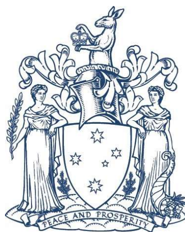

IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2013 2108

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)
Section 67 of the Coroners Act 2008

Findings of:	**JUDGE JOHN CAIN, STATE CORONER**
Deceased:	**BABY S**
Date of birth:	8 May 2012
Date of death:	15 May 2013
Cause of death:	I(a) Head injury
Place of death:	[redacted], VIC 3121
Keywords	Child homicide, family violence, non-accidental injuries, fatal head injuries

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HIS HONOUR:

BACKGROUND

1. Baby S was 12 months old at the time of his death. Baby S was the youngest of five children born to Ms A. Department of Health and Human Services – Child Protection services (**Child Protection**) had been involved with Ms A and all her children since 2002.[1]

2. On 7 May 2002, Child Protection received the first protective report regarding Ms A's first born child, who was four months of age at the time.[2] All reports on Ms A's first four children (excluding Baby S) referred to concerns of substance abuse by Ms A, lack of stable accommodation, neglect of the children and failure to engage with services. Subsequently, court orders placed her oldest three children into the care of others. Ms A's youngest daughter was also placed on a protective order with permanent kinship placement.[3]

3. When Ms A was pregnant with Baby S, she continued to use heroin. Ms A attended the alcohol and drug service at the Royal Women's Hospital due to her drug use.[4] Ms A was stabilised on methadone and admitted to Odyssey House Victoria's (**OHV**) residential facility in Lower Plenty, Victoria in January 2012. She continued her antenatal care at Mercy Hospital.[5]

4. On 27 February 2012, Ms A chose to leave OHV and relapsed into heroin dependency after exiting treatment. An unborn child report was made to Child Protection on 23 March 2012, approximately six weeks before Baby S was born.[6]

5. On 26 March 2012, Ms A was admitted a second time to OHV.[7] The available evidence indicates that Ms A had a long history of experiencing family violence and was in a violent relationship with Baby S's father, Mr K, leading up to Baby S's birth.[8]

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[1] Child Protection response to Court dated 25 October 2019 – Detailed chronology of child protection's management of Baby S' case, 1
[2] Child Protection records provided to Court (Child G) – Closure summary dated 18 February 2010, 12
[3] Child Protection response to Court dated 25 October 2019 – Detailed chronology of child protection's management of Baby S' case, 1
[4] Odyssey House Victoria records provided to Court – letter to Court dated 18 September 2012, 1
[5] Ibid
[6] Child Protection records provided to Court (Baby S) - CRIS note dated 23 March 2012
[7] Odyssey House Victoria records provided to Court - 'Re-admission Application' (Administrative Intake Form No 2, Odyssey House Victoria 9 March 2012) 1
[8] Child Protection records provided to Court (Baby S) – CRIS Note dated 17 May 2012; Odyssey House Victoria, 'Assessment Form Navigations and TC' (Administrative Form No 1, Odyssey House Victoria 16 January 2012) 22; *Coronial Brief*, Appendix 2: Banyule Maternal Child Health Service - Records relating to the Deceased, 233

6. Baby S was born on 8 May 2012 at Mercy Hospital in Heidelberg, Victoria.[9] Due to Ms A using heroin throughout the pregnancy, Baby S was born methadone dependent and experienced withdrawal at birth.[10]

7. Ms A continued to receive treatment at OHV following Baby S's birth and would periodically visit Baby S at Mercy Hospital while he received treatment for heroin withdrawal.[11] Ms A later admitted that she used heroin during her time away from OHV when she was visiting Baby S.[12]

8. Baby S was discharged from Mercy Hospital in June 2012 and lived with Ms A at OHV while she continued to receive drug rehabilitation treatment.[13] Ms A and Mr B met during this time, while they were both receiving drug rehabilitation treatment for heroin dependency at OHV.[14] Whilst it is unclear exactly when Ms A and Mr B formed their intimate relationship, it is believed that the two commenced an intimate relationship sometime between August and December 2012.[15]

9. Child Protection were involved with Ms A in the lead up to Baby S's birth because of her drug dependency. Records from Child Protection indicate that Ms A was assessed as being protective towards Baby S, and they were satisfied with him remaining in her care, on the condition that she continue to stay at OHV and participate in rehabilitation treatment.[16]

10. In September 2012, Child Protection closed their investigation and determined to have no further involvement with respect to Baby S whilst Ms A remained at Odyssey House. This was following:[17]

    (a) Contact with the Maternal Child Health Nurse who advised that they had no concerns for Baby S while he remained at Odyssey House with Ms. A;[18]

    (b) Odyssey House having 'no care and protection concerns for Baby S and is of the view that Ms. A is managing Baby S very well and is a good mother';[19] and

    (c) Odyssey House gave 'a verbal undertaking that they will contact Child Protection should Ms. A decide to make an unplanned exit.'[20]

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[9] *Coronial Brief*, Statement of Child Protection worker dated 20 May 2013, 70
[10] Child Protection records provided to Court (Baby S) – CRIS Note dated 14 May 2012
[11] Child Protection records provided to Court (Baby S) – CRIS Note dated 17 May 2012
[12] Child Protection records provided to Court (Baby S) – CRIS Note dated 29 May 2012
[13] Child Protection records provided to Court (Baby S) – CRIS Note dated 12 June 2012
[14] *Coronial Brief*, Appendix 13: Transcript of record of interview with Mr B dated 30 May 2013, 660-661
[15] Odyssey House Victoria records provided to Court, 'Ms. A Parenting Plan (Update 10.08.2012)
[16] Child Protection records provided to Court (Baby S) – CRIS Note dated 18 February 2012
[17] Child Protection records provided to Court (Baby S) – Closure Summary dated 13 September 2012
[18] Child Protection records provided to Court (Baby S) – CRIS Note dated 4 September 2012
[19] Child Protection records provided to Court (Baby S) – Closure Summary dated 13 September 2012

11. In December 2012, Mr B and Ms A were discovered by OHV staff to be engaging in an intimate relationship, against the OHV policies for residential treatment.[21] Because of this prohibited relationship, Mr B was requested to leave the OHV facility on 13 December 2012 as he was the more senior resident.[22]

12. On 18 December 2012, Child Protection made telephone contact with OHV staff who informed them that:[23]

    (a) Ms A was caught with a male resident, 'Mr B', in the basement of the facility having one on one contact;

    (b) That the two of them had been warned two to three times before about being involved with each other as no relationships were allowed between residents in OHV;

    (c) Ms A indicated that she wanted to leave as well and that she wanted Mr B to be a part of her and Baby S' life.

13. Later on, the same day, Child Protection attended OHV with OHV staff and discussed the following:[24]

    (a) Ms A had reaffirmed her desire to leave but was planning to do so in four weeks' time;

    (b) Ms A was advised by Child Protection that they were concerned about her leaving as she had lots of support at OHV to care for Baby S and it was unclear how she would manage on her own; and

    (c) Child Protection would need to assess her home and link her with appropriate services. OHV were to notify Child Protection immediately if she left without a proper plan.

14. On 24 January 2013, Child Protection and OHV held a discharge meeting with Ms A to put measures in place to prevent a relapse of drug use following her discharge.[25] Child Protection notes from this interview suggest that it was OHV's preference that Ms A remain in the residential treatment facility to complete the full program.[26] At the time of her departure,

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[20] Ibid
[21] Child Protection records provided to Court (Baby S) – CRIS Note dated 18 December 2012; Odyssey House Victoria records provided to Court, 'Family Mutual Services' (Practice Manual No 7, Odyssey House Victoria, 31 May 2014) 6
[22] Odyssey House Victoria records provided to Court – Mr B 'TC Circumstances for exit' form dated '13/12/2012', 2
[23] Child Protection records provided to Court (Child G) – CRIS Note dated 18 December 2012
[24] Child Protection records provided to Court (Child G) – CRIS Note dated 18 December 2012
[25] *Coronial Brief*, Statement of Child Protection worker dated 20 May 2013, 72-73.
[26] Child Protection records provided to Court (Child G) – CRIS Note dated 24 January 2013

Ms A had completed approximately 11 months of the potentially 24-month long program.[27] Child Protection confirmed that they would monitor Ms A and Baby S for the next three months and then make a decision about further involvement.

15. On 30 January 2013, Ms A left OHV and returned into her original public housing flat in Richmond.[28]

16. On 31 January 2013, Ms A contacted Mr B and their relationship recommenced shortly thereafter.[29]

17. On 1 February 2013, Child Protection conducted their first home visit.[30] The visit included an interview of Ms A, observations of the flat and sleeping arrangements for Baby S, observations of Baby S, and observations of Ms A's interactions with Baby S. Child Protection also had discussions with Ms A regarding drug screens, which she agreed to do twice weekly. Ms A was also spoken to about engaging Baby S with the Maternal and Child Health Nurse, and childcare arrangements.[31]

18. Ms A enrolled Baby S into the Lentara Uniting Care – Cooke Court Child Care Centre (**CCCC**) on 14 February 2013 and from 25 February 2013 until the fatal incident, Baby S was attending the centre five days per week.[32]

19. On 20 February 2013, Ms A disclosed to her general practitioner (**GP**) at North Richmond Community Health Centre (**NRCHC**), that she had experienced a lapse and used heroin again. Ms A reported to her GP that she wanted to immediately commence a detoxication program.[33]

20. Proximate to this lapse and use of heroin, Mr B discovered that Ms A was using heroin. It was at this time that both Mr B and Ms A began to use heroin together 'every Wednesday and Thursday' for the five or six weeks leading up to Baby S's death.[34]

21. Evidence in the coronial brief suggests that Ms A did not like the effect that heroin had on Mr B as Mr B began to believe that Ms A was taking advantage of him and using the relationship to obtain a frequent supply of heroin.[35]

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[27] Ibid
[28] Odyssey House Victoria records provided to Court – Ms A 'TC Circumstances for exit' form dated '30/01/2013', 1
[29] *Coronial Brief*, Statement of Ms A dated 20 June 2013, 126
[30] Child Protection records provided to Court (Baby S) – CRIS Note dated 19 February 2013; Child Protection records provided to Court (Baby S) – First Visit Case Note (which is incorrectly dated 27 February 2013, which is a date of an unannounced visit when Ms A was not at home)
[31] Ibid
[32] Child Protection records provided to Court (Baby S) – Letter from Lentara Uniting Care dated 20 May 2013, 1
[33] Response to the Court from Dr John Furler dated 28 August 2019, 2
[34] *Coronial Brief*, Statement of Ms A dated 20 June 2013, 126

22. It is during this decline in the relationship between Ms A and Mr B that Baby S was witnessed by CCCC staff with bruising in various areas of his body, including his face, legs, arms and pelvic region.[36] These bruises often appeared after Mr B had been playing with Baby S and Ms A often stated that the origins of the injuries were from Baby S bumping into things around the house or from falling over.[37]

23. Ms A noted in her statement to Victoria Police that only Mr B, CCCC staff and herself had shared care of Baby S prior to his death. Despite this fact, Ms A was unable to determine or explain how Baby S got his bruises.[38]

24. In her statement to police following Baby S' death, Ms A reported that on multiple occasions she had had to warn Mr B not to play with Baby S too roughly.[39] Additionally, Ms A claimed that when she questioned Mr B about the suspicious bruises found on Baby S's body, Mr B always dismissed these enquiries, saying he had no knowledge of how they were sustained.[40] Ms A further stated that when she questioned Mr A about bruises on Baby S, such injuries would stop appearing for a short period.[41]

25. On 28 March 2013, CCCC staff created an incident report for Baby S after observing a bruise on his right temple that was sustained outside of his time in childcare.[42] On the same day, Child Protection conducted their second home visit. Ms A was asked why she had not completed any drug screens and she admitted to using Heroin once about two weeks after she had moved out of OHV. Ms A confirmed that she had seen her GP at NRCHCC and was prescribed suboxone to start a detoxification program.[43]

26. On 8 April 2013, Ms A presented to St Vincent's Emergency Department following a seizure and was admitted overnight. Ms A told her GP on 1 May that this was a '*combo of heroin and Unison injection*'.[44]

27. On 17 April 2013, Ms A observed that Baby S sustained bruising across his face.[45] Mr B claimed that these injuries had been sustained during an incident in which Baby S had held

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[35] *Coronial Brief*, Appendix 13: Transcript of record of interview with Mr B dated 30 May 2013, 672-673
[36] *Coronial Brief*, Statement of Ayan Mohamed dated 27 May 2013, 83; *Coronial Brief,* Appendix 3: Cooke Court Child Care Centre records relating to the Deceased, 249-254
[37] *Coronial Brief*, Appendix 11: Transcript of record of interview with Ms A dated 30 May 2013, 594; Appendix 9: Transcript of record of interview with Mr B dated 15 May 2013, 455-457
[38] *Coronial Brief*, Appendix 11: Transcript of record of interview with Ms A dated 30 May 2013, 594
[39] *Coronial Brief*, Appendix 8: Transcript of record of interview with Ms A dated 15 May 2013, 396-399
[40] Ibid
[41] Ibid, 374-381
[42] *Coronial Brief,* Appendix 3: Cooke Court Child Care Centre records relating to the Deceased, 249-254
[43] Child Protection records provided to Court (Baby S) – CRIS Note dated 28 March 2013
[44] CRIS note dated 17 May 2013; Dr John Furler response dated 28 August 2019, 3

onto his pant leg, resulting in Baby S being lifted off the ground, thrown into the air, and hitting his face upon landing.[46] Ms A claimed that she was in a different room of the flat at the time that this incident occurred and that no one witnessed the incident apart from Mr B.[47]

28. On 18 April 2013, Ms A took Baby S to the NRCHC to determine if the bruises indicated more extensive damage. The GP described the bruising as '*mild bruising to his [sic] chin, forehead and across the bridge of his nose*'.[48]

29. On 3 May 2013, Child Protection conducted a third home visit. Baby S was present during this home visit and Child Protection observed Baby S and his relationship with Ms A and the condition of the flat.[49] Child Protection also asked Ms A to do a drug screen and confirmed that none had been completed to date. Ms A was also requested to provide details about her boyfriend which she never provided to Child Protection.[50]

30. On 13 May 2013, Ms A presented to CCCC with Baby S. A staff member noted that Baby S quickly fell asleep and slept longer than was usual that morning. Whilst changing Baby S' nappy that afternoon, the staff member observed a purple and yellow bruise, about four centimetres in diameter on Baby S' pelvic area.[51] The staff member noted that it was an unusual place to have a bruise and that Baby S was less active throughout the afternoon, wanting to be continuously held by the staff member.[52]

31. Another staff member also observed the bruise whilst changing Baby S' nappy that afternoon. The staff member disclosed this information to another staff member after work. Both agreed Baby S' nappy should have protected him from such a bruise and questioned how it occurred.[53]

32. The day before Baby S's death on 14 May 2013, Ms A took him to the NRCHC for treatment of gastroenteritis. During the appointment a student doctor, Mr Smith, examined Baby S's torso and found several bruises across his chest, as well as bruises and a small cut on his lip.[54]

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[45] *Coronial Brief*, Statement of Ms A dated 20 June 2013, 129
[46] Ibid
[47] Ibid
[48] *Coronial Brief*, Statement of Dr David Isaac dated 22 May 2013, 106-107
[49] Child Protection records provided to Court (Baby S) – CRIS Note dated 3 May 2013
[50] Ibid
[51] Coronial brief, 83; *Coronial Brief,* Appendix 3: Cooke Court Child Care Centre records relating to the Deceased, 249-254
[52] Ibid
[53] Ibid; Statement of Phuong HA dated 27 May 2013, 92
[54] *Coronial Brief*, Statement of Jason Smith dated 22 May 2013, 97-98

33. As a result of his concerns for these injuries, Mr Smith conferred with his supervising doctor who in turn commenced his own external examination of Baby S and noted no observations of bruising on the parts of Baby S' body that he examined. Baby S was wearing a nappy and a top at the time.[55] The supervising doctor did not remove any articles of clothing to perform the external examination and noted only subtle bruising on Baby S' face that was explained by Ms A as bumping into objects at childcare.[56] Baby S was treated for gastroenteritis.

THE PURPOSE OF A CORONIAL INVESTIGATION

34. Baby S's death constituted a '*reportable death*' under the *Coroners Act 2008* (Vic) (**the Act**), as the death occurred in Victoria and was violent, unexpected and not from natural causes.[57]

35. The jurisdiction of the Coroners Court of Victoria is inquisitorial.[58] The Act provides for a system whereby reportable deaths are independently investigated to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which the death occurred.[59]

36. It is not the role of the coroner to lay or apportion blame, but to establish the facts.[60] It is not the coroner's role to determine criminal or civil liability arising from the death under investigation,[61] or to determine disciplinary matters.

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

38. For coronial purposes, the phrase "*circumstances in which death occurred*,"[62] refers to the context or background and surrounding circumstances of the death. Rather than being a consideration of all circumstances which might form part of a narrative culminating in the death, it is confined to those circumstances which are sufficiently proximate and causally relevant to the death.

39. The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through the observations made in the investigation findings and by

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[55] Ibid, 99-101
[56] Response to the Court from Dr David Isaac dated 30 August 2019, 3-4
[57] Section 4 *Coroners Act 2008*
[58] Section 89(4) *Coroners Act 2008*
[59] See Preamble and s 67, *Coroners Act 2008*
[60] *Keown v Khan* (1999) 1 VR 69
[61] Section 69 (1)
[62] Section 67(1)(c)

the making of recommendations by coroners. This is generally referred to as the Court's "*prevention*" role.

40. Coroners are also empowered:

    (a) to report to the Attorney-General on a death;[63]

    (b) to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice;[64] and

    (c) to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice.[65] These powers are the vehicles by which the prevention role may be advanced.

41. All coronial findings must be made based on proof of relevant facts on the balance of probabilities.[66] In determining these matters, I am guided by the principles enunciated in *Briginshaw* v *Briginshaw*.[67] The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about individuals, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

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

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

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

43. On 15 May 2013, Ms A visually identified the deceased to be her son, Baby S, born 8 May 2012.

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

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

45. On 16 May 2013, Dr David Ranson (**Dr Ranson**), a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an autopsy upon Baby S's body. Dr

[63] Section 72(1)
[64] Section 67(3)
[65] Section 72(2)
[66] *Re State Coroner; ex parte Minister for Health* (2009) 261 ALR 152
[67] (1938) 60 CLR 336

Ranson provided a written report, dated 17 September 2013, which concluded that Baby S died from injuries to the head.

46. Dr Ranson commented on the following:

   (a) the internal examination of Baby S' body revealed no evidence of significant natural disease of a type that might be expected to have contributed directly or indirectly to the death. There were also no features on testing to indicate that Baby S suffered from any congenital abnormalities;

   (b) although a number of organisms were detected in the microbiological testing of body samples from Baby S' body, many of these would be commonly found in infants from time to time and there was no evidence of any significant infectious disease that might be expected to have contributed directly to the death;

   (c) there was evidence of severe head injury with multiple skull fractures and extradural, subdural and subarachnoid haemorrhage. Swelling of the brain was evident in association with the head injury. There was widespread bruising to the scalp prominently on the left side anterolaterally, but bruising was also present on the right side posteriorly in the deep scalp together with an area of abrasion of the skin surface;

   (d) in addition to the injuries to the head, lacerations of the liver were noted in association with blood within the peritoneal cavity. These liver injuries could have occurred as a result of force to the abdomen and or lower chest that took the form of direct blows or crush/squeeze processes; and

   (e) the injuries to the head and trunk appeared to be recent. The only macroscopic injury that showed unequivocal and substantial signs of healing was the fracture of the mid shaft of the right radius (forearm).

47. Dr Ranson also noted that the extensive nature of the injuries to the head indicates a very significant application of forces to the head. The head injuries may have occurred as a result of the infliction of one very severe force or by several applications of substantial force. He opined that a fall to the ground from a distance of approximately one metre could not cause these head injuries.

48. Toxicological analysis of postmortem blood specimens taken from Baby S were negative for common drugs or poisons.

49. Toxicological analysis of hair specimens taken from Baby S were positive for trace amounts of 6-Acetylmorphine[68], Morphine, Codeine[69], Diazepam[70] and Nordiazepam[71]. Dr Ranson confirmed that it is not possible to confirm that whether the presence of these drugs in the hair is the result of external exposure from Baby S' living environment or whether it is the result of drug consumption.

50. I accept the cause of death proposed by Dr Ranson.

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

51. On 15 May 2013, Mr B was staying at Ms A's apartment in North Richmond for the day. During the morning, Ms A left to go to obtain heroin from her supplier and whilst she was absent from the flat for these purposes, Baby S suffered serious injuries.[72]

52. Upon her return she saw Mr B putting Baby S into his cot. Ms A did not observe Baby S at this time.[73] Both Ms A and Mr B then took heroin intravenously.[74]

53. Ms A awoke a few hours later at approximately 5:00pm to check on Baby S and discovered his skin to be cold.[75] Emergency services were contacted, and Baby S was identified as deceased upon their attendance.[76]

54. On 9 September 2015, in the Supreme Court of Victoria - Court of Appeal, the Court dismissed Mr B's appeal and found that during Ms A's time away on 15 May 2013, Mr B had inflicted grievous injuries on Baby S by deliberately dropping or throwing Baby S onto the floor of the apartment.[77]

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[68] Heroin is an illegal drug produced from the morphine obtained from the opium poppy. Within minutes of injection into a person, heroin is converted to morphine via the intermediate compound 6-acetylmorphine. Heroin and morphine are depressants of the central nervous system causing reduced rate and depth of breathing and eventually cessation of the breathing reflux.

[69] Codeine is an opiate used to treat pain, coughing, and diarrhea. It is typically used to treat mild to moderate degrees of pain

[70] Diazepam is a sedative and hypnotic drug of the benzodiazepines class

[71] Nordazepam is a 1,4-benzodiazepine derivative. Like other benzodiazepine derivatives, it has amnesic, anticonvulsant, anxiolytic, muscle relaxant, and sedative properties

[72] *Coronial Brief*, Appendix 8: Transcript of record of interview with Ms A dated 15 May 2013, 315-320

[73] Ibid

[74] Ibid

[75] Ibid

[76] *Coronial Brief*, Statement of Tessa Anderson dated 17 May 2013, 117-118

[77] Mr B v The Queen [2015] VSCA 238, 27

COMMENTS PURSUANT TO SECTION 67(3) OF THE ACT

55. The unexpected, unnatural and violent death of a young child is a devastating event. Violence perpetrated by a family member is particularly shocking, given the family unit is expected to be a place of trust, safety and protection.

56. For the purposes of the *Family Violence Protection Act 2008*, the relationship between Baby S and Mr B was one that fell within the definition of family member[78] under that Act. Moreover, the actions of Mr B dropping or throwing Baby S and causing his death constitutes family violence.[79]

57. In light of Baby S' death occurring under circumstances of family violence, I requested that the Coroners' Prevention Unit (**CPU**)[80] examine the circumstances of Baby S' death as part of the Victorian Systemic Review of Family Violence Deaths (**VSRFVD**). The VSRFVD provides assistance to Victorian Coroners to examine the circumstances in which family violence deaths occur. In addition, the VSRFVD collects and analyses information on family violence-related deaths. Together this information assists with the identification of systemic prevention-focused recommendations aimed at reducing the incidence of family violence in the Victorian Community.

High Risk Indicators for Infant Child Deaths

58. Family violence literature on filicide defines it to be the murder of a child older than 12 months of age by a parent or step-parent.[81] Available statistics indicate that filicides affect female and male children equally[82], whilst younger children were found to be at greater risk of fatal harm from their mothers and older children at greater fatal risk from their fathers.[83] In addition to this, the majority of victims of filicide are below six years of age.[84]

59. Whilst research into filicides is considerably underdeveloped, a study of 378 cases of filicide in Canada provides evidence that step-parents are more likely to cause fatal injury to a child

[78] *Family Violence Protection Act 2008,* section 8.
[79] *Family Violence Protection Act 2008*, section 5(1)(a)(i)
[80] The Coroners Prevention Unit is a specialist service for Coroners established to strengthen their prevention role and provide them with professional assistance on issues pertaining to public health and safety
[81] Dominique Bourget, Jennifer Grace and Laurie Whitehurst, 'A review of maternal and paternal filicide.' (2007) 35(1) *Journal-American Academy of Psychiatry and the Law* 74.
[82] A. S. C. Ciani and L. Fontanesi, 'Mothers who kill their offspring: testing evolutionary hypothesis in a 110-case Italian sample.' (2012) 36 (6) *Child abuse & neglect*, 519-527.
[83] A. Debowska, D. Boduszek and K. Dhingra, 'Victim, perpetrator, and offense characteristics in filicide and filicide–suicide' (2015) 21 *Aggression and violent behavior*, 113-124
[84] A. Debowska, D. Boduszek and K. Dhingra, 'Victim, perpetrator, and offense characteristics in filicide and filicide–suicide' (2015) 21 *Aggression and violent behavior*, 113-124

than genetic parents. I note that this same study also evidences that step-parents kill younger children at a higher rate than genetic parents who kill their children.[85]

60. Research also suggests that step-parents are found to use more violent ways of killing their step-children compared to genetic parents who kill their children.[86] Step-parents were more likely to kill a child by beating or bludgeoning them and in another study were found to be "*more likely to kill after maltreating the child.*"[87]

61. Whilst there is limited Australian research on filicides, research surveying Canadian trends in filicide between 1961 and 2011 found that the proportion of step-fathers killing their step-children has increased from 11 per cent between 1974 and 1983, to 29 per cent from 2004 to 2011.[88] This research suggests that a rise in blended families has been a contributing factor to the increase in filicide deaths involving a step-parent.[89]

62. Literature on child deaths where the offender is in a de facto relationship with one of the child's parents is limited.[90] The principal reason for this is that there is limited data available regarding perpetrators of family violence using violence against children resulting in death, particularly regarding infant deaths.[91] Much of the data that is available has unclear classification of the relationship between the perpetrator and the child, often noting it as a carer or guardianship relationship without specifying the exact type of relationship.[92]

63. As Baby S was killed by Mr B, the de factor partner of his biological mother, it is hard to separate this relationship out in the larger data sets and ascertain how the literature applies to this case. Consequently, at this stage, only broad lessons can be learned from the literature around child deaths in a family violence context.

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[85] G. T. Harris, N. Z. Hilton, M. E. Rice and A. W. Eke, 'Children killed by genetic parents versus stepparents' (2007) 28 *Evolution and Human Behavior*, 85–95

[86] V. A. Weekes-Shackelford and T. K. Shackelford, 'Methods of filicide: Stepparents and genetic parents kill differently' (2004) 19(1) *Violence and Victims*, 75–81

[87] M. Liem and F. Koenraadt, F., 'Filicide: A comparative study of maternal versus paternal child homicide' (2008) 18 *Criminal Behaviour and Mental Health*, 166–176 in Agata Debowska, Daniel Boduszek, and Katie Dhingra, 'Victim, perpetrator, and offense characteristics in filicide and filicide–suicide' (2015) 21 *Aggression and violent behaviour,* 118.

[88] M. Dawson, 'Canadian trends in filicide by gender of the accused, 1961–2011' in Thea Brown, Danielle Tyson and Paula F. Arias (eds), *When Parents Kill Children: Understanding Filicide* (Springer International Publishing AG, 2018), 18.

[89] M. Dawson, 'Canadian trends in filicide by gender of the accused, 1961–2011' in Thea Brown, Danielle Tyson and Paula F. Arias (eds), *When Parents Kill Children: Understanding Filicide* (Springer International Publishing AG, 2018), 18-19.

[90] Heather Strang, 'Children as Victims of Homicide' (1996) 53 *Australian Institute of Criminology* 1, 2.

[91] Ibid.

[92] Ibid.

64. In a study conducted by the Australian Institute of Criminology (**AIC**) on child deaths between 1989 and 1993, deaths of children aged 12 months or less were most likely due to assault, at a majority of 57%.[93] This number was found to decrease as the age of the child increased.[94] This data indicates that infants are at greater risk of assaults such as shaking, throwing and punching.[95]

65. The research found that education around safe parenting was the primary prevention method for the prevention of child deaths amongst the general population.[96] In terms of secondary prevention for more at-risk families, particularly those with infants, home visiting services such as Maternal Child Health Nurses and Child Protection Practitioners were regarded as promising services for secondary prevention.[97] This highlights the key role that such services can play in the prevention of deaths such as Baby S's, and the importance of ensuring that such service intervention is conducted effectively and appropriately.

Review of relevant service contact with Baby S:

Child Protection

66. The Victorian Child Protection Service is specifically targeted to those children and young people at risk of harm or where families are unable or unwilling to protect them. The main functions of Child Protection are to investigate matters where it is alleged that a child is at risk of harm; refer children and families to services that assist in providing the ongoing safety and wellbeing of children and take matters before the Children's Court if the child's safety cannot be ensured within the family.

High risk infant best practice and information gathering

67. In the proximate period leading to the fatal incident, Child Protection practitioners were guided by additional practice requirements when working with children under the age of two years who are assessed as meeting the criteria of a high risk infant.[98] Age alone does not define or indicate high risk for an infant. The vulnerability of an infant under two years old

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[93] Ibid.
[94] Ibid.
[95] Ibid, 2-3.
[96] Ibid, 5.
[97] Ibid.
[98] Child Protection – High risk infants (HRI) – practice requirements advice 1012 dated 23 January 2013

may be compounded by the presence of environmental and other established risk factors, in Baby S' case the presence of the following risk factors:[99]

(a) a history of another child being removed from the parents' care;

(b) parental substance and alcohol abuse;

(c) history of family violence; and

(d) indiscriminate partnering with adults who have a criminal history or other concerning behaviour.

68. In cases involving a high-risk infant, a case conference should generally be held to develop a case plan, including all relevant parties. The meeting should be chaired by a supervisor (CPP5 or above) and documented in CRIS (Child Protection's record management system). Practitioners should use critical reflection and outcomes should be reviewed for high risk infants in all phases of child protection involvement.[100]

69. It is important that meetings proceed in a timely manner without delay and include all relevant people. The meeting should:[101]

(a) consider the immediate and future risks to the child's safety, stability and development;

(b) identify the cause/s of harm or risk;

(c) identify the strategies, support agencies and other resources to address the risks to meet the child's needs for safety, stability and development;

(d) establish information sharing arrangements, appropriate monitoring and review mechanisms, and support systems relevant to the goals of the plan;

(e) identify the roles and responsibilities of the case manager and other professionals;

(f) establish contact and monitoring arrangements with the child and the family; and

(g) the decisions of the meeting should be recorded in CRIS and provided to all parties who attended the meeting and key people who were absent.

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[99] Ibid, 1-2
[100] Ibid, 5
[101] Ibid, 5-6

70. However, despite these practice guidelines, it is apparent in this case that Child Protection lacked assertive engagement with other professionals, who could have assisted them in their analysis and contributed to balanced and well considered decision making concerning cumulative risk to Baby S.

71. At the time Ms A left OHV, Child Protection did not have an open investigation and a formal report was not made to open an investigation until 18 February 2013. The last open investigation relating to Baby S was closed in September 2012 whilst Baby S and Ms A were still in OHV. The 18 February 2013 intake report noted that:[102]

Ms. A had Baby S while in Odyssey House. CP were involved for 3 months after his birth, investigating how Ms A managed with Baby S as he was born Methadone addicted and seemed to be challenging. Ms A managed very well with the support of Odyssey house and a decision was made for CP to withdrawn, should Ms A however decide to exit the Odyssey program without completing the program and the staff endorsing that she is ready to leave, CP would open investigation again to confirm that Baby S is safe and well looked after.

In December 2012, Ms A and another Odyssey resident were found in the basement having one on one contact. The male resident was asked to leave the program, however Odyssey house decided to allow Ms A and Baby S to stay. Ms A initially wanted to exit the program immediately and a meeting was held with myself, Ms A and Ms A's therapist. The therapists strongly advised Ms A to stay in the program as she was still reducing her methadone. CP also had concerns that should Ms A leave the program unplanned she had no place to stay, no support for her and Baby S and that Ms A will struggle to cope out in the community and not use substances. Ms A agreed to stay, and it was decided that another care team meeting will be held in January 2013.

72. Despite the above concerns raised by Child Protection at the care team meeting and the first home visit, no efforts were made to make contact with Ms A's treating GP, her health service at NRCHC and maternal child health services.

73. The best interests practice model states that engaging specialists and other professionals in the analysis process results in a greater shared understanding of the safety, stability and development of the child and the planning and actions required to resolve the protective issues for the child.[103] This should especially be a focus in instances where a notification is made in relation to an identified high risk infant.

74. Prevailing Child Protection policies at the time of Baby S' death further indicate that the process of gathering relevant information is also meant to be an ongoing process in which

[102] Child Protection (Baby S) CRIS Note 18 February 2013 and Intake Record 18 February 2013
[103] Child Protection - Analysis and assessment in best interest case practice advice 1535 dated 1 December 2013

Child Protection regularly checks-in with key services to gather relevant information about risk. In this case, the available evidence indicates that Child Protection missed critical information from key agencies including:

(a) the fact that Ms A had attended St Vincent's hospital for an overnight stay in relation to her drug use;

(b) that Ms A had made no contact with maternal child health services; and

(c) that Ms A had ongoing contact with Mr B which was known to CCCC staff.

Failure to identify and assess the risk posed by Mr B

75. In relation to the risk that Mr B posed to Baby S, I confirm that the available evidence suggests that:

(a) On 18 December 2012, OHV staff provided Child Protection with information about the existence of Ms A's relationship with Mr B in OHV and her desire to continue that relationship after leaving OHV.[104]

(b) Despite claiming to be in regular contact with Ms A's childcare centre, Child Protection made no enquiries about Ms A's partner or if someone else other than Ms A was attending the centre to pick-up and drop-off Baby S.

(c) Child Protection records dated 22 April 2013 evidenced awareness that Ms A had a new partner, yet Child Protection had failed to establish the identity of the new partner and conduct an appropriate assessment or criminal history check of his suitability to have contact with Baby S.[105]

76. At the time of baby S' death, child protection were unaware of the identify of Ms A's partner, his involvement in Baby S' care and any risk he posed to Baby S.

Delays in taking protective action

77. The available evidence indicates that despite Child Protection experiencing ongoing difficulties with establishing contact with Ms A, her failing to complete any drug screens, her reported using heroin and only sighting Baby S once in the first ten weeks of Ms A leaving OHV, the decision to take further protective action was not made till 16 April 2013. On this

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[104] Child Protection records provided to Court (Baby S) CRIS notes dated 18 December 2012

[105] Child Protection records provided to Court (Baby S) dated 22 April 2013

date, Child Protection filed a Protection Application by Notice with the Children's Court more than ten weeks after her departure from OHV.[106]

78. The Protection Application was issued on 17 April 2013 and the Court allocated a hearing date of 6 May 2013. Child Protection records noted that the reasons for substantiation were:[107]

(a) Baby S is a 9-month-old baby that is totally depended on his mother for his wellbeing and safety.

(b) Ms A has been in Odyssey house residential program for 14 months. The program usually runs for 18-24 months. Odyssey house would have liked Ms A to finish the program and not leave prematurely.

(c) Ms A moved back to her environment where she used substances and had a relationship with a drug dealer.

(d) Ms A had a lot of support in Odyssey house to assist with caring for Baby S. Baby S attended the childcare daily and people would also look after him when Ms A needed to attend groups. Ms A will not have anyone to assist her in caring for Baby S.

(e) Ms A recently came off Methadone and previously indicated that she struggled to cope with reducing her Methadone.

(f) Baby S is Ms A's fifth child, 3 other children are in permanent care and Ms A has no contact with them. The other child is in a kinship placement and CP is involved.

79. However, the available evidence confirms that there were significant additional high-risk factors which also should have been considered when seeking a protection order from the Children's Court including the following information that Child Protection was aware of:

(a) between 30 January 2013 and 3 May 2013, Baby S had only been sighted twice by Child Protection when policy at the time required regular weekly sighting of high-risk infants;

(b) Child Protection confirmed that they would be engaged with Ms A for the next three months after her discharge on 30 January 2013, but the appropriate supports were not in

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[106] Child Protection records provided to Court (Child G) CRIS Notes dated 6 May 2013 and Court Activity Note dated 6 May 2013

[107] Child Protection records provided to Court (Baby S) CRIS Notes dated 3 May 2013

place to adequately address the concerns of her early discharge, even at the time of Baby S' death.[108]

(c) Ms A had not completed any urine drug screens during this period;

(d) Ms A had ceased using suboxone in late April 2013;[109]

(e) Ms A had been evading Child Protection and only three home visits had occurred with only two sighting of Baby S;

(f) Child Protection had still not confirmed the identity of Ms A's new partner and conduct an appropriate assessment or criminal history check of his suitability to have contact with Baby S; and

(g) Ms A had admitted taking heroin to Child Protection on 28 March 2013.[110]

80. Child Protection could also have gathered from other services the following critical information, including:

(a) Ms A presented to St Vincent's Emergency Department on 8 April 2013 following a seizure and was admitted overnight. Ms A told her GP on 1 May that this was a '*combo of heroin and Unison injection*'.[111] Apart from providing evidence of Ms A's relapse, this raises questions as to where Baby S was and who was caring for him when Ms A was using drugs and in hospital overnight. This was significant information that would have informed the assessment of risk, including whether Baby S should be placed in emergency care;

(b) gather critical risk assessment information from Ms A's GP, drug and alcohol counsellor or maternal child health nurse to determine engagement with Ms A; and

(c) Ms A had failed to engage with Maternal Child Health services since leaving OHV.

81. In light of this missing critical information and given the significance of prior Child Protection engagement with Ms A's other children who were removed from her care, Child Protection ought to have considered lodging an emergency application to the Children's Court seeking to place Baby S in the emergency care.

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[108] Child Protection records provided to Court (Child G) – CRIS Note dated 24 January 2013
[109] Child Protection records provided to Court (Baby S) CRIS Notes dated 16 May 2013
[110] Child Protection records provided to Court (Baby S) CRIS notes dated 28 March 2013
[111] Response to the Court from Dr John Furler dated 28 August 2019, 3

82. Even if an emergency care application was not filed, it is possible that if the matter was heard on time on 6 May 2013, the Court may have considered making interim orders that included conditions that Ms A return to OHV to continue treatment in an environment where she would also receive appropriate support to care for Baby S. I confirm that this was a missed opportunity for intervention in Baby S' death.

83. The available evidence also suggests that Child Protection did not prepare a report supporting their Protection Application by Notice and this caused the Court to adjourn the hearing date to 2 June 2013.[112] I confirm that the policies and procedures in place at the time required Child Protection to prepare a disposition or protection report prior to the first return date which was 6 May 2013. Child Protection had adequate time to prepare a report and had such a report been appropriately prepared, the significance of the cumulative risk to Baby S would have been more apparent.

84. Child Protection have reported that their policies and procedures have undergone significant changes since Baby S's death.

85. The Victorian Government has taken several steps to address areas of concern within the Child Protection system. In 2016, the *Roadmap for Reform: Strong Families, Safe Children* (**Roadmap for Reform**), was released.[113] Among their findings, this report identified that there had been a rapid increase in Child Protection notifications, that Child Protection and family services were '*not well connected to universal health and educational services*'[114], and that there were significant communication issues and a disconnection between Child Protection and the broader service sector. The report also identified that Child Protection often missed opportunities to '*build a complete picture of unmet needs*'[115] for families and that '*gaps in information sharing*' make '*it more difficult to monitor changing family circumstances and identify children who are most at risk*'[116].

<u>*Changes to Child Protection policies and procedures in relation to working with infants*</u>

86. Child Protection have provided a statement from Rosemary Ebel, Acting Assistant Director of Children Protection Policy, dated 25 October 2019 which outlines several significant changes to policy and procedure since Baby S' death. In June 2018 major changes were introduced to Child Protection's high risk infant policy, procedures and practice, with the aim of enhancing

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[112] Child Protection records provided to Court (Baby S) - Court Activity Case Note dated 6 May 2013
[113] Victorian Government, *Roadmap for Reform- strong families, safe children* (2016).
[114] Ibid, 6.
[115] Ibid, 6.
[116] Ibid, 6.

consistency in Child Protection practice in respect of children under two years of age. These changes were made in recognition of the fact that infants' fragility and developmental dependence significantly increases their vulnerability to potential harm, and where the severity and cumulative impact of risk is adversely affecting their safety and development, the case requires a specific response.

87. The most significant change was the introduction of an infant response classification system. The infant response classification system identifies those infants with whom Child Protection is involved who are most at risk and determines the Child Protection service response. The system includes two categories: infant intensive response and infant response.

88. The infant response classification matches the assessed level of risk for the infant with the Child Protection service response required to address the protective concerns. An infant response decision can be made by a team manager or a person holding a higher office. An infant is assessed as requiring an infant intensive response when there are risk factors that have had or are likely to have a significant impact on the infant and where there are insufficient safety factors evident, suggesting a more intensive Child Protection service response isrequired.

89. Policies, procedures and advice in the Child Protection Manual have been updated to support the implementation of these changes. For infants requiring an intensive response, the following requirements must be applied by Child Protection Practitioners and Managers. These requirements have been implemented to increase the monitoring and management of risks to infants requiring an intensive response:

(a) *The case must be allocated* - The infant is to have an allocated Child Protection Practitioner who will engage with the family or carers to maintain visibility of the infant and to address the protective concerns. It is critical that Child Protection Practitioners who are new to a case take the time to read the file, gain a clear understanding of the history of trauma, abuse, family and social networks, current risk issues and case planning. Once an infant is assessed as requiring an infant intensive response the case is to be allocated that day or during the next business day.

(b) *The infant must be visited weekly* - Visits are to include face-to-face contact with the parent and infant, and are to occur weekly, at a minimum. Depending on the level of risk, visits may be required more frequently than once a week.

All visits are to be discussed between the Child Protection Practitioner and their supervisor to develop an active plan for each visit. The visits are to include contact with the infant for the purpose of assessing risk, observing the interaction between the parent and infant, viewing the infant's sleeping environment, discussing SIDS risk factors and case planning with the parent.

(c) *A practice leader or principal practitioner must be involved in the case* - A discussion with a practice leader or principal practitioner provides a broader understanding of case dynamics and assists with planning and decision making. The intent is that the most 'at risk' infants have a higher level of oversight by multiple sources. If a practitioner is in doubt about risk issues, action plans or case direction, a discussion with the team manager should occur, who will involve a practice leader or principal practitioner if required.

(d) *A case conference or care team approach must be applied* - Depending on the level of risk, case conferences may need to occur on a fortnightly or monthly basis, to enable discussion of the risk issues, action plans and review of the intensive infant response status.

(e) *Regular reviews of the infant intensive response classification must occur* - The review of an infant's classification should include a discussion on a regular basis that considers all information relating to current risk issues, action plans and case plan direction. This review could be undertaken as part of the infant intensive meeting or through a practice leader and/or principal practitioner consultation, or an alternative meeting could be scheduled. Practitioners and supervisors must undertake case reviews that examine part of all of the history of an individual case to evaluate practice effectiveness and outcomes and identify opportunities for improvement. The decision regarding which infant response is required is to be subject to regular and ongoing case discussion. The receipt of any new information should prompt a review as to whether the infant response decision should be changed.

(f) *Case discussions at infant intensive response meetings* - The infant intensive response meeting provides a framework and mechanism to support the management of those infants who are highly vulnerable and at highest risk. The purpose of the infant intensive meeting is to consider which cases should be discussed at the infant intensive response panel; consider current case status and whether there is a requirement for the infant

intensive response status to remain in place at that time; and identify cases that require attention to promote targeted implementation of case plans.

(g) *Referral to the infant intensive response panel* - Of those infants discussed at the infant intensive response meeting, a smaller number of cases may be referred to the infant intensive response panel (**the panel**). The decision to refer an infant to the panel is made by the chair of the infant intensive meeting who is a senior manager within Child Protection (being a Child Protection Practitioner level 6 or a person who holds a higher office). The primary role of the panel is to support rigorous multi-disciplinary case review, planning and decision making, service integration and collaborative problem solving. It should provide support and direction to case managers and other direct service staff in respect of infants who have been identified as requiring an infant intensive response and presentation to the panel. Infants identified with cumulative concerns, lack of progress, or needing a collaborative approach to assist with the progress of addressing concerns can be taken to the panel.

Changes to policies and procedures in relation to information sharing

90. On 27 September 2018, section 192 of the *Children, Youth and Families Act 2005* was amended to simplify information sharing when a Child Protection Practitioner believes on reasonable grounds that sharing certain information is required to carry out delegated responsibilities. Child Protection may request information from, disclose information to, or receive information from:

    a) the Secretary;
    b) a protective intervener;
    c) an information holder;
    d) a service agency;
    e) a registered community service; or
    f) any other individual.

91. The Child Information Sharing Scheme (**CIS Scheme**) also commenced operation on 27 September 2018. The CIS Scheme evolved in response to numerous independent reviews and inquiries recommending changes to Victoria's information sharing arrangements to improve outcomes for children. The changes seek to promote shared responsibility for the

wellbeing and safety of children, increase collaboration between service providers, and modify a risk-averse culture in which some service providers were hesitant to share information due to privacy concerns, even when it would benefit children to share information. The CIS Scheme is intended to facilitate services working together to identify needs and risks, promote earlier and more effective intervention and integrated service delivery, and improve outcomes for children and families in Victoria.

92. On 27 September 2018, the Secretary to the department became a prescribed Information Sharing Entity (**ISE**), and the Secretary's powers and functions under the CIS Scheme have been delegated to all Child Protection Practitioners. Several organisations and services relevant to Child Protection practice are also now prescribed ISEs. However, some organisations and services with which Child Protection has contact are not currently prescribed ISEs, such as schools, hospitals, allied health services and disability service providers. Subject to consultation, the next phase of authorisation will occur in 2020.

Odyssey House Victoria (OHV)

93. Odyssey House Victoria (OHV) is a drug and alcohol organisation, and its residential treatment facility in Lower Plenty operates as a Therapeutic Community to help up to 143 residents recover from drug and alcohol dependency. As such, it is not a service which deals with family violence directly. Rather, family violence is dealt with tangentially as a potential casual factor for drug or alcohol dependency.

94. After giving birth to Baby S at Mercy Hospital, Ms A returned to OHV with Baby S, who was five weeks old at the time of his discharge from hospital due to his significant drug withdrawal. Ms A was referred to the parents' education program at OHV.[117]

95. Ms A had significant practical and emotional support in OHV, including access to a GP from NRCHC. She went from a high dose of methadone (while pregnant), to no methadone (prior to discharge from OHV). At OHV, Ms A attended parenting classes on bonding, forming attachments and routines.[118]

96. Upon discharge however, Ms A refused a referral by Odyssey House to Kids in Focus or Noah's Ark. OHV organised the discharge planning meeting on 24 January 2013 which Child Protection attended and confirmed that they were not happy that Ms A was leaving

[117] Odyssey House Victoria, 'Assessment Form Navigations and TC' (Administrative Form No 1, Odyssey House Victoria 16 January 2012) 22
[118] Ibid

prematurely.[119] OHV advised that its staff were concerned about the environment to which Ms A was returning to. Ms A subsequently discharged herself against their advice. Child Protection services confirmed that they would be engaged with Ms A for the next three months after her discharge, but the appropriate supports were not in place to adequately address the concerns of her early discharge.[120]

97. During Ms A's discharge meeting on 24 January 2013, OHV did not disclose Mr B's identity as Ms A's intimate partner even though an earlier OHV staff member did inform Child Protection on 18 December 2012, that '*Ms A was caught having an intimate relationship with another resident, Mr B, whom she wanted to continue to be in her life and Baby S'*.[121] If OHV had shared Mr B's identity, Child Protection may have been in a position to assess Mr B for any risk that he posed to Baby S and make a more accurate assessment with respect to Baby S's overall safety in the care of Ms A and Mr B.

Cook Court Child Care (CCCC)

98. CCCC was a childcare centre operated by Lentara Uniting Care. CCCC staff knew Ms A as Baby S' elder sibling had also attended the childcare. However, the childcare centre staff thought that Ms A only had three children in total (including Baby S). Other than the previous contact with Baby S' sibling, professionals working at the centre did not have a full understanding of the family history or protective concerns and this relevant information was not conveyed by Child Protection to CCCC staff.

99. The available evidence confirms that Mr B would attend with Ms A most evenings to pick Baby S up from childcare. Mr B never attended on his own to collect Baby S.

100. The childcare centre confirmed that they were in communication with Child Protection either through letter or by telephone.[122] Child Protection would sometimes phone the childcare centre for general *'well-being updates'* on Baby S and would ask the childcare staff to pass on messages to Ms A.[123] However, there were no conversations with Child Protection in relation to Mr B, and the childcare centre staff assumed that Child Protection was aware of Mr B's relationship with Ms A.

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[119] Odyssey House Victoria records provided to Court – Ms A 'TC Circumstances for exit' form dated '30/01/2013'
[120] Child Protection records provided to Court (Child G) – CRIS Note dated 24 January 2013
[121] Child Protection records provided to Court (Child G) – CRIS Note dated 18 December 2012
[122] Response provided to the Court from Child Protection dated 25 October 2019 – Submissions, 3, 8
[123] Ibid

101. In hindsight, the child care centre provided responses to the Court indicating that staff would have had more contact with Child Protection if they had been aware of the broader protective concerns and risks in relation to Ms A's history with Child Protection and removal of all of her children.[124] However, the staff confirmed that Child Protection did not inform them of any specific protection concerns with any of the children. It worth noting that the last contact childcare staff had with Ms A and Baby S, on 13 May 2013 evidenced concerning injuries that were of an unknown origin and that best practice would dictate that CCCC staff ought to have contacted Child Protection to inform them of the injuries, especially given that CCCC staff had regular contact with Child Protection in the lead up to this incident.

102. Since Baby S' death, UnitingCare agencies have undergone significant organisational change. Prior to the merger of childcare services, there had been a continuous focus on improvements at UnitingCare Lentara, including in relation to staff training and policies and procedures.[125]

103. As part of the merger of services, there has been a significant review and alignment of staff training, policies and procedures. In particular, in relation to Uniting's provision of early learning services and the reporting of suspected child abuse, neglect or family violence.[126] Further, since 1 March 2019 early childhood workers are now mandatory reporters. Uniting's staff training, policies and procedures have been updated to incorporate the mandatory reporting obligations.[127]

North Richmond Community Health Centre

104. Both Ms A and Baby S sought services from the NRCHC. Ms A attended NRCHC to undertake drug dependency treatment and Baby S received treatment for physical injuries and illness.[128]

105. Generally, Ms A was seen by the same GP each time when she visited the North Richmond Community Health (the clinic). Her GP prescribed her methadone or Suboxone medication. Ms A's GP had minimal understanding of CP's involvement. The GP was unaware that Ms A had four other children, who were all subject to court orders and placed in the care of other people.

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[124] Response provided to the Court from Uniting Vic.Tas Limited dated 30 August 2019, 2
[125] Response provided to the Court from Uniting Vic.Tas Limited dated 30 August 2019, 3
[126] Ibid
[127] Ibid
[128] *Coronial Brief*, 'Consultation Notes for Baby S', 362; North Richmond Community Health Limited, 'Patient Health Summary – Ms A' (Medical Record, North Richmond Community Health Limited, 22 May 2013).

106. GPs are often the first point of contact for families under stress and for children at risk of abuse. It is important for GPs to remain aware of the possibility of abuse when treating children, particularly children with emotional or behavioural issues or unexplained injuries. Child abuse can present in myriad ways and these effects vary from child to child. While some children may present with bruising or injuries that raise suspicion, most will not.[129] Children in families where one or both parents are abusing alcohol or other drugs will have a high incidence of neglect and other forms of abuse.[130]

107. Whilst Baby S was never observed to have unexplained bruises, best practice for GPs treating families would be to reference all records of primary carers for children if they are also treated at the same clinic to consider comprehensive risk assessment in the context of family violence.

108. If consideration had been given to the overall information available to GPs at NRCHC, appropriate enquiries may have been made with Child Protection to share relevant information regarding Ms A's reported heroin relapse and more importantly the information about her presentation to St Vincent's Emergency Department on 8 April 2013 following a seizure and admission overnight. Ms A told her GP on 1 May 2013 that this was a '*combo of heroin and Unison injection'*.[131] Apart from providing further evidence of Ms A's relapse, this raises questions as to where Baby S was and who was caring for him when Ms A was using drugs and in hospital overnight. This was significant information that would have informed Child Protection's assessment of risk to Baby S.

109. I confirm that since Baby S' death, NRCHC has made changes to its policies and procedures in the period since the death of Baby S.[132] NRCHC has implemented a system to alert clinical staff to information that may assist them in forming an opinion on whether child abuse, neglect or family violence has occurred. NRCHC patients are generally seen by their regular doctor, however, on occasion this is not possible. In these circumstances, the doctor who sees the patient may not be familiar with the background information known by the patient's regular doctor. NRCHC considered this an area of potential risk in relation to the reporting of

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[129] RACGP, *Abuse and Violence – Working with our patients in general practice* (4th Edition – June 2014), 43
[130] Meredith V, Price-Robertson R. Alcohol misuse and child maltreatment. Australian Government, Australian Institute of Family Studies; 2011
[131] Response to the Court from Dr John Furler dated 28 August 2019, 3
[132] Response to the Court from North Richmond Community Health dated 10 May 2019, 1-2

suspected child abuse, neglect or family violence. To limit this risk, NRCHC has implemented an alert system.[133]

110. If a staff member discovers information which might assist someone to form an opinion in relation to the occurrence of child abuse, neglect of family violence, that information must be placed on the patient's record as an alert.[134] The alert is prominently displayed on the file in bolded red font to ensure that it is noticed by clinical staff. The alert is entered on a patient's file in all patient record systems used by NRCHC, allowing all clinical staff to see the alert. If the alert is to be entered on a child's file, it will also be entered on the child's parent's file.

111. NRCHC have also implemented a Child Safety Policy and Procedure. This policy was developed to support staff and volunteers to recognise and respond to incidents of witnessed, or suspected abuse or neglect of children, including under the mandatory reporting scheme.[135]

Summary

112. Although Baby S and his family were involved with multiple services including Child Protection, no service had a complete understanding and knowledge of Ms A's ongoing drug abuse, the nature of her relationship with Mr B or the abuse that Baby S experienced.

113. The analysis of each key service that had proximate contact with Baby S and Ms A in the lead up to the fatal incident highlights the importance of:

a) comprehensive information gathering and effective sharing of information between key agencies and services;

b) well informed risk assessments by key agencies and services;

c) timely court intervention by Child Protection;

d) thorough drug and alcohol assessments, including monitoring and drug screens; and

e) a child-focused approach to practice and service delivery.

Criminal justice outcome

114. On 9 September 2015, in the Supreme Court of Victoria on appeal, Mr B conviction for the murder of Baby S was upheld including his sentence of 25 years imprisonment with a non-

[133] Ibid
[134] Ibid
[135] Ibid

parole period of 20 years by Justice Emerton in the Supreme Court of Victoria on 13 November 2013.[136]

115. I am satisfied that the available evidence does not identify any other missed opportunities that could have prevented Baby S' death.

116. I am also satisfied, having considered all the available evidence, that no further investigation is required.

[136] Mr B [2015] VSCA 238, 36

RECOMMENDATIONS PURSUANT TO SECTION 72(2) OF THE ACT

117. The Victorian Government has taken several steps to address areas of concern within the Child Protection system. In 2016, the *Roadmap for Reform: Strong Families, Safe Children* (**Roadmap for Reform**), was released.[137] Among their findings, this report identified that there had been a rapid increase in Child Protection notifications, that Child Protection and family services were '*not well connected to universal health and educational services*'[138], and that there were significant communication issues and a disconnection between Child Protection and the broader service sector. The report also identified that Child Protection often missed opportunities to '*build a complete picture of unmet needs*'[139] for families and that '*gaps in information sharing*' make '*it more difficult to monitor changing family circumstances and identify children who are most at risk*'[140].

118. The statement of Rosemary Ebel, Acting Assistant Director of Children Protection Policy, dated 25 October 2019, outlines significant changes to Child Protection policies and procedures that have been implemented since Baby S's death. Many of the changes have only recently occurred and it is important as part of reflective practice to review the effectiveness of changes implemented. This is particularly important in cases involving vulnerable high-risk infants.

119. As such, I recommend that the Secretary of the Department of Health and Human Services conduct a review and audit of the updated Child Protection policies and procedures listed above in paragraphs 86 to 89, to determine whether these changes have effectively improved Child Protection's response to and management of high-risk infants. In addition I recommend that the Secretary of Department of Health and Human Services conduct a compliance audit to ensure that staff are complying with the policies and procedures listed in paragraph 86 and 89. The review and audit should be completed no later than 30th June 2021.

[137] Victorian Government, *Roadmap for Reform- strong families, safe children* (2016).
[138] Ibid, 6.
[139] Ibid, 6.
[140] Ibid, 6.

FINDINGS AND CONCLUSION

120. Having investigated the death, without holding an inquest, I make the following findings pursuant to section 67(1) of the Act:

    (a) the identity of the deceased was Baby S, born 8 May 2012;

    (b) the death occurred on 15 May 2013 at [redacted], Richmond, VIC 3121, from injuries to the head; and

    (c) the death occurred in the circumstances described above.

121. I convey my sincerest sympathy to Baby S's family.

122. Pursuant to section 73(1A) of the Act, I direct that a copy of this finding be published on the Coroners Court website.

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

    (a) Ms A, senior next of kin;

    (b) Ms Colleen Carey, Principal Solicitor, Children, Youth and Disability Law Team;

    (c) Mr Greg King, Special Counsel, Hall & Wilcox;

    (d) Ms Lara King, Solicitor, Ball+Partners;

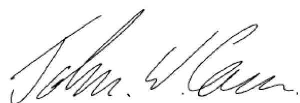
    (e) Ms Liana Buchanan, Principal Commissioner, Commission for Children and Young Persons;

    (f) Ms Annette Lancy, Acting Chief Executive Officer, Family Safety Victoria;

    (g) Ms Kym Peake, Secretary, Department of Health and Human Services; and

    (h) Detective Senior Constable Anthony James Hupfeld, Victoria Police, Coroner's Investigator.

Signature:



JUDGE JOHN CAIN

STATE CORONER

Date: 20 November 2020