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IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2018 4096

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)

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

Inquest into the Death of Baby A

Delivered On:	30 August 2023
Delivered At:	Coroners Court of Victoria 65 Kavanagh Street Southbank Victoria 3006
Hearing Dates:	12 – 26 September 2022, 25 November 2022
Findings of:	Coroner John Olle
Representation:	Ms J Munster with Mr T Noonan on behalf of Baby A's mother, instructed by Ms Rochelle Francis of Victoria Legal Aid Ms M O'Sullivan KC with Ms M Isobel of Counsel on behalf of the Secretary to the Department of Justice and Community Safety, instructed by Kate Davey and Anna Pejovic, Victorian Government Solicitor's Office Mr R Harper of Counsel on behalf of Correct Care Australasia, instructed by Jeremy Smith of Meridian Lawyers

	Ms J Davidson of Counsel on behalf of Department of Families, Fairness and Housing, instructed by Stephanie Davies of Department of Families, Fairness and Housing Mr D McWilliams on behalf of Western Health, instructed by Kate Cooch and Stephanie Van Lierop of Minter Ellison
Counsel Assisting the Coroner	Ms R Ellyard of Counsel, instructed by Ms I Giles and Ms P Davie of the Coroners Court of Victoria
Keywords	SIDS, death at a correctional facility, whether deceased was in care or custody, safe sleeping practices, multi-disciplinary hospital discharge

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I, Coroner John Olle, having investigated the death of Baby A, and having held an inquest in relation to this death on 12 – 26 September 2022

at Coroners Court of Victoria, 65 Kavanagh Street, Southbank, Victoria, 3006

find that the identity of the deceased was Baby A born on 6 August 2018

and the death occurred on 18 August 2018

at Dame Phyllis Frost Centre

from:

1a: SIDS CATEGORY TWO

THE CORONIAL INVESTIGATION

I find, under section 67(1) (c) of the ***Coroners Act 2008*** ('the Act') that the death occurred in the following circumstances:

1. Baby A[1] was a lovingly anticipated and cherished baby who was born at the Sunshine Hospital on 6 August 2018. Baby A was born by caesarean-section after an attempt to induce labour was unsuccessful.

2. Baby A's mother[2] was in custody on remand at the Dame Phyllis Frost Centre (**DPFC**) women's prison throughout her pregnancy with Baby A. Her antenatal care was provided by staff at Sunshine Hospital, one of the hospitals managed by Western Health. Baby A's mother was taking methadone to manage her addiction to illicit drugs.

3. Following Baby A's birth, she remained in hospital for eight days, much of it in the special care nursery. Baby A was treated for jaundice and monitored for signs of methadone withdrawal. Baby A and Baby A's mother were discharged to the DPFC on 14 August 2018. On 15 August 2018, the DPFC visiting midwife observed that Baby A had lost more weight and was showing signs of jaundice. Baby A and Baby A's mother were both readmitted to Sunshine Hospital later that day. They remained at Sunshine

[1] By order dated 7 September 2022, pursuant to section 55(2)(e) of the *Coroners Act 2008*, this is a pseudonym.
[2] By order dated 7 September 2022, pursuant to section 55(2)(e) of the *Coroners Act 2008*, this is a pseudonym.

Hospital until they were discharged back to DPFC at approximately midday on 17 August 2018.

4. On 18 August 2018 at approximately 5.30am, Baby A's mother called out for help via the prison intercom system after finding that Baby A was not breathing. Other women participating in the Mothers and Children Program (**MCP**)[3] at DPFC attempted to help by delivering cardiopulmonary resuscitation (**CPR**) as they waited for prison guards to open the doors to permit medical intervention. The on-duty nurse attended but did not perform CPR after making an assessment that Baby A was already deceased and had been for some time. Country Fire Authority (**CFA**) and Ambulance Victoria (**AV**) members responded, however tragically Baby A was pronounced deceased at the scene.

JURISDICTION

5. Baby A's death was a reportable death under section 4 of the Act because it occurred in Victoria and appeared to be unexpected and unnatural. Baby A's cause of death was identified as SIDS category 2, meaning that no other cause of death was found. As discussed in greater detail below, SIDS category 2 relates to the otherwise unexplained deaths of children under three weeks of age.

6. A related issue before me, which formed part of the scope of inquest, was whether there was another basis for Baby A's death being reportable, namely whether she was a person placed in custody or care immediately before death, given that at the time of her passing, she resided at DPFC in the care of her mother who herself was incarcerated (see ss 3 and 4(2)(c) of the Act). Under section 52(2)(b) of the Act, where a person is in custody or care immediately prior to their death, an inquest is mandatory unless the coroner considers an inquest is not required because the death was due to natural causes. I will return to this issue further below.

7. In any event, I determined at an early stage that, irrespective of whether an inquest was mandatory under the Act, it was appropriate to exercise my discretion to hold an inquest[4]

[3] The Mothers and Children Program (which is now known as the "Living with Mum" program) allows mothers in custody who have pre-school aged children to apply to have their children live with them in their correctional facility.
[4] Pursuant to section 52(1) of the *Coroners Act 2008*, a Coroner may hold an inquest into any death the Coroner is investigating.

into Baby A's passing as there remained discrepancies in the documentary evidence before me that could only be resolved through the hearing of *viva voce* evidence, and further, I consider the circumstances of Baby A's passing entailed critical matters of public health and safety that warranted further exploration through a public hearing.

PURPOSE OF THE CORONIAL INVESTIGATION

8. The purpose of a coronial investigation of a *reportable death*[5] is to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which the death occurred.[6] The cause of death refers to the medical cause of death, incorporating where possible the mode or mechanism of death. The circumstances in which death occurred refers to the context or background and surrounding circumstances but are confined to those circumstances sufficiently proximate and causally relevant to the death, and not all those circumstances which might form part of a narrative culminating in death.[7]

9. The broader purpose of any coronial investigation is to contribute to the reduction of the number of preventable deaths through the findings of the investigation and the making of recommendations by coroners, generally referred to as the prevention role.[8] Coroners are also empowered to report to the Attorney-General in relation to a death; to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and 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.[9] These are effectively the vehicles by which the coroner's prevention role can be advanced.[10]

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[5] Defined exhaustively in section 4 of the Act to include relevantly "the death of a person who immediately before death was a person placed in custody or care;" For the purposes of the Act, a person placed in custody or care is defined in section 3 of the Act and includes relevantly "(e) a person in the legal custody of the Secretary to the Department of Justice…".
[6] Section 67(1) of the Act.
[7] 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).
[8] The 'prevention' role is now explicitly articulated in the Preamble and purposes of the Act, cf: the Coroners Act 1985 where this role was generally accepted as 'implicit'.
[9] See sections 72(1), 67(3) and 72(2) of the Act regarding reports, comments and recommendations respectively.
[10] See also sections 73(1) and 72(5) of the Act 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.

10. It is important to stress that coroners are not empowered to determine the civil or criminal liability arising from the investigation of a reportable death and are specifically prohibited from including in a finding or comment any statement that a person is, or may be, guilty of an offence.[11]

11. I was assisted in my investigation by Detective Senior Constable Branka Jurjil. In addition, I have been greatly assisted by the respective submissions of members of Counsel, including Counsel Assisting, following the close of evidence. I also wish to acknowledge and thank Ms Ingrid Giles, Senior Legal Counsel (as she then was), and Ms Pru Davie, Coroner's Solicitor, who have provided me with invaluable assistance during this investigation and during inquest.

EVIDENCE AND STANDARD OF PROOF

12. This finding is based on the entirety of the investigation material comprising of the coronial brief of evidence compiled by Detective Senior Constable Branka Jurjil, as well as material obtained directly by the Court after the provision of the brief. I further base the finding on the statements and testimony of those witnesses who gave evidence at the inquest and any documents tendered through them, together with other documents tendered at inquest. All this material, together with the inquest transcript, will remain on the coronial file and comprise my investigation into the death of Baby A.

13. I have thoroughly and carefully considered all the material, however, will only refer to that which is directly relevant to my findings or necessary for narrative clarity.

14. In the coronial jurisdiction, facts must be established on the balance of probabilities.[12]

SECTION 67 FINDINGS

15. Prior to the commencement of the inquest, it was apparent that Baby A's identity was not in dispute and required no further investigation.

[11] Section 69(1) of the Act.
[12] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

16. Baby A's cause of death was classified as being sudden infant death syndrome (**SIDS**). Victorian Institute of Forensic Medicine (**VIFM**) pathologist, Dr Yeliena Baber, who conducted the autopsy of Baby A, defined SIDS as the sudden and unexpected death of an infant less than one year of age, usually in the context of sleeping.[13] Dr Baber outlined that SIDS was essentially death due to natural causes. Baby A's death was classified as SIDS category 2, as she was below the age of 21 days at the time of her death. Dr Luig, neonatologist, also opined that SIDS has a prescribed process which includes a complete post-mortem, consideration of all the medical history, the examination of the scene of the death, and looking at all the other circumstances.[14]

17. Accordingly, the scope for this inquest was confined to the circumstances surrounding Baby A's death, with specific key issues detailed below.

Scope of Inquest

18. My scope of inquest was as follows:

    a. The scope and operation of the Mothers and Children Program (**MCP**) at DPFC.

    b. The planning in the lead up to Baby A's birth.

    c. The circumstances of Baby A's birth.

    d. The first discharge from hospital.

    e. The readmission and second discharge from hospital.

    f. The immediate circumstances of Baby A's death; and

    g. Whether Baby A was in care or custody.

Witnesses

19. The following witnesses gave evidence at the inquest:

    a. Dr Yeliena Baber (Victorian Institute of Forensic Medicine Pathologist)

[13] Transcript 26.3-9.
[14] Transcript 1061.3-12.

b. Melissa Westin (Deputy Commissioner, Custodial Operations, Corrections Victoria)

c. Celia Whelan (Former Offender Services Manager, DPFC)

d. Jayne Cole (MPC Program Worker, DPFC)

e. Kirstie-Lee Lomas (Acting Chief Practitioner and Executive Director, Office of Professional Practice, Department of Families, Fairness and Housing)

f. Alice, [15] a former prisoner participating in the MCP at DPFC the time of Baby A's death

g. Beth, [16] a former prisoner participating in the MCP at DPFC the time of Baby A's death

h. Cathy, [17] a former prisoner participating in the MCP at DPFC the time of Baby A's death

i. Donna, [18] a former prisoner participating in the MCP at DPFC the time of Baby A's death

j. Dr Rosalynn Pszczola (Neonatologist, Western Health)

k. Benjamin Orams (Social Worker, Western Health)

l. Dr Elske Posma (Head of Unit Obstetrics, Western Health)

m. Karyn Smith (Clinical Midwife Consultant, Western Health)

n. Dr Foti Blaher (Chief Medical Officer, Correct Care Australasia)

o. The attending nurse (Registered Nurse, Correct Care Australasia)[19]

p. Janine Slater (Prison Officer, DPFC)

q. Amir Gabalawi (Prison Officer, DPFC)

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[17] By order dated 7 September 2022, pursuant to section 55(2)(e) of the *Coroners Act 2008*, this is a pseudonym.
[18] By order dated 7 September 2022, pursuant to section 55(2)(e) of the *Coroners Act 2008*, this is a pseudonym.
[19] Although I did not grant a pseudonym order in respect of this witness, in my view there is no merit to naming the attending nurse. The use of the phrase 'attending nurse' denotes the registered nurse who immediately attended at Gilbert B Unit upon being advised of an emergency.

r. John Howden (Operations Support Supervisor, DPFC)

s. Associate Professor Julia Charlton (Expert)

t. Dr Melissa Luig (Expert)

u. Professor Paul Colditz (Expert)

INTRODUCTION

20. Baby A was a baby whose vulnerabilities and associated needs posed enormous maternal demands. Further, despite unquestioned devotion to Baby A, the background and personal circumstances of Baby A's mother elevated the magnitude of the maternal challenge to the highest level. Baby A's mother was the product of childhood neglect and deprivation, which unsurprisingly set the foundation for an adolescence and adulthood shaped by drug addiction and incarceration.[20] In all the circumstances, Baby A's mother was the embodiment of a first-time mother, whose capacity to meet the challenges of a vulnerable baby demanded dedicated maternal support. I consider the most significant omission identified in my investigation is the failure to ensure Baby A's mother received 24 hour dedicated maternal support in the period following the discharges of Baby A from hospital to DPFC. I will address this and other identified issues in due course.

21. I take this opportunity to unequivocally state that shortcomings identified in my investigation are not attributable to any individual, whose role has been scrutinised in my investigation. This is especially applicable to Baby A's mother who displayed unstinting love and devotion to Baby A. I restate here my characterisation of Baby A's mother in open Court as remarkable. Further, I make no adverse finding against any individual.

22. In my view, systemic failings, in the nature of miscommunication and misunderstanding of respective roles, decisions and capacity of various organisations set the foundation for sub-optimal, albeit inadvertent, decisions and/or omissions in respect to Baby A's welfare.

[20] Coronial Impact Statement of Baby A's mother.

FINDINGS RELEVANT TO SCOPE ISSUES

The Mothers and Children Program (MCP) at DPFC

23. The legislative basis for the MCP arises from section 31 of the *Corrections Act 1986* (Vic) (**Corrections Act**). Section 31(1) of the Corrections Act states that a prisoner's child may be permitted to live with the prisoner if the Secretary [to the Department of Justice and Community Safety] is satisfied that it is in the best interests of the child to live with his or her parent in the prison and the management good order or security of the prison will not be threatened by the child living in the prison.

24. At the time of Baby A's mother's application to have Baby A reside with her, the MCP was conducted pursuant to a Delivery Framework in the context of a protocol between Corrections Victoria and Child Protection, and other relevant documentation.

25. Baby A's mother, who was pregnant upon entering custody in January 2018, was informed about the existence of the MCP, and advocated for her and Baby A to participate in the program when Baby A was born. Counsel appearing for Baby A's mother submitted that Baby A's mother's application for admission to the program was appropriate. Noting the supports that the program offered and having regard to Baby A's mother's circumstances and the relevant considerations, I accept Counsel's submission.

Planning in the lead up to Baby A's birth

26. Baby A's mother was in custody from late January 2018 and thus spent nearly the entirety of her pregnancy in custody. Baby A's mother was on remand in custody on drug-related charges, and had a long history of drug use, including methamphetamine and heroin. Baby A's mother was prescribed methadone throughout her pregnancy.

27. Baby A's mother received antenatal care from a midwife and a social worker. She also met with the MCP worker who helped her to make an application to join the MCP, and who then prepared the necessary report for consideration by the Steering Committee.[21]

28. Applications to have a child reside with their parent in prison were considered by a Steering Committee, on which relevant organisations including Corrections Victoria and Child Protection were represented. The Steering Committee's role was to determine whether to recommend an application be approved. The decision-making power to approve or refuse an application was delegated to the Deputy Commissioner, Operations who would receive a recommendation from the General Manager of the prison.

29. In the case of Baby A, Baby A's mother made an application which was considered by the Steering Committee on 8 May 2018. A decision was postponed pending information about how long Baby A's mother was likely to remain in custody. It appears from documents I received that the Child Protection representative on the committee and her manager both felt the application should be refused, though it is unclear whether that view was expressed during the meeting.

30. Counsel for DFFH submitted that I should accept the account of the Steering Committee meeting held on 8 May 2018 contained in Ms Arnold's email.[22] The email was prepared within two days of the meeting, and there was no reason for Ms Arnold to falsely report the substance of the meeting. The minutes of the meeting do not record discussions in respect of this or any of the applications but noted that the outcome of this case was postponed pending sentence length. Concerns were also raised in relation to Baby A's mother's long term drug use.

[21] The Steering Committee consisted of managers, support workers and various representatives from governmental organisations. The Steering Committee is responsible for considering all new Program applications, including urgent applications; seeking expert advice in matters pertaining to the best interests of the child; conducting a monthly review of the progress of mothers and children participating in the Program; making recommendations for Program participation to the General Manager, including continued participation in the Program where a review of the mother's behaviour and compliance with the Agreement (between Corrections Victoria and the Prisoner for the Care of a Child in custody) is warranted; monitoring demand for the Program, including outstanding applications; resolving operational issues pertaining to the Program as they arise; and regular review of this Commissioner's Requirement and any Local Operating Procedures.
[22] Submissions on behalf of DFFH, paragraph 29.

31. After it became clear that the length of Baby A's mother's sentence would not be known for some time, on 20 May 2018 the person responsible for the program emailed members of the committee seeking their agreement to support the application. It appears a sense of urgency was felt. For reasons which are unclear, regrettably the email did not go to the Child Protection representative. In respect to this oversight, Counsel for Corrections rightly conceded this omission created problems with respect to Baby A's mother's application, primarily the omission of a significant party from the email thread.[23] I accept Counsel's submission that lessons have been learned and am comforted to hear that systemic improvements have been made to ensure such a mistake will be avoided in the future.

32. Other members of the Committee supported the application, as did the General Manager of DPFC after a meeting she had with Baby A's mother on 25 May. Baby A's mother's application was ultimately approved on 30 May 2018. Counsel Assisting submitted that there was no real need for Baby A's mother's application to be considered urgently outside of the otherwise regularly scheduled Steering Committee meetings.[24] There was no evidence to suggest there was input from Child Protection, which Counsel Assisting submitted inferred that therefore it was Ms Arnold who had held up the application from being considered at first instance by requesting additional information. Ms Arnold was not included in the email chain seeking out-of-hours approval.[25]

33. It was not until early June that Child Protection first learnt that the application had been approved. No action was taken to challenge the decision or to commence involvement with Baby A's mother by way of an unborn child report. As I understand it, once an unborn child report was made, Child Protection could have contacted Baby A's mother and potentially offered additional supports. It could also have then formed a view as to whether Baby A would be at risk after birth so that plans could be made for a notification and investigation.

34. As events would subsequently transpire, the erroneous belief that Child Protection knew of and approved the decision offered comfort and likely influenced the decision making of

[23] Submissions on behalf of the Secretary to the Department of Justice and Community Safety, paragraph 51.
[24] Submissions on behalf of Counsel Assisting, paragraph 14.
[25] Submissions on behalf of Counsel Assisting, paragraph 14.

others. In fact, as correctly noted by Counsel for DFFH, the only information DFFH received after Baby A's birth was the fact of her birth and that she was well.[26] Counsel further submitted that there was no reason that they should not have relied upon that information that was provided to them as part of their role on the Steering Committee, and the concerns that they held prior to her birth had, in part, diminished because of her demonstrated behaviour with respect to discontinuing her drug use and the coinciding negative urine screens. Ultimately, Counsel submitted that DFFH would only have made independent inquiries if Baby A's mother was to be released into the community.[27]

35. The consensus was that Baby A's mother would greatly benefit from having her baby with her in custody – a view shared by the Committee and the General Manager in supporting the application. It is less clear what attention was given to the potential risks to Baby A or the particular needs she might have and whether they could be met in a prison setting.

36. On 6 June 2018, Ms Whelan sent an email to Ms Arnold apologising for not including the Department in communication between Committee members regarding Baby A's mother's application that occurred on 21 May 2018. It noted that, prior to the endorsement of the application going to the Deputy Commissioner, the General Manager Ms Jones met with Baby A's mother to discuss her intentions and advise her of the opportunity and possible consequences of relapse whilst on the program. The email further noted that Ms Jones was satisfied that Baby A's mother demonstrated sufficient insight into her barriers and areas of improvement, and that she further demonstrated a genuine desire to have an opportunity to parent her first child. The emails between Ms Whelan and other Committee members on 21 and 22 May 2018 making comments in relation to the application were attached. Counsel Assisting submitted that the evidence suggests that it was Baby A's mother who was given primary consideration, rather than Baby A, when assessing Baby A's mother's application.[28] Baby A's mother had the support of Ms Cole, Ms Whelan, the Steering Committee and Ms Jones.

[26] Submissions on behalf of DFFH, paragraph 79.
[27] Submissions on behalf of DFFH, paragraphs 80-82.
[28] Submissions of Counsel Assisting, paragraph 17.

37. Counsel Assisting correctly submitted that the responsibility for ensuring the protection of Baby A's interests rested with Corrections Victoria and Child Protection. She further submitted that the absence of Child Protection meant that there was nobody advocating on behalf of Baby A. Western Health also had a potential role in this regard to the extent that those providing antenatal care became aware of any risk that Baby A would face after birth. Counsel Assisting identified those responsibilities as:

    a. In the case of Corrections Victoria, ensuring that Baby A was only permitted to be in the prison if it was in her best interests to be there, which involved consideration of her clinical and social wellbeing.

    b. In the case of Child Protection, to satisfy itself that Baby A, once born, would not be at risk of harm and to take appropriate action if risk of harm were to be identified.[29]

38. Counsel Assisting submitted that these responsibilities were not discharged sufficiently. Counsel Assisting submitted that Corrections Victoria gave primacy to the benefits that Baby A's mother would derive from having her child with her. She was known to the members of the Steering Committee, and they all understandably wanted to support her. They did not critically examine the starting assumption that the best place for a child would be with her mother. [30]

39. I accept Counsel Assisting's submission that the deliberations of the Steering Committee can be presumed to have included reference to the report prepared by Ms Cole and then added to by Ms Whelan. Counsel Assisting added that although the official decision to grant Baby A's mother's application was made by the Deputy Secretary, it was announced to Baby A's mother several days prior to the official announcement, reflecting the fact that the decision was more likely made by Ms Jones, who was persuaded by Baby A's mother to support the application. In the absence of evidence from Ms Jones, I cannot speculate about the contents of such a conversation or conversations.

[29] Submissions of Counsel Assisting, paragraph 11.
[30] Ibid, paragraph 12.

40. Baby A's mother was receiving regular antenatal care. However, the Steering Committee did not seek any information or input from those providing antenatal care to Baby A's mother. Therefore, there was no consideration of the particular medical issues that were relevant to Baby A upon her birth. In this way, Corrections Victoria had, and have, an assumption that any child living with them is medically well unless and until they are told otherwise. On the other hand, Western Health had a not unreasonable expectation that there would be supports available of certain kinds that would mitigate what might otherwise be risks posed to medically vulnerable babies. In my view, this lack of communication resulted in missed opportunities for various departments to make informed decisions about Baby A's circumstances once she was at DPFC.

41. Counsel for Western Health submitted that there was no evidence to suggest that, prior to Baby A's birth, Baby A's mother was unfit to parent Baby A. Counsel for Western Health relied on the evidence of Ms Cole, who attended seven midwifery appointments with Baby A's mother, and who had no concerns about her desire to be a mother.[31] I accept that Baby A's mother was devoted to Baby A. However, the devotion and desire of a parent is the starting point, not the determining factor, in the assessment of the safety and welfare of a vulnerable baby. The question ought to instead be – does maternal capacity match maternal desire?

42. As stated above, there was no unborn child report made in relation to Baby A. The Secretary to DFFH conceded that further consideration should have been given to making an unborn child report, particularly following receipt of the information regarding sentence length.[32] Indeed, DFFH acknowledged that it was a failure in process that such a consideration did not occur. DFFH referred to the significant concerns for the wellbeing of Baby A as related to the risk of Baby A's mother returning to illicit drug use if released from prison and whilst in prison Baby A's mother was already being provided with the necessary and appropriate supports. DFFH asserted that it does not follow that an unborn child report would have any consequences that would have altered the outcome in this

[31] Transcript 315.
[32] Submissions on behalf of DFFH, paragraph 37.

case.[33] In my view, an unborn child report would have automatically prompted involvement from Child Protection, which would necessarily have resulted in another department being involved in the welfare of Baby A, which would have been beneficial to Baby A.

43. Western Health submitted that, as there were no concerns about Baby A's mother's willingness to fulfil her role as a mother, there was no catalyst that warranted an unborn child notification to Child Protection.[34]

44. There was no explanation offered as to why there was no unborn child report made once Child Protection became aware that Baby A's mother's application had been approved. An unborn child report was not commenced, with the most likely explanation being that Child Protection would have drawn comfort that no concerns were identified for the welfare of Baby A in the weeks following the approval. Counsel Assisting submitted thereafter a source of expertise and support to potentially advocate specifically for Baby A's interests, as opposed to Baby A's mother, was lost. She conceded the accuracy of DFFH submissions that nobody could have predicted the particular circumstances that Baby A would face after she was born, nor the particular risks that emerged.[35] In my view, Child Protection was best placed to support Baby A's mother and Baby A had they been engaged and aware of their unique circumstances after Baby A was born.

45. If engaged, Child Protection could have agitated for different outcomes on Baby A's behalf. Notably, as submitted by Counsel Assisting, by advocating for a longer admission in hospital for Baby A's mother so that she could stay with Baby A. Alternatively, Child Protection could have offered support to Baby A's mother to help her to come to terms with the possibility that there might be a day or two when she and her child might need to be separated. Child Protection could have liaised with hospital staff about the situation. Absent Child Protection's involvement, I accept Counsel Assisting's submission that an opportunity was lost for better and different decisions to be made in respect of Baby A.

[33] Submissions on behalf of DFFH, paragraphs 37 and 60.
[34] Submissions on behalf of Western Health, paragraph 11.
[35] Submissions on behalf of DFFH, paragraph 78.

46. Counsel for DFFH conceded that Child Protection is able to gather together supports, however noted that Child Protection did not need to be involved for such supports to be provided. Other organisations could have arranged for those supports. However, I note that no other organisation did in fact agitate for those supports in this particular scenario, which adds credibility to the submission that Child Protection was the best placed organisation to do so.

47. Accordingly, although I do not criticise the Steering Committee's decision to allow Baby A's mother to have her daughter with her at DPFC, in my view there could have been more thorough planning in the lead up to Baby A's birth, particularly with regard to a notification to Child Protection, and improved communication between the various bodies and departments responsible for monitoring the health and wellbeing of Baby A's mother and, in turn, Baby A.

Baby A's birth

48. Baby A was born at Sunshine Hospital on 6 August 2018 and was cared for by nurses, physicians, and social workers. The neonatologist in charge of Baby A's care was Dr Pszczola. Dr Pszczola is a vastly experienced and dedicated neonatologist.

49. Baby A's mother was prescribed methadone throughout pregnancy and accordingly Baby A was born addicted to methadone and was monitored for symptoms of opioid withdrawal. She was admitted to the special care nursery on 9 August 2018 for closer monitoring of her Neonatal Abstinence Syndrome (**NAS**) scores – which were a measure of how severe her withdrawal symptoms were – and remained there for several days during which time she was treated for jaundice and her mother received support with establishing breastfeeding. Baby A also received supplemental formula feeds.

50. Baby A's mother was very distressed at any suggestion that she might be separated from her daughter, so much so that she roomed in with her. It appears that Baby A's mother wanted to hold Baby A as much as possible, in an attempt to reduce her crying (which was a factor in NAS scores), and that she resisted advice from nurses and doctors about safe

sleeping practices, preferring to hold her baby. She was reluctant to breastfeed but was expressing breast milk as well as using formula.[36]

51. Child Protection were not aware of the birth of Baby A until 14 August 2018 – eight days after her birth. No doubt due to an erroneous belief Child Protection were aware of Baby A's birth and would raise any protective concerns in respect to Baby A, Dr Pszczola did not consider a notification to Child Protection was necessary. Dr Pszczola considered Baby A's mother was fit to provide care for Baby A. She did not appear overly anxious or particularly sleep deprived.[37] The critical information, not known by Dr Pszczola, throughout her involvement with Baby A, was that Baby A's mother would be alone and unsupported throughout the night, upon her return to prison. I will address the significance of this information upon Dr Pszczola later in my Finding.

52. Child Protection learnt about the birth of Baby A on 14 August 2018, via the Steering Committee meeting. By the time the Committee met to discuss Baby A, the information in their report was no longer current and did not reflect Baby A's clinical condition. There is no evidence to suggest that any action was taken by Child Protection to satisfy itself that Baby A was safe and being released to her mother's care. Even if Child Protection had powers to conduct an investigation and take action in respect of Baby A when it became aware that she would be living with her mother in prison, on the material that was available to Child Protection, there was no basis for concluding that Baby A was a child in need of protection, nor that she would be at an unacceptable risk of harm so as to justify removal of Baby A from her mother's care.

53. Counsel for DFFH submitted that the proposition that DFFH should have satisfied itself that Baby A was safe in her mother's care is unfair.[38] They posited that such a submission would only be capable with the benefit of hindsight, with the knowledge of the following:

    a. That the information provided to DFFH at the meeting on 14 August 2018 was out of date.

[36] Statement of Baby A's Mother, Coronial brief 54.
[37] Transcript 648 – 649.
[38] Submissions on behalf of DFFH, paragraph 80.

b. That Baby A had been admitted to the special care nursery a few days post-birth.

c. That Baby A had been suffering severe withdrawal symptoms, loss of weight and feeding issues.

d. That, on 14 August 2018, concerns began to emerge with respect to Baby A's mother falling asleep with Baby A in her arms and not following advice to put Baby A to sleep in her cot.

e. That Western Health were about to discharge her from hospital when, if I accept the evidence of Dr Luig and Associate Professor Charlton, her withdrawal symptoms, weight and feeding issues had not resolved such that Baby A was not medically fit for discharge.[39]

54. Counsel for DFFH submitted that the mere fact that the report that DFFH was given was dated 7 August 2018 is not a basis upon which the DFFH would question the accuracy or currency of the information when it was presented to the Steering Committee on 14 August 2018. Given her involvement in the program, if circumstances had changed since 7 August 2018, that information should have been provided to the Steering Committee at the meeting on 14 August 2018. Members of the Steering Committee were entitled to assume that those administering the program were meeting their obligations under it, including monitoring the wellbeing of children, and that the information provided to the Steering Committee was, therefore, accurate.

55. Counsel for DFFH further submitted that the fact of Baby A's birth did not, in and of itself, give rise to any obligation for DFFH to satisfy itself that it was safe to discharge Baby A into her mother's care. On the information provided to DFFH, there was no basis to think that Baby A would not be safe if discharged into her mother's care in prison. As noted earlier, the concerns previously identified by DFFH related to significant risks posed to Baby A in the event that her mother was to be released from prison and relapse. Insofar as the concerns that DFFH had regarding possible drug use and previous incidents whilst in

[39] Submissions on behalf of DFFH, paragraph 80.

prison, Baby A's mother had successfully remained drug and incident-free and was engaging with all supports.

56. Counsel Assisting submitted that had Child Protection had an open unborn child report, been working with Baby A's mother on a voluntary basis, or had a line of communication open with Sunshine Hospital, it would have had the opportunity to take some or all of the steps detailed in Ms Lomas's statement.[40] Such steps might have included advocating for Baby A's interests, as distinct from Baby A's mother's, when decisions were being made about discharge.

57. Western Health submitted that the primary medical team involved in Baby A's care involved neonatologists, paediatricians and paediatric nurses, all of whom specialise in treating babies and neonates. Associate Professor Charlton firmly clarified that Baby A was the patient, not Baby A's mother, as was put to her by Counsel for Western Health.[41]

58. Associate Professor Charlton and Dr Luig gave evidence regarding the circumstances of Baby A's birth and potential living situation, with both experts expressing their respective views that Baby A's birth warranted a notification to Child Protection by Western Health.[42]

59. It may be that Western Health assumed that Child Protection had already flagged Baby A and her mother, however any such assumption would have been unjustified given the absence of any Child Protection involvement with Baby A or her mother during their hospital stay.

60. Counsel Assisting submitted that it was a failing on the part of Western Health that no notification was made. Western Health submitted that the lack of notification to Child Protection was not a failing as there was insufficient evidence to warrant one.

61. I am of the view that a notification ought to have been made. For the reasons outlined above, Western Health were of the erroneous belief that Child Protection had been notified.

[40] Statement of Kirstie-Lee Lomas, Coronial Brief, p 854.
[41] Transcript 1096 – 1097.
[42] Transcript 1000 – 1001.

Had a notification been made, I am of the belief that Baby A's mother would have been better supported to care for Baby A in their unique circumstances.

First discharge from Sunshine Hospital on 14 August 2018

62. Baby A was first discharged from Sunshine Hospital on 14 August 2018.

63. At discharge, Baby A weighed 2550 grams, a 13.5% weight loss since birth and eight grams less than the last weight taken a day earlier. This is significant because, while it is expected that babies will lose weight in the early days after birth, Baby A's weight loss was more than the average and the loss from the day immediately before suggests she had not begun to regain weight despite a careful regime of supplementary feeding.

64. The weight loss was noted by nursing staff and drawn to the attention of the paediatric consultant and paediatrician; however, Dr Pszczola was content for Baby A to be discharged back to DPFC with a review the following day from a midwife.[43]

65. It appears that the decision to discharge Baby A was made in the context of her mother's distress at the thought that Baby A might remain in hospital without her, and where Baby A was still underweight and medically compromised. It appears, too, that those making or contributing to discharge decisions did not consider Baby A was at any risk being discharged to her mother's care in prison and that they may have been influenced by a belief that there would be supports for them in the prison and that Child Protection had no concerns.

66. Professor Colditz noted that he would have discharged Baby A on the information available to him.[44]

67. Associate Professor Charlton formed the view that Baby A was not medically fit to be discharged on this occasion. She cited Baby A's continued weight loss, in the context of feeling uncomfortable about whether or not there were suitable plans in place to address

[43] Transcript 603.25-29.
[44] Transcript 1023.17-18.

that.[45] Associate Professor Charlton further opined that she would have been satisfied with discharging Baby A once she had observed weight gain.[46]

68. Counsel Assisting submitted that Baby A was not well enough to be discharged on 14 August 2018, as she was losing weight and was displaying continued signs of opioid withdrawal which fell only just short from the point at which methadone treatment was indicated, according to the NAS scale. Counsel Assisting further submitted that Dr Pszczola's inclination to keep Baby A with her mother meant that she did not give sufficient weight to the signs that Baby A was not clinically well enough to be discharged. Dr Pszczola accepted that, in hindsight, it is possible that Baby A's discharge was premature, given that she ultimately had to return [to hospital], though she noted that this is a common occurrence.[47]

69. The evidence suggests that embarking on a methadone treatment would have been a very significant step with profound and prolonged medical consequences for Baby A. The evidence does not enable me to make a determination regarding whether or not treatment should have been commenced, and I do not propose to make any further comments in relation to that issue.

70. Notes made by nursing staff record that Baby A's mother was resistant to nursing advice and that she was focused on lowering NAS scores to ensure Baby A would be discharged.[48] I note that it is immensely difficult to score NAS appropriately when the mother of a child is always holding the baby. I make no criticism of the mother or the nursing staff in that regard, though I do flag it as being an obstacle to obtaining the most accurate NAS score.

71. Nursing staff had concerns about whether Baby A was ready to be discharged, and such concerns were escalated within the hierarchy of the hospital.[49] Dr Luig opined that Baby A was not well enough to be discharged.[50] Dr Luig gave evidence that, in New South Wales, if any member of the multi-disciplinary team opposed discharge, then the baby

[45] Transcript 1011.4-10
[46] Transcript 1011.10-14
[47] Transcript 618.
[48] Submissions of Counsel Assisting, paragraph 22.
[49] Ibid, paragraph 25.
[50] Transcript 1013.5.

would not be discharged.[51] It was ultimately Dr Pszczola's decision to discharge Baby A, though it seems that there was extensive intervention by social workers who were advocating for Baby A's mother. Western Health submitted that they arranged for there to be a follow-up appointment with Midwife Smith the day after Baby A's discharge. Western Health further submitted that Dr Pszczola would have ensured Baby A and her mother remained in hospital had the follow-up appointment not been arranged.[52] Associate Professor Charlton accepted that the follow-up appointment was reasonable. I accept this, though I note that the differences between the New South Wales and Victorian systems, as described by Dr Luig, would have meant that Baby A would not have been discharged had she been in New South Wales, noting that some hospital staff did raise concerns with the discharge. Although I understand that the practice at Sunshine Hospital was that the relevant neonatologist had the ultimate decision regarding discharge, it does seem as though the discharge decision resting with one particular practitioner is yet another missed opportunity in the case of Baby A.

72. Dr Pszczola authorised the discharge of Baby A on 14 August 2018, though gave evidence that the timing of the discharge was probably influenced by prison resources.[53] This is, in some ways, an inevitable situation when a baby is residing in a correctional facility with his or her parent and is one of the unfortunate realities of limited resources in such situations.

73. I accept Dr Pszczola's evidence about the advice that she provided to Baby A's mother about safe sleeping practices. I cannot infer whether or not Baby A's mother understood or accepted that advice.

74. It is unclear what advice was given to Baby A's mother about breastfeeding Baby A. Midwife Smith's observations suggest that Baby A's mother did not appreciate the importance of measuring the amount of supplemental feeding, was not breastfeeding and did not know that Baby A had been discharged whilst she was still losing weight.

[51] Transcript 989, 1075.29-1076.5.
[52] Transcript 609.
[53] Transcript 601

75. Counsel Assisting submitted that the clearest sign that Baby A was not well enough for discharge was that, less than 24 hours later, she was assessed by an experienced midwife who deemed that Baby A required readmission to hospital via the emergency department. Counsel Assisting submitted that the readmission is evidence that therefore it was the wrong decision for Baby A to be discharged on 14 August 2018.

76. Counsel for Baby A's mother submitted that, with the benefit of hindsight, Baby A may not have been sufficiently well for discharge on 14 August 2018.[54] Counsel for Baby A correctly noted that the discharge proceeded on the basis that Baby A was to be reviewed the following day. Baby A was readmitted within 24 hours of discharge, which Counsel for Baby A's mother noted was appropriate. There is no evidence that the first discharge had any direct or indirect connection with Baby A's death. Baby A's mother supports practices that provide sick babies and their mothers in a custodial setting the same level of access to supports as would be made available in the community, and I share this view.

77. Associate Professor Charlton noted that it was not unusual for mothers to be separated from their children where the child must remain in hospital and the mother must return home. Counsel Assisting submitted that the evidence suggested that daily visits would have occurred to ensure Baby A's mother could continue to bond with and feed her child, though it is unclear whether or not Baby A was breastfeeding at this point in time.[55]

78. Western Health submitted that, whilst it may have been the intention of DPFC to allow Baby A's mother to return to visit Baby A on a daily basis, practically and realistically that would not have happened. Western Health relied on evidence of Ms Cole who said that mothers generally return every day or every second day to see their child, but given the resourcing difficulties, a mother may not be able to return on a particular day.[56] Midwife Smith also gave evidence that mothers were unable to return to the hospital daily because of resourcing issues. Mothers visiting from DPFC would have to return to the hospital under guard escort which was not always achievable due to resourcing difficulties.[57]

[54] Submissions on behalf of Baby A's mother, paragraph 41.
[55] Counsel Assisting's submissions, paragraph 24.
[56] Transcript 255, 321, 322.
[57] Transcript 760.

79. Counsel Assisting submitted that had Baby A and her mother needed to be separated, then every effort would have been taken by Corrections Victoria to ensure that Baby A's mother could come and see Baby A every day. Whilst witnesses allowed for possibilities that may have prevented that from happening, Counsel Assisting submitted that any such delay in Baby A's mother seeing her baby would only have been a short period of time, and certainly not a matter of weeks. Counsel Assisting submitted that it may well have been only a few days before Baby A was stronger and thus well enough to be discharged.

80. Although I acknowledge that any separation between parent and child is not ideal, it does sometimes happen and in one sense may be inevitable for some situations. Understandably any separation between mother and child can be distressing, especially to the mother.

81. There is conflicting expert evidence about whether Baby A was sufficiently medically well for discharge on 14 August 2018. However, I accept the evidentiary consensus that the follow-up review with the midwife the following day was appropriate, resulting in her readmission to hospital – in which circumstances, I do not consider it necessary to determine whether or not Baby A was medically fit for discharge on 14 August 2018.

Readmission to Sunshine Hospital on 15 August 2018

82. On 15 August, Midwife Smith visited DPFC at midday and noted Baby A appeared jaundiced and had lost further weight.[58] Baby A's continued weight loss, signs of opioid withdrawal and indication of poor feeding resulted in Midwife Smith recommending Baby A's readmission to hospital. Accordingly, Baby A was readmitted to the special care nursery. Upon admission, she was mildly dehydrated and jaundiced. She stayed in the special care nursery until 17 August 2018.

83. After the second discharge (discussed in detail below) Baby A's mother spoke of the readmission to some of the other women in the Gilbert B Unit at DPFC in ways which might suggest she did not appreciate why the readmission had occurred or its potential significance. I heard evidence from Beth, Cathy, Alice and Donna that Baby A's mother

[58] Transcript 698.28 – 699.4.

told them that she felt that the hospital was being dramatic.[59] These conversations suggested that either she did not fully appreciate the seriousness of Baby A's condition or did not want to frankly and candidly disclose such reasons to the other women there, and I cannot speculate which of those options, if either, are accurate.

84. No party took issue with Baby A's readmission to hospital on 15 August 2018.

Second discharge from Sunshine Hospital on 17 August 2018

85. On 17 August 2018, Baby A was again discharged from hospital. At this time, her weight remained 10% below her birth weight. She was still showing signs of opioid withdrawal. There was no sufficient explanation for why Baby A had lost weight. At the time of discharge, she was estimated to weigh 2582 grams, which was still 368 grams less than her birth weight. The plan was for a careful program of supplemental feeding. Child Protection was not involved in the second discharge of Baby A from hospital. Social workers were not involved in this discharge.

86. Dr Pszczola maintained that Baby A was clinically well enough to be discharged on this occasion.[60] However, in evidence, she explained the potential impact upon her decision to discharge Baby A, upon learning that Baby A's mother would be alone throughout the evening.[61]

87. As I have mentioned, Dr Pszczola is a dedicated, experienced clinician. Professor Colditz shared her assessment that Baby A was medically fit for discharge – a view not shared by Dr Luig and Associate Professor Charlton. In my view, Dr Pszczola's decision, which she acknowledged was a difficult decision, was not unreasonable.

88. I have no doubt however, had Dr Pszczola been aware of the lack of dedicated support for Baby A's mother, she would not have discharged Baby A on either occasion. In my view, were she armed with that knowledge, she would likely have notified Child Protection.

[59] Written statements of Alice, Beth, Cathy and Donna in the Coronial Brief, 58 – 73.
[60] Transcript 637.18
[61] Transcript 611-612, evidence of Dr Pszczola.

89. Dr Luig opined that, at the second discharge, Baby A was still a medically vulnerable baby.[62] Associate Professor Charlton opined that the second discharge was safer than the first but noted that the lack of follow-up plan was concerning, particularly in circumstances where Baby A had already been readmitted once.[63]

90. Professor Colditz opined that the second discharge was appropriate given Baby A looked well, was feeding adequately, had NAS scores between 2 and 5, had gained weight relative to the previous day, and was being discharged into the MCP at the DPFC.[64]

91. Counsel for Baby A's mother made no submission relating to the decision to discharge Baby A home to DPFC on 17 August 2018. At the time, Baby A's mother understood that Baby A was getting better, that she had to stop holding her, get her milk to come in and supplement breast milk with formula. Baby A's mother knew Baby A needed to gain weight and was appropriately concerned for her health.

92. Counsel Assisting submitted that it was unrealistic to assume that Baby A's mother would be able to sustain a rigid feeding plan when, on the information available including the observations from Midwife Smith, Baby A's mother had not been following the previous plan, which was less rigid. Baby A remained a vulnerable and demanding baby. Associate Professor Charlton opined that sending Baby A and her mother home with the feeding plan in place without providing any additional structural supports was doomed to fail.[65]

93. Counsel for Baby A's mother took no issue with the proposition that at the time of the second discharge, Baby A was a vulnerable and demanding baby, and that Baby A's mother was also vulnerable and tired. Despite this, Baby A's mother was proud of her baby and fully committed and determined to provide for the needs of Baby A as best as she was able. I make no comment about the intention of Baby A's mother, however I accept Associate Professor Charlton's view that, in the circumstances, with such a strict feeding plan, failure may have been inevitable.[66]

[62] Transcript 1039.3-16.
[63] Transcript 1039.23-1040.10.
[64] Submissions on behalf of Western Health, paragraph 33.
[65] Transcript 1044, 22-28.
[66] Transcript 1012.1-6.

94. Counsel for Baby A's mother further submitted that, given the cause of Baby A's death is in some ways unknown, there is insufficient evidence to enable a finding to be drawn that the second discharge contributed directly or indirectly to Baby A's death. There are rare occasions of SIDS deaths and near misses in hospitals when there is no medical cause. Even if Baby A had not been discharged, there was still the possibility that she may have died of SIDS.

95. Counsel Assisting submitted that Baby A may not have died on 18 August 2018 if she had stayed in hospital overnight. Dr Luig gave evidence that she had not seen a SIDS death of any baby in a cot in hospital.[67] However, Associate Professor Charlton astutely highlighted that if medical professionals were worried about any baby on any given day dying of SIDS they would never discharge anyone.[68] I accept that, for obvious reasons, babies are safest in hospitals where they have an entire team concerned for their welfare, but also readily acknowledge that babies cannot remain in hospital in perpetuity.

96. Western Health noted that Dr Luig's criticisms about Baby A's discharge relied on best practice methods rather than what is necessarily reasonable. I accept that in some of Dr Luig's evidence, she agreed that she was talking about best practice.[69]

97. Counsel for Western Health submitted that it is not open to the Court to conclude that Baby A's death was preventable by keeping her in hospital and that Western Health acted reasonably in discharging Baby A on 17 August 2018.

IMMEDIATE CIRCUMSTANCES OF BABY A'S DEATH

98. In the Mothers and Children Unit (**MCU**), Baby A's mother had access to medical, social, parenting and therapeutic supports. I have heard and accept evidence there are opioid addicted babies in the prison. I further accept the MCU created the opportunity for women to support each other after lockdown when other sources of support were no longer available. Of course, the opportunity to seek assistance from other mothers is predicated

[67] Transcript 1051.21-27.
[68] Transcript 1050.17-25.
[69] See, for example, Transcript 1098.9-29.

by the individual to appreciate being in need of assistance, and if so, to have the confidence to seek assistance.

99. There is no evidence or suggestion that Baby A's mother was wilfully non-compliant with clinical advice in the hospital. However, the hospital records reveal Baby A's mother struggled to comprehend advice on a range of issues with respect to maternal care. There is no recorded history of Baby A's mother seeking assistance.

100. Whether support would in fact be offered and/or accepted was entirely dependent on the circumstances and personalities of the women in the unit at any particular time. I accept the submission of Counsel Assisting that the MCU operated on the assumption mothers would support each other. However, Baby A's mother had only spent one evening in the MCU since the birth of Baby A. In fairness to her, she had not had the time, if indeed she had the inclination, to develop a rapport with fellow inmates. In any event, the evidence established that, although Baby A and her mother had access to support services via DPFC during the day, they were largely isolated during the night, especially as the other mothers in the unit were in their own rooms looking after their own children. As alluded to at the outset of my Finding, Baby A's mother did not have the benefit of her greatest need - dedicated overnight maternal support.

101. Baby A was discharged from Sunshine Hospital at around lunchtime on 17 August 2018.[70] Upon arriving back to DPFC, Baby A's mother took Baby A to meet her godmother, who was residing in another unit.[71]

102. Baby A's mother recalls that Baby A was crying upon returning from the visit to Baby A's mother's godmother.[72] Baby A's mother fed her and then Baby A fell asleep in the cot for the afternoon. She then had a further bottle and a half while they were out in the pram. The pair returned to Gilbert B Unit at around 9.00 pm.[73]

[70] Statement of Baby A's mother, Coronial Brief, p 55.
[71] Ibid.
[72] Ibid.
[73] Ibid.

103. Alice recalled that Baby A's mother was 'go, go, go' and recalled that Baby A's mother was holding Baby A in her arms while she was doing the washing, cleaning and bending down to pick things up.

104. Beth held Baby A for about half an hour while Baby A's mother had a shower. Baby A appeared fine to Baby A's mother when she returned. Baby A's mother took her into her room and changed her nappy and prepared her for bed by putting her into a jumpsuit.[74]

105. At some time between 10.30 and 11.00 pm, Baby A's mother was lying in her bed with Baby A next to her, playing with her. Baby A's mother put her on her chest to try and get her to sleep. Baby A went to sleep, and Baby A's mother put her in the cot, at the bottom.[75] Baby A had a further 100ml at 11.00 pm.

106. At approximately 2.00 am, Baby A's mother woke up Baby A for a quick feed of 25ml. Baby A went back to sleep.[76]

107. At some time between 5.00 and 5.30 am, Baby A's mother knew that Baby A would be hungry shortly and knew to wake her. When Baby A's mother sat up to wake Baby A, she observed that Baby A's mouth was open, and she was blue. She was lying on her back but had kicked the blanket off and was uncovered. Her dummy was out of her mouth.[77]

108. Baby A's mother immediately started yelling and calling for help. Alice heard these cries for help and immediately got up.[78] Alice observed that Baby A was already deceased and felt cold to touch.[79]

109. Prison staff arrived at Gilbert B Unit in under five minutes.[80] The attending nurse conducted a head-to-toe assessment of Baby A, and observed that her lips looked to be blue and curling.[81] She further observed that Baby A was not responsive to stimuli, no breath felt, no brachial pulse, no pedal pulses, pupils fixed, ears cold to touch, peripheries hands and

[74] Statement of Baby A's mother, Coronial Brief, p 55.
[75] Ibid.
[76] Ibid.
[77] Ibid.
[78] Statement of Alice, Coronial Brief, p 60
[79] Ibid.
[80] Statement of Cathy, Coronial Brief, p 66.
[81] Transcript 795.29

feet cool to touch.[82] The attending nurse was not observed performing CPR, and when asked why she was not performing CPR she explained that she had formed the opinion that it was too late.[83]

110. Emergency services also arrived on scene, after following the various requirements to gain entry to the prison. Attending firefighters commenced CPR on Baby A. Whilst firefighters were attempting to revive Baby A with the use of defibrillators, Ambulance Victoria paramedics attended. Tragically, the attending paramedics declared Baby A deceased.[84]

111. At the time of her death, Baby A was in her mother's care, residing in the Gilbert B Unit at DPFC. Although Baby A had gained some weight during her second admission to hospital, as described above, at the time of her second discharge she was still more than 10% below her birth weight and showed continued signs of NAS. Counsel Assisting submitted that for those reasons, Baby A ought to have remained in hospital.

112. Baby A's mother had no supports available to her overnight in the Gilbert B Unit. She was caring for Baby A alone. Baby A remained vulnerable due to her low weight, ongoing opioid withdrawal and continued signs of NAS. For these reasons, Baby A would have been a challenging baby to care for in any circumstances, but especially when Baby A's mother had so little support overnight.

113. It would be remiss of me not to acknowledge the unique physical location within which Baby A's death occurred. Counsel for Baby A's mother eloquently noted four clear demonstrations of the practical impacts of 'residents' living within a prison environment which arose during this inquest, namely:

    a. Upon arrival at the prison at 5.48am on 18 August 2018, the two ambulances were unable to travel immediately to the Gilbert B Unit as they had to gain access through the prison sallyport, and were escorted to the Gilbert B Unit after approximately five to six minutes;[85]

[82] Transcript 795.31 – 796.1-3.
[83] Transcript 796.4-6.
[84] Statement of Kieren Walsh, Coronial Brief, p 95.
[85] Statement of Kieran Walsh, 24 September 2018, Coronial Brief pp 94-96 [4].

b. Unlike hospital or community access, Baby A's family had to obtain approval to visit her or her mother in prison.

c. As a 'resident', Baby A was dependent on prison staff or health providers facilitating bookings for health appointments. Baby A needed to be accompanied by her mother to such appointments, and Baby A's mother required a Custodial Community Program Permit to leave custody to take Baby A to a health appointment; and

d. Some community-based organisations were reluctant to deliver services to mothers and babies inside the prison.[86]

114. Although there are obvious impediments to prison staff gaining access to Gilbert B Unit, I accept that prison staff arrived at the unit as soon as was practicable, noting the obstacles to a quicker arrival. Although I accept that staff attended with the urgency that the situation warranted, I accept that, for Baby A's mother, and indeed the other women residing in the unit, the wait would have been anxiety-inducing and may indeed have felt like significantly longer than it was.

115. Counsel for Baby A's mother conceded that the attending nurse's acts and omissions did not contribute to Baby A's death. Counsel for Baby A's mother further submitted that it is unfortunate that she did not provide information or assistance to Baby A's mother or to emergency services personnel. I accept that the attending nurse did not contribute to Baby A's death through either her acts or omissions, and I make no criticism of her in what were very stressful and traumatic circumstances to all present.

116. Throughout the inquest, there was speculation regarding where Baby A was sleeping on the night of her death. Some evidence indicated that Baby A may have been sleeping in the bed with Baby A's mother, rather than in her cot. Evidence supportive of such a conclusion is as follows:

[86] For example, Child First was unwilling to enter the prison: evidence of Ms Jayne Cole, Transcript 294-295.

a. Baby A's mother had received SIDS education and knew about the importance of a cot being uncluttered. In those circumstances it is highly unlikely that she would have put Baby A down to sleep in the cot as it appears in photographs taken immediately after Baby A's death.

b. Baby A was seen by Alice and Cathy lying on the bed some time on the afternoon or evening before her death.

c. Photographs of the bed show a long narrow cushion along the wall of the bed consistent with being used to enable a baby to be placed on the bed without being at risk of bumping the wall or falling down between the bed and the wall.

d. Other women in the unit were co-sleeping with their children, suggesting that, notwithstanding SIDS training and the rules against co-sleeping, women were making choices which worked for them and for their babies during the night.

e. Baby A's mother was seen to be holding Baby A throughout the evening and to be reluctant to put her down.

f. Baby A's mother was severely under slept and likely to fall asleep unintentionally on the bed when feeding or holding her daughter overnight.

g. Baby A's mother had previously demonstrated a preference for holding her daughter while she slept to reduce the signs of NAS, even when told not to by nurses.

h. Baby A was crying through the night and would have been very hard to settle in her cot.

i. Baby A's mother had no one to advise or help her through the night.

117. There is also significant evidence to suggest that Baby A did not co-sleep with her mother on the night of her death:

a. Critically and importantly, Baby A's mother denied that she slept with Baby A on the night of her death.

b. At 6.00am on the morning of Baby A's death, Baby A's mother told a firefighter that "bubs was in her cot".[87]

c. That same morning, Baby A's mother told attending police officers that Baby A had been asleep in her cot.[88]

d. Baby A's mother's statement to police detailed that she positioned Baby A on her back, down the bottom of her cot. When Baby A's mother awoke at approximately 5.30am Baby A was still in that position.[89]

e. Baby A's mother later expressed a feeling of guilt and regret that she had not been holding Baby A between feeds, and felt it was her fault for falling asleep.[90]

118. Counsel for Baby A's mother submitted that there was no evidence that Baby A was co-sleeping with her mother at the time of her death, though Counsel Assisting also noted that there were compelling reasons why Baby A's mother may not have been frank about the circumstances immediately prior to Baby A's death. Beth gave evidence that mothers would get into trouble and the baby might be taken away if they were found co-sleeping.[91]

119. Hospital staff were concerned about the risks of Baby A's mother falling asleep while nursing the baby at an earlier time (during her first admission), and she received frank advice from Dr Pszczola about the dangers of doing so. There is nothing in the medical notes or the observations of Dr Pszczola to indicate that Baby A's mother was falling asleep with the baby or co-sleeping with Baby A during the second admission.

120. Further, there was no evidence of the set-up of the cot before or while Baby A was sleeping in it.[92] There were photographs and a drawing of the cot once Baby A was found. Counsel

[87] Statement of Nigel Hill, Coronial Brief p 89.
[88] Handwritten Victoria Police notes of conversation with Mother, Coronial Brief pages 581, 583, 584
[89] Police statement of Baby A's mother, Coronial Brief page 55-56.
[90] Notes of Anthony Barnes, Psychiatric Registrar, 21 August 2018, Coronial Brief, p 117.
[91] Transcript 450.22-28.
[92] Transcript 289.29 – 290.5.

Assisting submitted that the photographs are the best evidence of the way the cot looked at the time of Baby A's death, whether or not Baby A was in it when she died. Counsel for Baby A's mother conceded that, on the basis of the evidence of Ms Cole, Professor Colditz, Associate Professor Charlton and Dr Luig, the bed would not have been SIDS-compliant if Baby A had been sleeping in the cot whilst the various items were also in the cot.[93]

121. Irrespective of the appropriateness of either discharge, the three experts were in heated agreement that Baby A's mother required post-discharge maternal support to ensure that she could comply with the strict feeding regime. To avoid continued weight loss, Professor Colditz stated Baby A's feeding as central and required close monitoring. According to Professor Colditz, 'the feeding clearly' was the issue.[94] Professor Colditz went on to add, 'that who is going to provide the close monitoring – if the baby's not feeding that baby will be hungry so the baby becomes unsettled … what the baby needs is closer observation.'[95]

122. As earlier stated, Dr Pszczola conceded had she known the lack of monitoring and support of Baby A's mother overnight, she may have re-considered her decision to discharge.

123. Associate Professor Charlton and Dr Luig were adamant, in all the circumstances, the challenges confronting Baby A's mother were monumental and frankly, impossible to overcome.

124. In evidence, Dr Luig eloquently explained the compelling need for Baby A's mother to have support. Dr Luig used the example of a mother falling asleep holding the baby:

> *"So caring for a new born baby is a 24 hour job, and all newborn mothers are incredibly tired. And the woman who is substance dependant can be very sleepy. So here, we've got a description of a woman who's fallen asleep more than once. And I have seen this happen before, as well. It's the particular combination of sleep deprivation of having a newborn baby, which could reasonably expect to continue …. But also the risk of sleeping due to the methadone itself. So that's what I'm talking about another adult*

[93] Submissions on behalf of Baby A's Mother, paragraph 70.
[94] Transcript 1034.19-1035.1.
[95] Ibid.

who has, responsibilities to watch over, to supervise, to care for, over and above simply being on call when called for."[96]

125. At the 2.00am feed, Baby A's mother would have been exhausted. She recalled feeding Baby A, and subsequently, placing her in the cot. Though speculative, it is both conceivable and understandable that Baby A's mother may have fallen asleep during the 2.00am feed. And sometime thereafter, awoke and placed Baby A in her cot. If so, Baby A's mother would have no reason to believe Baby A was anything other than sleeping. At 5.30am, Baby A's mother found Baby A unresponsive in her cot.

126. Whether Baby A was placed in her cot laden with various items or was co-sleeping with her mother, the inherent risk to the baby remained. Neither sleeping setting is compliant with safe sleeping guidelines. An overnight maternal support worker would have assisted Baby A's mother to carry out the complex supplementary feeding plan, remove all items from the cot and ensure Baby A was placed in the cot once she was fed and settled.

127. There is absolutely no criticism of Baby A's mother, in whatever circumstance Baby A slept. In my view, without a dedicated overnight maternal support worker, her task was overwhelming.

Whether Baby A was in care or custody

128. Pursuant to section 31 of the Corrections Act, Baby A was in the care of her mother whilst living at DPFC. However, at the time, Baby A's mother was a prisoner on remand. As a prisoner, Baby A's mother was subject to the control of prison authorities and could not leave the prison without permission and a prison guard escorting her. Within the prison, her movements were restricted during lockdown and as a result, there were significant periods each day where she was required to remain inside her unit, tending to any of Baby A's needs alone.

129. It was the Secretary (or delegate) who had the power to grant or refuse permission for Baby A to reside with her mother in the prison. Likewise, it was within the Secretary's power to

[96] Transcript 991.14-27.

withdraw consent for Baby A to live in the prison. This gave the Secretary a crucial power and responsibility in relation to Baby A and made Baby A's death one which ought to have been reviewed as a death in custody.

130. The decision to discharge Baby A to her mother's care was a decision made by Baby A's doctors, who had the power to keep her in hospital either for a continued medical admission or for a social admission. The decision to permit Baby A to live in the prison was made by the Deputy Secretary as delegate of the Secretary and was taken well before Baby A was born and never revisited. That decision was taken after inadequate intervention and investigation by Child Protection, whether through the Steering Committee or otherwise.

131. Baby A's mother undoubtedly wanted the best for Baby A. Baby A's mother's desire to remain with Baby A was normal and natural, however any such desire should not have been given primacy over the needs of Baby A.

132. Counsel Assisting submitted that Baby A's needs were beyond the scope that Baby A's mother could reasonably manage by herself. I accept this submission.

133. Counsel Assisting accepted that, as a matter of legislative construction, Baby A was not in custody and was not herself a prisoner, however she was living in the prison. Deaths in custody attract certain review processes that enable any risks or potential findings for prevention to be identified by the Justice Assurance and Review Office (**JARO**). In this way, there is a potential gap and a potential loss of opportunity to conduct timely and appropriate reviews if the systems that exist to review and respond to the deaths of prisoners are not able to be engaged when in response to the death of a child also living in the prison, but not legislatively regarded as a 'prisoner'. I accept this submission and acknowledge the importance of critical review processes in such unfortunate situations.

CONCLUSION

134. Whether or not Baby A was medically fit for discharge on either occasion, noting that clinical opinions varied, the consensus expert opinion was that Baby A should not have been discharged without appropriate support and monitoring.

135. In my view, however, absent speculation, whether Baby A had received appropriate support and monitoring at MCU or within the hospital setting as required, in light of a SIDS Category 2 death as defined by Dr Baber, I am unable to find that the tragic outcome could have been averted.

136. Dr Luig identified two matters she believed meant that Baby A would not have been discharged on 14 or 17 August 2018, namely a multi-disciplinary, multi-agency discharge planning meeting and/or a report to Child Protection. Dr Luig explained that this is not necessarily because Child Protection would have then intervened, but because an investigation usually takes time, and a social admission may have been arranged while that occurred.

137. Counsel for DFFH acknowledged, had a report been made to Child Protection, it may have meant that Baby A would not have been discharged on either 14 or 17 August 2018 as Child Protection may have advocated for a social admission while they conducted their investigation.

138. Counsel for DFFH further submitted that, on the evidence in this matter, there is the opportunity to improve the discharge planning processes for vulnerable infants. DFFH indicated they would support the adoption of the kind of multi-disciplinary, multi-agency discharge planning process as referenced by Dr Luig.

139. Professor Colditz referred to the significance of a multi-disciplinary process in vulnerable infants. For her part, Dr Luig explained that discharge planning ordinarily commences during pregnancy, but in New South Wales, it involves a further documented meeting after birth involving a number of disciplines and agencies. These meetings are a mandatory component of discharge planning for the baby born to a mother who is substance dependent, irrespective of whether Child Protection is involved. It includes medical, obstetrics, social work and drug staff from the hospital but also includes external agencies such as a drug centre at which the mother is receiving methadone treatment. In a case such as Baby A's, that multi-disciplinary, multi-agency team would be large, and would likely include government agencies and representatives of the prison. Apart from addressing fragmentation, improving planning and providing coordinated supports, Dr Luig explained

that concerns are more likely to be identified which prevent or delay the discharge. If Child Protection is involved with the family, they would also be included in the meeting. If they are not already involved, consideration would be given in the meeting to whether a report should be made.[97]

140. There is no evidence of this kind of process occurring in Baby A's case. On the evidence of Associate Professor Charlton, multi-agency meetings are not standard practice in Victorian hospitals.

141. DFFH submitted that there are a number of gaps in the discharge planning in Baby A's case that would have been addressed by a multi-agency meeting, particularly with respect to the communication between agencies. While the social worker's notes record a plan to 'liaise with DPFC Operations Manager and Family Support Worker in regard to Corrections processes and discharge planning', it does not appear that this occurred. Communication between hospital staff and the prison after birth appears to have been limited and much of that communication appears to have been with prison guards accompanying Baby A's mother at the hospital. There were a number of support services available at the prison, including the Mothers and Children Support Worker, Maternal and Child Health Worker and Western Health's visiting domiciliary midwife, who could have contributed to discharge planning. Although there was a referral to the enhanced maternal and child health service, which could have checked the environment and addressed safe sleeping issues, inclusion of the service in a multi-agency meeting would enable steps to be taken to ensure this service is in place before discharge. I accept and adopt DFFH's submissions in this regard.

142. The key learning before me is that multi-disciplinary approaches for vulnerable children is essential. This is the only approach that will best guarantee that vulnerable children will never be placed at risk due to miscommunication and misunderstandings between the agencies charged with respective responsibilities to ensure their care and safety.

[97] Transcript references 979.9 – 980.8, 1073.3 – 107.15, 1075.21 – 1075.24, 980.16 – 908.25, 1073.10-1073.25.

COMMENTS

I make the following comment connected with the death under section 67(3) of the Act:

1. The inherent danger of co-sleeping with an infant is an irrefutable reality. I made Findings to highlight this danger almost a decade ago, in respect to 33 babies who had died in the setting of co-sleeping.[98] I leant in those investigations mothers may have been receiving mixed messages about the danger of co-sleeping. The inherent danger of co-sleeping is now uniformly disseminated throughout all hospitals in Victoria. Nonetheless, babies continue to die in the setting of co-sleeping. I was dismayed to hear evidence in this inquest that, prior to Baby A's mother and Baby A's reception the DPFC, several mothers in the MCU were regularly co-sleeping with their babies. I take this opportunity to again voice the inherent danger of infant co-sleeping and urge all parents to consider asking for help if and when they need it.

RECOMMENDATIONS

I make the following recommendations connected with the death under section 72(2) of the Act:

1. Dr Luig's evidence regarding the multi-disciplinary approach to discharge in hospitals in New South Wales was most compelling. I have not criticised Dr Pszczola's clinical judgement that Baby A, though vulnerable, was medically well for discharge on 17 August. However, Dr Pszczola did not have the critical information relating to the circumstances into which Baby A would be discharged. Had Victoria had a similar multi-disciplinary approach at the time that Baby A was in hospital, it is my view that she likely never would have been discharged, on either the 14th or 17th August, as other medical professionals within the hospital would have investigated the circumstances into which Baby A would be discharged, and it would have been self-evident that Baby A did not have the necessary supports for safe discharge. Accordingly, I recommend that the Victorian Department of Health implement a multi-disciplinary approach to discharge throughout hospitals in Victoria, akin to what exists in New South Wales, whereby if any healthcare practitioner

[98] COR 2009 3369.

holds concerns about the discharge of a baby, having particular regard to the environment into which they will be discharged, the baby is not to be discharged.

2. Any child who is living in a prison ought to be regarded as being in custody for the purposes of critical incidents and deaths.

3. Children who reside in a correctional facility with their parent or guardian ought to have improved access to healthcare. Currently such children are reliant upon the resources of the prison, and do not have easy access to a team of specialists on-site. I recommend that DPFC consider having an attending neonatologist or midwife on-site every day whenever they have infants residing there. Whilst healthcare is an important and fundamental right of any prisoner, children – and especially vulnerable children – require access to healthcare outside of the structure ordinarily available to prisoners.

I express my sincere condolences to Baby A's family, particularly Baby A's mother, for their loss. I also wish to acknowledge the grief you have endured throughout this coronial process.

I order that this finding be published on the Internet.

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

Baby A's mother, Senior Next of Kin, c/o Victoria Legal Aid

Secretary to the Department of Justice and Community Safety, c/o Victorian Government Solicitor's Office

Correct Care Australasia, c/o Meridian Lawyers

Secretary to the Department of Families, Fairness and Housing

Western Health, c/o Minter Ellison

Ambulance Victoria

Country Fire Authority

Secretary to the Department of Health

Signature:

Coroner John Olle

Date: 30 August 2023

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