHILD PROTECTION SYSTEM

Child Protection

[82] Also reflected to some extent in the girls' poor school attendance, pages 220 and following of the coronial brief.
[83] Transcript of EG's Recorded Interview conducted 17 September 2013, at pages 1517-1745 of the coronial brief, especially at pages 1679 and onwards of the coronial brief.
[84] DHHS/Child Protection records from pages 265 of the coronial brief.
[85] Calculations by the police indicate that between 13 March and 31 July 2013, EG sent and received 8216 messages, many of which refer to drug activity and/or are of a sexual nature. See summary at page 11 of the coronial brief, Telstra records from page 604 and Facebook information from page 1447 of the coronial brief.

96. Three relatively senior employees of the Department of Health and Human Services Child Protection program provided statements which were included in the coronial brief. It is telling that, apart from the first report received on 8 July 2005 when HB was an infant, the remaining five reports to Child Protection all relate to the period commencing with the parent's separation on Boxing Day 2011.

97. Ms Narelle Goodland, Child Protection Operations Manager in the West Division since March 2010, was Operations Manager in the Barwon Area at the time of HB's death. Ms Goodland provided a detailed nine-page statement setting out the family's history with Child Protection up until 13 June 2012 when the fourth report was closed at Intake. At that time, interim Family Court Orders were in place pursuant to which the girls resided in the primary care of their mother and had regular contact with their father, a referral had been made to Child FIRST an EG expressed an intention to engage with appropriate supports for HB and it was deemed that there was no further role for Child Protection.[86]

98. Ms Karen Sutherland, Senior Child Protection Practitioner with some twenty years' experience in Child Protection, provided a three-page statement addressing the fifth report made on 7 April 2013. While not directly involved with HB and her family, Ms Sutherland was the Team Leader in Intake and Assessment in Child Protection at the time of HB's death and her statement sets out the action taken by Child Protection in response to the fifth report.

99. This included obtaining information from Disability Client Services (DCS) about contact with the family in the past; obtaining information from ChildFIRST about EG's engagement with family support services provided by Catholic Care between July and September 2012 at which time EG appeared to be managing well with the care of the children and was planning to move back to Geelong (which did not eventuate). Catholic Care raised no concerns about her level of engagement and EG consented to re-referral to ChildFIRST.[87]

100. As Child Protection's assessment was that the children were not at significant risk of harm in their mother's care, a referral to ChildFIRST was made at Intake and the case closed on 16 April 2013. This decision was based on an assessment that the concerns reported were fundamentally wellbeing concerns and more appropriately managed by a family support services with which EG had previously engaged well.[88]

101. Mr Eddy De Nardis, was the West Division Area Manager in Child Protection from August 2014 with some 22 years' experience in Child Protection. He had no direct case

[86] Statement of Ms Narelle Goodland dated 8 November 2016 at pages 42.3-42.7c of the coronial brief.
[87] Statement of Ms Karen Sutherland dated 11 January 2017 at pages 42.8 to 42.10 of the coronial brief.
[88] Ibid at page 42.10 of the coronial brief.

management involvement with HB and her family and based his statement about the sixth report made on 15 July 2013 on Child Protection's records including the Client Relationship Information System (CRIS).[89]

102. As mentioned above, the sixth report arose out of an alleged incident of domestic violence involving DB, his father and BB and was endorsed on 16 July 2013 for a Planned Investigation[90] and transferred to Investigation and Response on 19 July 2013.[91]

103. As part of their investigation, Child Protection contacted ChildFIRST regarding the referral made 16 April 2013 as a result of the fifth report and were advised that attempts had been made to visit EG however, she had cancelled the scheduled appointments on 24 June and 2 July 2013.

104. The only other substantive action, an attempted "unannounced" visit to EG's home on 23 July 2013, was thwarted by Child Protection not having her current address and attending the former home in Tarneit when the family had already moved to Hoppers Crossing. Contact with EG was made by telephone one week later, on 30 July 2013, during which the recent (sixth) report was discussed and arrangements made to meet on 7 August 2013, including HB and her younger sister.[92]

105. Mr De Nardis' statement also addressed the internal review conducted by Child Protection following HB's death. That review, which involved Child Protections response to all six reports involving the family, concluded that case practice was substantively compliant with applicable policy and practice guidelines but could have been strengthened through clearer interagency collaboration to inform assessments and required supports.

106. The review identified a number of actions that would have strengthened the Child Protection response to the family including, *inter alia,* the use of case conferences and professionals meetings involving known services including Child Protection, the RCH, Disability Client Services, ChildFIRST and Catholic Care to guide interventions based on known needs, service involvement and complex family issues; and greater consideration in assessments and referrals to services that focused on the vulnerability and needs of HB; and a review and more thorough understanding of the complex needs of HB to inform risk assessments.[93]

---

[89] State of Mr Eddy De Nardis dated 14 November 2016 at pages 42.12-42.15 of the coronial brief.
[90] See paragraph 17 above.
[91] Ibid, as well as Child FIRST/Anglicare and Child Protection case notes at pages 1440-1441 and page 396 respectively of the coronial brief.
[92] Statement of Mr Eddy De Nardis at page 42.13-42.14 of the coronial brief.
[93] Ibid.

107. Mr Peter Clout, Practice Leader, Child Protection, Western Melbourne Area, West Division, who had been in this position since January 2013, gave evidence on behalf of DHHS. Mr Clout provided a statement and gave evidence at inquest.[94] He had been in practice as a social worker since 1988 and had worked in statutory Child Protection for over 15 years and in non-government and family support services for ten years, as well as holding a policy position in DHHS focused on child and family services system in Victoria.

108. Mr Clout provided an outline of the child and family services system in place since 2007 and mandated by the ***Children Youth and Families Act 2005*** (CYFA). Under the CYFA, concerns about the wellbeing of a child held by members of the community can be reported to Child Protection or referred to a community-based child and family Service (family service). If a matter is reported to Child Protection, they can seek information from information holders to clarify any issue, and it is open to them to either provide advice and assistance to the reporter or to refer the matter to a family service for provision of support to the family.[95]

109. Similarly, if a matter is referred to a family service in the first instance, they may also seek information, provide advice and assistance, make referrals and share information while determining the nature of risk to the child. If they determine that the concerns reported are more serious and involve the risk of significant harm to the child, the family service must report the concerns to Child Protection, and often use the Senior Child Protection Practitioners – Community Based (SCPP-CB) to do so.[96]

110. Community services organisations are organised into integrated family services alliances in each area and a ChildFIRST service is funded in each area as the intake point for referrals to integrated family services. In the western Melbourne area, Anglicare is the funded ChildFIRST provider and undertakes an assessment of the family before referring them on to a particular family service which then allocates a worker to the family to arrange the provision of services and, in some instances, to provide case management support.[97]

111. At inquest, Mr Clout was able to assist by explaining the Child Protection system as it operates in practice, relevantly around Child Protection intake, wellbeing referrals to Child FIRST and the Child Protection investigation phase. Mr Clout explained that Child

[94] Exhibit C is Mr Clout's statement dated 6 April 2018 at pages 42.42-42.45 of the coronial brief and his evidence is at transcript pages 57-137.
[95] Exhibit C at page 42.43 of the coronial brief.
[96] Ibid. SCPP-CB have been an integral part of the Child and Family Services System since its inception in 2007. Their role is to provide the ink between the two sectors (Child Protection and Family Services) so as to ensure information moves between the two and that issues of risk are addressed quickly. A fuller description of the role is contained in Exhibit C, Mr Clout's statement at page 42.44 of the coronial brief.
[97] Exhibit C at page 42.43 of the coronial brief and transcript page 74, 105-106.

Protection interventions are divided into phases and the first phase, referred to as intake, spans from the first contact which is usually a telephone call from the person reporting concerns about the safety or living circumstances of a child or children, until a determination or decision is made by Child Protection Intake workers to close the case altogether, to treat the case as a wellbeing report and refer it to Child FIRST or if it is to be investigated as a planned intervention/investigation.[98]

112. Mr Clout's evidence was that Child Protection guidelines require that intake should be completed as quickly as possible and should be completed within about three days.[99] Further, that Child Protection action at intake phase is usually limited to telephone contact with families and accessing information from other potential sources such as doctors, schools, police and Disability Client Services for example. As the notion of minimal intrusion into family life underlines the CYFA, a home visit or face-to-face meeting with family members is not undertaken until there is evidence of significant harm or risk of harm.[100]

113. If a report is closed by Child Protection at Intake and a wellbeing referral made to ChildFIRST for assessment and allocation of a family services provider, the expectation would be that a home visit or face-to-face meeting would be undertaken as part of the assessment process. In the western metropolitan area, where Anglicare fulfil the Child FIRST role, the practice is to make telephone contact and to undertake a home visit at the assessment phase.[101] Child Protection's expectation is also that ChildFIRST will accept a referral or advise that it is not accepted within five days of receipt of the referral. While he could not say that it was State wide practice, Mr Clout's evidence was that in fulfilling its ChildFIRST role in the west, Anglicare would at least make telephone contact with a family within ten days of receipt of a referral.[102]

114. Mr Clout's evidence was that the CYFA attempts to clarify responsibilities so it is clear which entity has child protection responsibility at any given time. When a report is with Child Protection in Intake, Child Protection is case responsible; if a wellbeing referral is

[98] Transcript page 60.
[99] As outlined in Ms Goodland's statement, the third report made on 11 January 2012 remained in intake phase until transfer to the Child Protection Investigation and Response Unit on 3 February 2012, some 23 days. Although significantly longer than the three days mentioned by Mr Clout in evidence, he did not think this was unreasonable in a complex case while there was active information gathering – transcript page 67.
[100] Transcript page 122. Mr Clout's evidence is that the legal test or trigger for protective intervention is the presence of significant harm or the likelihood of significant harm as a result of a range of issues – physical or sexual abuse, neglect, emotional or psychological harm, and or cumulative harm.
[101] Transcript page 79.
[102] Transcript page 81.

made to ChildFIRST and they have yet to complete their assessment and refer to a family service, they are case responsible; once a family service is allocated, they are responsible.

115. Child Protection does not proactively seek information about how a referral is progressing and they are not encouraged to keep an eye on a child or family while a wellbeing referral is afoot. Under the current paradigm, the child protection system relies on ChildFIRST/family services to report afresh if the family the subject of a Child Protection wellbeing report/referral does not engage, or if the ChildFIRST or family services determine that the child/children are at significant risk of harm.[103]

116. Mr Clout outlined practice improvements and changes put in place in the western metropolitan area that reflected learnings from HB's death, including ongoing training and reflective practice around issues for children with complex needs and cumulative harm, and ongoing fortnightly case consultations between Child Protection practitioners and Disability Client Services also accessible by the SCPP-CB and their consultations with family service providers.

117. Another improvement in the Child Protection system is the introduction since 2016 of an "enhanced referral" which is a mechanism for Child Protection Intake to flag a particular referral to alert both ChildFIRST and the SCPP-CB of the potential for a higher risk level if the family do not engage with a family service either because of the circumstances of a particular family or due to a pattern of past non-engagement. Enhanced referrals are reviewed by the SCPP-CB before they are sent to ChildFIRST and a follow-up discussion is scheduled to discuss the issues raised.[104]

118. Both in his statement and at inquest, and despite cross-examination by Ms Ellyard on behalf of Anglicare, Mr Clout maintained his view that HB's family circumstances involving features of a complex family situation, high medical and disability needs and repeated reports would have (or rather should have) been flagged as an enhanced referral (if the concept were in place at the time) and the resulting consultation would have allowed the SCPP-CB to be aware of any issues or delays with engagement or service provision.[105]

Disability Client Services

119. Ms Danuta Mayshak is a Senior Disability Information and Support Practitioner within the DHHS Disability Client Services (DCS) who provided a statement about her involvement,

[103] Transcript page 81-82, 91. Also note Mr Clout's evidence at transcript page 130 that some 10% of referrals by Child Protection to ChildFIRST are not accepted, usually on the rationale that there is a better referral elsewhere – for example a Mental Health Service or a Family Violence service provider.
[104] Exhibit C at page 42.45 of the coronial brief and transcript pages 118 and following.
[105][105] Ibid and transcript at pages 118-121,

and that of her colleagues, with HB's family between 29 December 2011 and 6 September 2012.

120. Ms Mayshak also attended the inquest and expanded on her evidence. While Ms Mayshak's evidence was about a period ending some nine months before HB's death, it was instructive about DB's ability to advocate on his own and HB's behalf for access to supports/services, and about the breadth of supports/services that could have been made available to anyone caring for HB.[106]

121. At the time when Ms Mayshak was involved with the family, HB and her sisters moved from being primarily in the care of DB to moving between both parents. This added a level of complexity as the parents resided some distance apart and service catchment areas did not generally extend to both residences. Ms Mayshak had contact with both DB and EG and, a fair reading of her statement and evidence at inquest indicates that DB could be encouraged to accept supports/services, whereas EG was more reluctant, and only seemed interested in financial support or the provision of equipment rather than the range of supports/services suggested to assist with her care of HB in particular.[107]

122. At inquest, Ms Mayshak explained that the DCS program under which she works is a voluntary program and that while she and other DCS workers can offer a range of supports to those with disabilities and their families, they may choose not to engage and cannot be compelled to accept any supports.[108]

123. In her dealings with HB's family, Ms Mayshak became concerned for EG who was caring for four children on her own including HB who had 'severe support needs but was refusing supports' so she kept calling and offering supports until EG relented and agreed to engage with one of the DCS workers based in Geelong, where EG was living with her mother at the time. That engagement was thwarted by EG then moving to the Melbourne area. However, Ms Mayshak continued to contact EG and referred her to Northern Division (DCS) intake which was appropriate given her new address in Melbourne's outer north.[109]

ChildFIRST/Anglicare

[106] Statement of Ms Danuta Mayshak dated 4 October 2016 at pages 42.16-42.21 of the coronial brief. The services with which the family was engaged or at least referred to include – Skipton RDNS for assistance with personal care and PEG feeding; arrangements for Target Group Assessment and linking the family with support services including the Continence Clinic at Ballarat Queen Elizabeth Centre, an occupational therapist, a counsellor, Community Connections, Mpower, Uniting Care Home and Community Care Services, the provision of information about Centrelink, the Family Law Hotline, Lifeline, and Medicare Enhanced Primary Care Program and others.
[107] Exhibit B at pages 42.17 to 42.20 and transcript pages 40 and following.
[108] Transcript page 38.
[109] Transcript pages 41-43.

124. As mentioned above, as well as being an organisation that provides family services, Anglicare is also contracted to perform the ChildFIRST function in the western metropolitan area. Mr Tom Hadgkiss and Ms Jennifer Smith co-authored a comprehensive report about HB and her family on behalf of Anglicare dated 16 September 2016.[110]

125. As Mr Hadgkiss was unavailable to attend the inquest, Ms Smith attended to speak to the report and to be cross-examined about its contents and matters pertaining to ChildFIRST and EGs engagement with them following referral by Child Protection on 16 April 2013 of the fifth report regarding the family, to ChildFIRST.[111] The referral was acknowledged by ChildFIRST by email sent to Child Protection on 29 April 2013.[112]

126. On 6 May 2013 a ChildFIRST worker called EG to inform her of the referral. EG indicated that she was aware of the referral and open to support, including support in getting HB into school, housing and other family support. EG said she had very good support from friends and family; that she and the children were doing well; and that she needed to find new accommodation as their house was being sold. When offered an initial assessment by a partner agency due to demand for ChildFIRST being high at the time, EG said she was content to wait, as this would allow her time to move into new accommodation and settle, and the worker sent her contact details in the event that she needed to contact western metropolitan ChildFIRST or required support in the meantime.[113]

127. A ChildFIRST intake worker was allocated on 12 June 2013 and called EG to introduce herself. At that time, EG said she was still trying to arrange new accommodation and was having difficulties with the Office of Housing. EG also said she was keen to receive family services support as she felt she could do with some support, especially in relation to HB, and had a positive experience with Catholic Care the last time.[114] EG mentioned that HB might need a new wheelchair and possible linkage with an occupational therapist and a school. Matters were left on the basis that the worker would call EG for a detailed discussion/assessment at 1.30pm on 24 June 2013.[115]

128. On 24 June 2013, EG called ChildFIRST to cancel her appointment and no reason is documented in the relevant case notes. On 26 June 2013, ChildFIRST called EG to re-schedule the appointment to 1.00pm on 2 July 2013. That appointment was cancelled by EG

[110] Exhibit D, report from Anglicare dated 16 September 2016 at pages 42.26-42.41 of the coronial brief.
[111] Transcript pages 140 and following. The referral document is at pages 1406 and following of the coronial brief.
[112] See Anglicare Case Notes at page 1439 of the coronial brief.
[113] Exhibit D and Anglicare Case Notes at pages 42.29 and 1440-1441 respectively of the coronial brief.
[114] The fourth report was closed at intake with a referral to ChildFIRST and the engagement of the family with Catholic Care between July and August 2012.
[115] Exhibit D and Anglicare Case notes at pages 1440 and 42.30 respectively of the coronial brief.

on 1 July 2013 who said that the children had gastro and asked if they could call her on the first day of school being 15 July 2013. Unfortunately, the allocated worker was on sick leave on that date and another worked called EG to advise that she would call her when back at work. As a result, ChildFIRST did not undertake any other risk or initial assessment in relation to HB's family before closing the case once aware of the sixth report to Child Protection moving to the investigative phase.[116] It follows that no substantive family services were engaged.

129. ChildFIRST/Anglicare conducted its own internal review following HB's death and made a number of findings – these included the absence of a formal risk assessment in the appropriate referral from Child Protection; the lack of overt guidance about when ChildFIRST intake assessments should be made by home visit rather than via telephone; and the failure to make an intake assessment in more than two months between the first contact with EG and file closure (and three months since receipt of the referral).[117]

130. The internal review made seven recommendations which addressed the findings, including most relevantly –

a) training and supervision of intake workers to ensure all referrals are read carefully so as to identify information that can inform a robust risk assessment; a need for training and supervision of all workers to assist them to identify disengaging or disengaged clients and have the capacity, time and resources to re-engage them;[118]

b) formal institution of a clear procedure and template which identifies and ranks risk within a family at the point of referral based on the contents of the referral document, and when the referral is characterised as high risk or the risk cannot be confidently established from the referral, a home-based assessment is to be scheduled *unless* it is *known* that another professional is engaging in *frequent and current* home-based contact;[119]

c) managers of all programs to calculate the maximum number of cases that can be held by a worker without practice standards becoming compromised, and when the number is exceeded, a management response to be triggered including but not limited to temporary additional staffing, assistance from partner agencies to undertake assessments and consideration of restricted intake.[120]

[116] Exhibit D and Anglicare Case notes at pages 1441 and 42.30 respectively of the coronial brief.
[117] Exhibit D at pages 42.31-42.32 of the coronial brief.
[118] Ibid and transcript pages 143-144 where Ms Smith testified that the "engagement" training had been delivered.
[119] Op cit. and transcript pages 144 and following.
[120] Exhibit D at page 42.33 of the coronial brief. A home-based assessment might be made if an interpreter were required or there were issues in the referral that suggested a home-visit might be appropriate to engage with the family, say in the case of a young mother. Transcript page 153.

131. The latter relates to the unchallenged evidence at inquest that as at 16 April 2013, the second referral of HB's family ChildFIRST, intake assessments were made strictly in the order in which the referrals were received, without any triage or priority overlay and generally on the basis of a telephone assessment.[121] At inquest, the unchallenged evidence was that unusually high demand for ChildFIRST services partly explains the delay in allocating and assessing HB's family. The delay can also be attributed in part to EG's indication that she preferred to wait for ChildFIRST to undertake an intake assessment rather than be allocated to another agency.[122]

132. Documents tendered through Ms Smith describe changes to ChildFIRST procedures made since HB's death which inform risk assessment and prescribe tighter timelines for their intake, assessment and referral processes.[123] In the most recent iteration, the procedures require aims for allocation of high priority cases to an intake worker and contact with the family within 24-48 hours of receipt of the referral, depending on the level of risk, and completion of the assessment within four weeks, again depending on the level of risk.

133. Ms Smith's evidence was that if this procedure had been in place when HB's family had been referred to ChildFIRST, the family would have been high priority for first contact/allocation of a worker and completion of assessment.[124] Ms Smith also testified that the new procedure envisages an assessment made at a home visit in those cases where risk at referral point is assessed as "high" or "very high" but that ChildFIRST would defer to the family's preference for telephone assessment if requested.[125]

134. Ms Smith was cross-examined about the "enhanced referral" mechanism introduced by Child Protection in 2016. When cross-examined about Mr Clout's view that the referral of HB's family to ChildFIRST on 16 April 2013 should have been made as an enhanced referral, if available at the time, Ms Smith did not agree.

135. While conceding that the decision to make an enhanced referral was one made by Child Protection Intake, Ms Smith was of the view that the family did not present with both required features – that is being difficult to engage *and* having a pattern of reports/referrals. Ms Smith was not as confident that HB's family had a known history of failure to engage with services at the time of the second referral to ChildFIRST. Moreover, she noted that it

[121] Transcript page 153.
[122] Exhibit G is a Table Summarising Referral Levels to Western Melbourne ChildFIRST and shows an increase in between January and June 2017 (May and June in particular) compared with 2012 and 2013 levels.
[123] Exhibit E entitled "Referral Risk Assessment" and Exhibit F entitled Western Melbourne ChildFIRST Intake, Assessment and Referral process (Reviewed). These appear to embody the internal review recommendation set out in paragraph 132(b) above.
[124] Transcript pages 145 and following, pages 170 and following, Exhibits F and G.
[125] Transcript pages 145 and following, especially at page 153.

was always open to ChildFIRST to accept an enhanced referral but indicate to Child Protection (via the SCPP-CB) that they proposed treating the referral as a normal referral.

THE ROYAL CHILDREN'S HOSPITAL

136. There was no suggestion that there was any want of clinical management and care on the part of the clinicians or staff of the RCH that caused or contributed to HB's death or that any such want had a detrimental impact on her health. The focus of the coronial investigation was on the fact that (with the benefit of hindsight) one of the early warning signs that things in HB's family may be amiss was her failure to attend appointments in 2013 after her last appointment with Dr Freeman on 9 January 2013.

137. Ms Sarah Connolly is a social worker who is the Manager of Social Work, Aboriginal Health and Pastoral Care Service at the RCH who was involved in the Critical Incident Review (CIR) which reviewed HB's care at the RCH following her death and provided a statement in response to my request at the directions hearing on 7 July 2017 for further information about systems and processed at the RCH to identify a potentially vulnerable child.[126]

138. By way of context, prior to the current system, it was open to clinical staff (including nursing staff) to put a social alert on the medical records to flag a vulnerable child. HB's family had been referred to the RCH Social Work department in July 2013 and a meeting scheduled with EG, but the meeting was not held despite several contacts to re-schedule. In any event, the referral related to a counselling enquiry around HB's diagnosis and not to any protective concerns.[127]

139. The CIR identified that the system to alert key staff to repeated failures to attend clinical appointments, especially in the setting of a patient with complex medical and social needs was not clear. Recommendations arising from the CIR included the development of clear systems for flagging and then notifying clinical staff involved in the care of child/patient who repeatedly fails to attend outpatient appointments. The recommendations were implemented and the system for flagging and monitoring vulnerability is in place and continues to evolve as the capability of the RCH's new electronic medical record (EMR) is fully realised.[128]

[126] Exhibit A is Ms Connolly's statement dated 7 August 2017, tendered through Ms Nicola Watt who assisted in the preparation of the statement and attended the inquest as a witness.
[127] Statement of Ms Nadine Stacey dated 21 October 2016 at pages 42.1-42.2 of the coronial brief.
[128] Ibid.

140. As Ms Connolly was unavailable to attend the inquest, Ms Nicola Watt who assisted in the preparation of her statement attended in her place. Ms Watt's testified that the EMR was rolled out at the RCH in 2016 and allows alerts to be placed by clinicians, external agencies or families themselves about vulnerable children/patients. Once an alert is placed, the social work department become aware of any missed appointments, they review the medical record/file and follow-up as appropriate in the circumstances. This may involve a telephone call to the clinician, to a parent or family member.

141. The system is premised on someone having apprehended that a child is vulnerable in the first place and having placed an alert on the EMR. It is only then that a missed appointment may elicit a social work response. Otherwise, the patient demographic at the RCH is such that there is a high rate of missed appointments and following-up all missed appointments poses logistical problems. Even then, the likely response of the social work department was a telephone discussion with Dr Freeman who is unlikely to have been concerned about one missed appointment given the family's presentation to him and HB's reasonable progress. The likely outcome was no more than a re-scheduled appointment.[129]

142. While the RCH has procedures for information sharing with Child Protection, they rely on Child Protection to approach them and do not necessarily know all patients who are Child Protection clients or who have court orders in place. This underlines that primary Child Protection responsibility lies with Child Protection and the RCH's fundamental role is to provide clinical management and to play an adjunct role in Child Protection. Where RCH staff have reasons to be concerned about a patient's safety or have protective concerns, they are of course under mandatory reporting obligations under the CYFA.[130]

FINDINGS/CONCLUSIONS

143. The standard of proof for coronial findings of fact is the civil standard of proof on the balance of probabilities, with the *Briginshaw* gloss or explication.[131] The effect of the authorities is that coroners should not make adverse comments or findings against individuals in their professional capacity unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death, and in the case of individuals acting in a professional capacity, only where the evidence also supports a finding that they departed

[129] Transcript pages 4-5, 19.
[130] See Ms Watt's evidence about staff training and education around vulnerable children/protective issues at transcript page 9 and following.
[131] *Briginshaw v Briginshaw* (1938) 60 C.L.R. 336, especially at 362-363. *"The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite, or indirect inferences…"*

materially from the standards of their profession and, in so doing, caused or contributed to the death.

144. It is axiomatic that the assessment of a departure from norms or standards must be determined strictly without the benefit of hindsight on the basis of what was known or should have been known by the individual at the material time. The trajectory that leads to a death of a child in the care of a parent may well be obvious after the event. Patterns or causal connections that can be traced after the death from the privileged position of knowing the tragic outcome, may not have been obvious or even appreciable at the material time/s before the death. This involves the exercise of standing in the shoes of those involved with the family at the material time and assessing their response objectively.

145. Having applied the applicable standard of proof to the available evidence, I find that:

a) HB's weight fluctuated between 18 and 20 kgs during 2012.

b) When seen by RCH paediatric dietician Ms Clark on 19 December 2012 and RCH neurologist Dr Freeman on 9 January 2013, HB was estimated to weigh 20 kgs.

c) When she died on 1 August 2013, HB weighed only 12 kgs, had a height/length of 130 cm, a Body Mass Index of 7 and was in a parlous metabolic and immunological state in terms of her vulnerability to infection.

d) EG was well aware of the need to feed HB her prescribed formula five times per day at a rate of 250 ml per feed, to administer her antiepileptic/anticonvulsant medications regularly, and to monitor her weight.

e) HB's weight loss in the seven months immediately preceding her death resulted from a failure by EG, her mother and primary carer, to provide her with adequate nutrition, *probably* over a significant number of months and *possibly* as many as seven months.

f) It is inconceivable that EG did not notice HB's extreme and ongoing weight loss and did not therefore apprehend the need to seek medical attention for her.

g) I am unable to determine why EG failed to act in this regard and the extent to which her own personal issues may have caused or contributed to this failure.

h) HB's dirty and unkempt condition when she died also bespeaks neglectful care on her mother's part.

i) In failing to provide adequate nutrition to HB and to seek medical attention for her in the seven months immediately preceding her death, EG caused or contributed to her death.

j) EG's failure to keep HB's medical and allied health appointments after 9 January 2013 likely reflects a degree of disadvantage and chaos that was a feature of her living circumstances at the time. However, in combination with her refusal to facilitate regular contact with DB, it denied HB the care and protection he could have provided and prevented her deteriorating health coming to the attention of others.

k) There was no want of clinical management and care on the part of the staff of the Royal Children's Hospital that caused or contributed to HB's death.

l) Child Protection Intake decisions are crucial threshold decisions in the Child Protection system but are only as good as the information on which they are based.

m) The Child Protection response to the fifth report involving HB's family was flawed as it was insufficiently informed about the extent of HB's disability and care needs; it attached too much weight EG's self-serving assertions about the family's circumstances in the face of serious allegations of neglect; and it paid too little heed to the family's protective history which revealed poor past engagement with services and the potential for cumulative harm and/or chronic neglect.

n) The ChildFIRST response to the referral made by Child Protection on 16 April 2013 was tardy, and while I accept that an unusually high demand for services and EG's indicated preference not to be referred to another agency account for much of the delay, the result was a lost opportunity to intervene in the family dynamic in the interests of HB and her sisters.

COMMENTS

Pursuant to section 67(3) of the ***Coroners Act 2008***, I make the following comments on matters connected with the death, including matters relating to public health and safety or the administration of justice:

1. The Child Protection system preferences the best interests of child, and also recognises the importance of the family unit in society. It is trite to say that if all parents or carers always did what was in the best interest of the children in their care, there would be no need for a Child Protection system.

2. Whatever else can be said of a policy of minimal intervention in family life or private matters, where it is interpreted to mean that the State, in its Child Protection iteration, will not intrude unless there is (already) a known risk of significant harm to a child, such a policy does not serve the interests of vulnerable children like HB who are completely dependent, indeed as

dependant as a newborn infant, and may remain unseen even through several episodes of contact with the Child Protection system.

3. Had it been in place at the time of the fifth report of HB's family to Child Protection, the Enhanced Referral mechanism introduced by Child Protection since 2016 had the potential for better and earlier assessment and provision of services to HB's family and the potential to change the tragic outcome.

4. Had it been in place at the time of the second referral of HB's family to ChildFIRST, the improvements made by ChildFIRST to their Intake, Assessment and Referral Process had the potential to result in more timely allocation and referral of HB's family to family services and the potential to change the tragic outcome.

RECOMMENDATION

Pursuant to section 72(2) of the Act, I make the following recommendation on matters connected with the death, including matters relating to public health and safety or the administration of justice:

1. Conscious that policy is a matter for the government and should not be dictated by isolated or extreme circumstances, the level of risk to a child such as HB can never be properly determined without a comprehensive understanding of her vulnerabilities and needs at the very least and, optimally, an appraisal of her current medical condition, preferably informed by a contemporary medical assessment. If this is beyond the current Child Protection paradigm, then I recommend that the Minister for Health and Humans Services considers modifying the paradigm to make special provision for vulnerable children like HB, analogous to initiatives for high-risk infants and high-risk adolescents where they exist, to ensure they remain visible to Child Protection.

PUBLICATION OF FINDING

Pursuant to section 73(1) of the Act, unless otherwise ordered by a coroner, the findings, comments and recommendations made following an investigation must be published on the Internet, and I make no such order.

However, I order that the names of HB's sisters and parents be redacted from this finding prior to publication on the Internet in the interests of her sisters.

I further order, pursuant to section 115(3) of the Act, that the names of HB's sisters and parents be redacted from this finding prior to provision to any third parties in the future pursuant to section 115(2) of the Act.

DISTRIBUTION OF FINDING

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

Mr DB

Ms EG

Department of Human Services/Child Protection

Department of Human Services/Disability Client Services

Child FIRST Western Melbourne/Anglicare

Catholic Care

Child Safety Commission

Consultative Council on Obstetric and Perinatal Morbidity and Mortality

Detective Senior Constable Chris Hill (#31446) c/o O.I.C. Homicide Squad

Signature:

Paresa Antoniadis Spanos
Coroner
Date: 13 January 2020