IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 003484

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:	GFD
Date of birth:	[redacted]
Date of death:	3 July 2021
Cause of death:	1(a) Complications of malnutrition
Place of death:	[redacted]
Keywords:	Malnutrition; history of family violence; vulnerable infant

Aboriginal and Torres Strait Islander readers are respectfully advised that this content contains the name of a deceased Aboriginal person. Readers are warned that there are words and descriptions that may be culturally distressing.

INTRODUCTION

1. On 3 July 2021, GFD was two years old when he passed away at his family home in regional Victoria. GFD is survived by his older brother, UHB (born 2017), mother, TFC and father, JUY. TFC and JUY were 31 and 26 years old, respectively, at the time of GFD's passing. JUY is a proud Aboriginal man, although not much is known about his history.

2. When TFC was about 11 or 12 years old, she was involved in a motor vehicle collision as a passenger and sustained various injuries including an acquired brain injury (**ABI**). TFC received compensation from the Transport Accident Commission (**TAC**), which was managed by the State Trustees. TFC worked various jobs after leaving school; however, was unemployed at the time of GFD's passing.

3. TFC's records indicate that she disclosed a history of childhood trauma, and she was diagnosed with epilepsy, post-traumatic stress disorder, borderline personality disorder and arrythmia. She was reportedly a heavy smoker and was not known to use illicit substances, however a small bag of amphetamines was found at her home at the time of GFD's passing.

4. TFC and JUY moved to a regional Victorian town before UHB was born in 2017 as JUY's brother lived nearby. TFC's family lived in [redacted], and TFC often stayed with her parents for two weeks at a time, as she felt isolated in the area she lived.

5. JUY reportedly perpetrated family violence against TFC from 2016 to 2019, and was largely not involved in GFD's life, due to this violence. JUY assaulted TFC in April 2019 while she was pregnant with GFD. This resulted in a full family violence intervention order (**FVIO**) protecting TFC and prohibited any contact. This was the end of TFC and JUY's relationship, and JUY was required to leave the home.

6. GFD was born prematurely at 36 weeks and three days gestation. He was born underweight/undersized, however prior to his passing, was considered to be a healthy and energetic two-year-old boy. GFD's maternal grandmother, HTR described GFD as having a beautiful smile and was a very cuddly boy who loved to be picked up and cuddled. HTR noted that GFD did not have any issues with consuming food, unlike his older brother, and did not have any known medical conditions.

7. GFD and UHB were not enrolled in kindergarten or other activities at the time of GFD's passing. Both infants were wearing 'pull-up' nappies, however UHB was almost toilet trained.

GFD generally went to sleep most nights at 7.00pm and usually awoke at about 6.00am or 6.30am. UHB's sleep pattern was not as regular as that of GFD.

THE CORONIAL INVESTIGATION

8. GFD's passing was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

9. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

10. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

11. Victoria Police assigned Detective Senior Constable Thomas Asciak to be the Coronial Investigator for the investigation of GFD's passing. The Coronial Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating paramedics and investigating officers – and submitted a coronial brief of evidence.

12. This finding draws on the totality of the coronial investigation into the passing of GFD including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[1]

[1] 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.

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

Identity of the deceased

13. On 3 July 2021, GFD, born 2 May 2019, was visually identified by his mother, TFC.

14. Identity is not in dispute and requires no further investigation.

Medical cause of death

15. Forensic Pathologist Dr Melanie Archer, from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on 3 July 2021 and provided a written report of her findings dated 1 December 2021.

16. The post-mortem examination revealed the cause of death was complications of malnutrition. There was evidence of chronic malnutrition as well as dehydration. Dr Archer explained that malnutrition includes undernutrition, which can result in short stature (stunted), low weight (wasted), and deficiency in certain minerals and vitamins. Malnutrition is associated with multiple adverse outcomes, including risk of infection, cardiac arrythmia (including sudden cardiac death) and metabolite imbalance. In this case, the deceased had a very low body weight and height, as well as reduction below average of most organ weights and reduced fat deposits seen at autopsy around the bowel region. There was also generalised reduction in body fat and muscle bulk noted from the post-mortem radiology.

17. There was evidence of dehydration, which can also be associated with adverse outcomes, such as organ failure and death:

    a) The child appeared dehydrated, with sunken eyes and flaccid skin over the abdomen.

    b) Vitreous humour biochemistry showed significant elevation of sodium (hypernatraemia), which can be associated with dehydration. There was also elevation of urea and creatinine, suggestive of significant ante-mortem renal impairment (possible kidney failure). The test was repeated due to the extreme nature of the results, especially in a paediatric case. The repeat testing confirmed the original results.

    c) Myoglobin immunohistochemical staining was also performed on the kidney sections. There was no significant myoglobin cast formation (this can sometimes be seen in dehydration, especially with rhabdomyolysis).

18. In the information provided to Dr Archer, there was mention of a trail of ants in the baby's bedroom. Three ants were found under the child's eyelids. Ants can produce characteristic feeding damage on the skin, which has a parchment-like quality. However, there was no evidence of ant feeding damage to the skin of the deceased.

19. Dr Archer noted that the eroded and ulcerated skin on the genitalia, groin and buttocks was favoured to have resulted from irritation by prolonged skin contact with urine and faeces. There was microscopic evidence of acute inflammation, but histology did not show convincing evidence of herpetic skin infection.

20. Forensic Pathologist, Dr Linda Iles, performed a neuropathological examination on the brain. She identified type 2 astrocytosis, which is a non-specific response to metabolic derangement that can be seen within astrocytes (cells of the brain tissue). A specific cause for this could not be identified, however this was consistent with the overall picture of malnutrition and dehydration.

21. Post-mortem radiology showed no evidence of unexpected skeletal trauma.

22. The inflammatory marker C-reactive protein was within normal limits, however there was elevation in the level of procalcitonin. This may have been caused by inflammation, skin infection or skin injury. Dr Archer noted that these results were difficult to interpret, given the divergence between the two markers

23. Toxicological analysis of post-mortem blood samples did not identify the presence of any alcohol or other common drugs or poisons. Toxicological analysis of post-mortem hair samples revealed the presence of methylamphetamine and its metabolite, cocaine, codeine, doxylamine, and diazepam and its metabolite. Dr Archer explained that exposure to the drugs found in the hair may have been environmental or could be derived from breast milk or across the placenta (although this would rely on hair from that stage of life being present at the time of death). Dr Archer opined that these results were not considered to have been a significant factor in causing the death.

24. Microbiology testing showed *Staphylococcus aureus from blood culture (admixed with Enterobacter cloacae* complex and *Raoultella planticola*). *S. aureus* was also isolated from the left and right lung swabs and left middle ear swab. Scanty growth of *Staphylococcus aureus* and *Escherichia coli* were also shown in urine. Dr Archer opined that the significance

of these results was unclear, however the bacteria likely represented post-mortem contamination in the absence of any evidence of a bacterial infective focus seen at autopsy.

25. There was widespread *Herpes simplex* virus type 1 DNA detected from the nasopharyngeal aspirate, left and right lung swabs, cerebrospinal fluid and large and small bowel contents. Microscopic examination of these tissues did not show any convincing evidence of active viral infection. Disseminated *Herpes simplex* virus type 1 infection is unusual and tends only to be associated with immunocompromised individuals. This infection can result in vesicular rash, skin ulceration, pneumonia, hepatitis, and meningitis/encephalitis, although there was no evidence of any significant herpetic activity in the organs. This included no evidence of herpes infection in the mouth or oesophagus that might have impeded the child's ability to eat.

26. There was no evidence of any significant injury that could have caused or contributed to the death. There were a small number of bruises and abrasions on the body that appeared mainly aged, but there were no patterned injuries.

27. Dr Archer provided an opinion that the medical cause of death was *1(a) Complications of malnutrition.*

28. I accept Dr Archer's opinion as to the medical cause of death.

Circumstances in which the death occurred

29. TFC's parents, HTR and IHF, attended TFC's home on 23 May 2021 to collect TFC, UHB and GFD and drive them back to their home for a two-week visit. When HTR and IHF arrived, TFC did not want them to enter her home and stated that she was embarrassed because it was messy. HTR suggested that she could help clean TFC's house, however TFC refused and said it would not be "*good for [her] mental health*". Due to the COVID-19 lockdowns imposed, TFC's two-week visit was extended to five weeks.

30. During TFC's visit from 23 May to 27 June 2021, HTR recalled that the GFD and UHB loved playing outside and watching Bluey on television. She explained that she made a large pot of porridge for the boys every morning and they generally had a sandwich for lunch. HTR and IHF encouraged the boys to eat fruit, however they did not like same. Both boys had a bottle of milk before bed. GFD was able to feed himself when given a bottle or prepared food. HTR noted that she did not regularly change the boys' nappies during their five-week stay and recalled that TFC normally did this herself. HTR believed that TFC "*kept them [the boys] spotless*".

31. When HTR and IHF dropped TFC back home on 27 June 2021, HTR observed that TFC was "*tired, quiet, and sad*". HTR opined that TFC did not want to go home. On the drive home, HTR and IHF drove TFC to a Woolworths where she purchased nappies, milk, thickened cream, sour cream, a loaf of bread and baby wipes. When they arrived at TFC's home, HTR again offered to clean TFC's house; however she declined, and HTR thought TFC was likely embarrassed.

32. HTR spoke to TFC every day after dropping her home on 27 June 2021. Via phone calls and messages, TFC indicated to her mother and others that she was caring for herself and her sons by preparing meals, cleaning her home, bathing the children, seeking medical treatment for her sick children, attending hospital for herself and washing clothes and dishes.

33. During this time, the only event that stood out to HTR was a conversation she had with TFC on 1 July 2021. TFC told HTR that her boys "*had a bit of gastro*". HTR provided general advice to keep their fluids up and to watch what they consumed. On 2 July 2021, HTR spoke to TFC over the phone and TFC opined that they were still unwell and that "*GFD [had] it the worst*". HTR did not recall anything unusual about the phone call.

34. On the morning of 3 July 2021, TFC was observed on CCTV exiting her home multiple times to smoke cigarettes and use her phone. At 8.47am, TFC used Menulog to order coffee and two kid's meals.

35. At 9.32am, TFC called 000, distraught, and advised that GFD had passed away. She explained to the 000 call-taker that she went to wake him up, however found that he had passed away. She explained that he had soiled himself and appeared to suddenly develop a severe nappy rash. She noted that GFD was fine the day before, he had a bottle the night before, and she last saw him alive at about 1.00am that morning.

36. At 9.35am, TFC exited the house to open a packet of nappies that were located on the porch and returned inside with one new nappy. GFD was wearing a soiled jumpsuit and nappy, which TFC changed prior to the arrival of paramedics. While on the phone to 000, TFC expressed concerns that "*they're gonna take my eldest off me*".

37. Advanced Life Support (**ALS**) paramedics Leanne Gardner and Thomas Dukic arrived at TFC's home at about 9.40am. Paramedic Gardner observed TFC running towards the ambulance, screaming and holding GFD to her chest as they arrived at the location. Paramedic

Dukic immediately commenced cardiopulmonary resuscitation (**CPR**) and requested police attendance.

38. A Mobile Intensive Care Ambulance (**MICA**) unit comprising paramedics Peter Dowling and Nathan Grimshaw arrived on scene within minutes and confirmed with the ALS paramedics that GFD had passed away. The four paramedics made a joint decision to cease CPR. After CPR ceased, Paramedic Gardner observed that GFD's eyes appeared sunken, he had a small bruise on his right forehead, his stomach appeared to be sunken, and he was wearing a clean nappy with areas of raw skin above his genitals and in between both legs. She observed what appeared to be dry faeces on his perineum, he had an odour, and he had two small bruises on his right knee.

39. MICA Dowling explained to TFC why they were not performing CPR and observed that TFC presented as a typical distraught mother. Over the course of his interaction with TFC, her initial distress turned to anger, and she started hitting herself and threatened to end her life. A third paramedic unit comprising ALS paramedic Nicole Roberts and MICA Ian Eddington arrived shortly before 9.50am. MICA Eddington attended to TFC and monitored her welfare, while MICA Dowling entered the house with Paramedic Roberts.

40. MICA Dowling and Paramedic Roberts located UHB inside the house and observed that he was only wearing a nappy that was extremely wet and soiled. UHB tried to reach for one of the 'pop tops' juice containers that were on the bench and MICA Dowling opined that he was very hungry. When he went to give UHB a pop top, he realised that it was mouldy, so he opened the fridge and gave UHB some milk. MICA Dowling observed UHB consume more than 750mL in a short period of time and became very concerned about the last time that UHB or GFD ate or drank anything. Paramedic Roberts changed UHB's nappy and observed it was extremely heavy, full of urine and faeces, and appeared as though it had not been changed in some time.

41. As MICA Dowling moved around TFC's house, he observed that the house was "*the worst [he] had ever seen by far*". He noted broken furniture, open packets of prescription medicine, pop top containers full of mould, furniture and rubbish blocking walkways and access to cupboards, dirt and debris throughout the property, and numerous empty fast-food packets. There was a child's cot in one of the bedrooms that was soiled with faeces and a heavily soiled nappy in the cot.

42. Police first arrived on scene at 10.03am, spoke to TFC and investigated the scene. Police also observed the unkempt state of the house and photographed all rooms. Police shared the concerns of attending paramedics and in addition, observed dried food on the floor, walls and furniture, a significant ant infestation throughout the house, a dead rodent on the kitchen floor and rodent faeces in one of the toilets. The floor of the bedroom containing the cot was littered with old fries and nuggets and the room was largely inaccessible due to furniture and other items strewn across the room. Inside the garage, police located a small Ziplock bag of a white crystal substance (later found to be amphetamines), as well as various drug paraphernalia (a glass 'ice' pipe and bongs).

43. Police and paramedics accompanied TFC to the Northern Hospital due to concerns for her mental state. During the commute, TFC spoke to police and explained that GFD was sick the day before and she tried to make a doctor's appointment for him but was unable to book same. She noted that he last saw GFD alive at about 3.00am or 3.30am when he had a bottle of milk, however when she went to wake him up later that morning he had passed away. She recalled that GFD vomited milk the day before at about 2.00pm, and both boys had some chips and nuggets the night two days earlier (1 July 2021), but GFD was not interested in eating since then.

FURTHER INVESTIGATIONS

44. As part of their investigation, police spoke to TFC's parents who observed her to be a competent and attentive mother when she stayed with them. HTR and IHF were adamant that they did not observe anything concerning during the five weeks that TFC stayed with them. HTR recalled that she did not have to do any nappy changes during the time TFC stayed with her and believed that TFC handled all of these herself. She observed the boys ate well while they were with her, noting that UHB had some food texture related sensitivities and was occasionally picky with his food.

45. Police noted that the supplies purchased by TFC on 27 June 2021 were largely unused. The thickened cream and sour cream were unopened in the fridge, the three-litre bottle of milk was about half-full, and the loaf of bread was unused on the kitchen bench. According to attending paramedics, they gave UHB about 750mL of milk when they attended, which meant that only 1.25 litres of milk was consumed from 27 June to 3 July 2021.

46. Child Protection workers spoke to TFC on 3 July 2021, and she reported that she had "*been doing 'nothing' since Sunday*" and that the boys "*trashed the house, it was filthy with food*

everywhere". TFC reported that she had organised a cleaner for the following week. TFC recalled that on 2 July 2021, she watched Bluey with the two boys, and she tried to get GFD a doctor's appointment due to his gastrointestinal symptoms but was unable to obtain same. She noted that GFD was still drinking his milk, and both boys did some drawing. TFC made 'packet pasta' for dinner and GFD did not eat anything. TFC described applying eczema cream to both boys, read them a book and put them to bed at about 7.00pm. GFD woke up and called out for TFC at about 3.30am so she gave him a bottle of milk. TFC awoke again at 5.30am and watched YouTube for a while before UHB woke up. TFC denied any drug use and stated she only drank alcohol occasionally. She explained that the 'bong' found in her garage belonged to her former partner.

Expert report

47. Victoria Police obtained an expert report from Dr Jennifer Sutherland Smith, of the Victorian Forensic Paediatric Medical Service (**VFPMS**). Dr Smith reviewed all of GFD's medical records, maternal child health nurse (**MCHN**) records, previous Ambulance Victoria records and hospital records in conjunction with the post-mortem report produced by Dr Archer.

48. Dr Smith noted that GFD's weight was documented as 10.4kg at 21 months of age, although it is unclear whether this was an actual weight or was the weight estimated by TFC and given to the MCHN. At the post-mortem examination, GFD's weight was 8.6kg, which was well below the third percentile. Dr Smith noted that the absence of reliable weight measurements between the age of 2.5 months and 21 months meant that there was a degree of uncertainty about GFD's growth measurements and parameters in the months prior to his passing. Dr Smith opined that GFD's post-mortem weight likely reflected a combination of acute dehydration (recent fluid loss from body tissues) and chronic malnourishment.

49. Dr Smith explained that if GFD's weight at 21 months of age (10.4kg) was accurate, then his weight percentile fell from above the 15th percentile at 21 months to more than 2kg below the third percentile at the time of his passing, at 26 months of age. She noted that it was "*improbable that dehydration alone accounted for all of GFD's weight loss*" and that it was probable that some of this weight loss was caused by malnutrition. Dr Smith stated that the duration of malnutrition could not be stated with certainty, however opined that it was likely in the order of weeks to a few months. She noted that this calculation is impacted by the estimated 10.4kg weight at 21 months and whether this was an overestimate. Regardless of the precise weight change, Dr Smith noted there was strong evidence to indicate that GFD

was severely dehydrated at the time of his passing. She opined that this evidence suggested that GFD was not provided with sufficient fluids to sustain life in the hours to days prior to his passing. She further opined that "*It is difficult to understand how, if GFD was frequently sighted by the person caring for him during the hours to days prior to his death, that signs of dehydration and illness might have been missed*".

50. Following a comprehensive police investigation, no criminal charges were laid against TFC.

CPU REVIEW AND SERVICE CONTACT

51. As GFD's passing occurred in circumstances suggestive of neglect and his mother experienced family violence prior to his birth, I requested the Coroner's Prevention Unit (**CPU**)[2] examine the circumstances of his passing as part of the Victorian Systemic Review of Family Violence Deaths (**VSRFVD**)[3].

52. I make observations concerning service engagement with GFD and his family as they arise from the coronial investigation into his death and are thus connected thereto. However, the available evidence does not support a finding that there is any direct causal connection between the circumstances highlighted in the observations made below and GFD's passing.

53. I further note that a coronial inquiry is by its very nature a wholly retrospective endeavour and this carries with it an implicit danger in prospectively evaluating events through the "*the potentially distorting prism of hindsight*".[4] I make observations about services that had contact with GFD and his family to assist in identifying any areas of practice improvement and to ensure that any future prevention opportunities are appropriately identified and addressed.

54. There were several services involved with TFC as a result of her ABI including the State Trustees, the TAC and a neurologist. After GFD's birth, the family were engaged with or were referred to multiple services in the context of family violence perpetrated by JUY towards TFC. These services are considered in further detail below. I note that UHB and GFD were

[2] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

[3] 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.

[4] *Adamczak v Alsco Pty Ltd (No 4)* [2019] FCCA 7, [80].

not engaged in childcare, kindergarten or any other social activities, in part due to TFC's desire to relocate closer to her parents' home.

Cleaning services

55. TFC's friend, ZXC, previously assisted TFC by cleaning her house when TFC stayed with her parents. ZXC stopped cleaning TFC's house in early 2021 after ZXC fell pregnant. During the time that she cleaned TFC's house, ZXC noted various concerns, including:

    a) The home was dirty with rotten food in the refrigerator.

    b) She found UHB in a bathtub filled with cold water and bleach. TFC stated that she had filled the bath the night before with the intention of cleaning it.

    c) She observed UHB and GFD in soiled nappies, sometimes from the night before.

    d) She observed TFC self-harming and struggling to leave the house from February/March 2021.

    e) GFD's cot was unstable and contained multiple mouldy milk bottles.

56. TFC also engaged a professional cleaner at some point; however, this was prohibitively expensive, and she was unable to continue to afford same. It does not appear that concerns about the state of TFC's house were communicated to any services, including Child Protection.

Child Protection

57. Child Protection had limited involvement with TFC and her children prior to GFD's passing. A report was received on 15 March 2019 due to concerns about JUY's mental health issues, alleged drug use and family violence. Child Protection file notes included:

    a) TFC attended all antenatal appointments and engaged well, with no concerns other than the reported family violence by JUY.

    b) A full no contact FVIO was in place against JUY, and TFC was actively engaging with police.

    c) A referral was made to Child FIRST and a family violence service. TFC indicated that she would engage with both.

d) TFC engaged with a MCHN after UHB was born and indicated she would do the same once GFD was born.

e) TFC had no criminal history and no previous involvement with Child Protection.

f) TFC advised she did not use illicit substances.

g) TFC disclosed she had an ABI from an accident when she was 11 years old, but this did not impact her daily activities. She also disclosed a diagnosis of borderline personality disorder, depression and anxiety.

h) There were no concerns for UHB's development, nor the home environment.

The Regional Shire MCHN and Enhanced MCHN

58. After GFD's birth, TFC was referred to the Enhanced MCHN (**EMCHN**) due to her experience of family violence. This referral was closed on 18 November 2019 and TFC was referred to the standard MCHN.

59. According to the records provided, the MCHN did not physically sight GFD after February 2020. Two phone appointments occurred in May and August 2020 and three appointments in October and November 2020 and January 2021, were not attended. TFC did not respond to follow-up calls or messages after these missed appointments. There was no further follow-up after January 2021. GFD therefore did not have his one year, 18 month or two-year MCHN reviews.

60. MCHN checks are not compulsory and there is no method of reporting MCHN non-attendance. If a MCHN had concerns about a particular family, they could make a report to Child Protection, however in this case, that did not occur. I note that TFC's disengagement occurred during the COVID-19 pandemic, with significant lockdowns in Victoria during 2020 and 2021.

61. MCHNs can use the Child Information Sharing Scheme (**CISS**) to attempt to gain further information about a family and why they have disengaged from their service. However, given that TFC was reporting to other services that she was managing well in the lead up to GFD's passing, it is unlikely that any concerns would have been raised unless someone attended the home. Home attendance was highly unlikely in the context of COVID-19 lockdowns, and TFC refused to allow family or friends to enter the house when they attended.

62. I have not identified any issues with the MCHN contact with TFC and note the significant lockdowns in place during 2020 and 2021 prevented MCHNs from visiting TFC at home. As noted above, the MCHN service is not compulsory and there is no suggestion that it should be made compulsory. However, in circumstances where a family is involved with the EMCHN and later disengages from the standard MCHN, I am of the view that there is room for more active follow-up by the MCHN in those discrete circumstances. I therefore intend to make a recommendation to the Department of Health and the Municipal Association of Victoria (**MAV**) to work with all local councils and associated MCHNs to review their policies to ensure that they all have documented processes of follow-up and assessment where a family has previously been engaged with EMCHN and then disengages.

General Practitioners and the Northern Hospital

63. TFC attended two local general practices. The most recent consultation at [redacted] occurred in 2019 and the most recent consultation at [redacted] occurred in July 2020 due to a rash. GFD's immunisations were noted as up to date during the July 2020 appointment.

64. The Northern Health records indicate that TFC was previously able to call for an ambulance when she was concerned about the children, and this indicated her help-seeking capability. For example, in July 2019 she called with concerns that one of her children had a cold and a runny nose. In February 2021, she called an ambulance due to concerns that one of the boys had a cough, which was later found to be croup. It is unclear why she was unwilling or unable to seek help in the lead-up to GFD's passing.

Melbourne Clinic

65. TFC had five admissions to the Melbourne Clinic from 2013 to 2021 (after GFD's passing) for mental health treatment. The most recent admission prior to GFD's passing occurred in 2016. It appears that TFC was booked in for an admission in 2021 prior to GFD passing, however there were no details in TFC's records about the reason for same.

66. During TFC's 2021 admission, TFC denied any recent drug or alcohol use, however noted use of alcohol, cannabis and methamphetamine in early adulthood.

67. TFC told clinicians that her mood had gradually declined over the preceding 12 months, leading to poor dietary intake and poor sleep.

68. Within TFC's Melbourne Clinic records, there were multiple references to GFD's passing as being due to Sudden Infant Death Syndrome (**SIDS**), and it is not clear whether TFC genuinely believed GFD's passing was due to SIDS. The records indicate many expressions of grief; however, none provided insight into the circumstances of GFD's passing.

Regional NDIS Service Provider

69. A regional NDIS service provider's involvement with TFC and her children ended in December 2019. Their records indicate that part of their support included the provision of two skip bins to clear rubbish from her property. TFC explained that the skip bins were required to remove rubbish that accumulated during her previous relationship. No concerns were raised by staff in relation to the home environment or TFC's parenting. One worker noted that TFC's "*description of the rubbish to be removed was worse than the reality of the rubbish*".

70. The regional NDIS service provider conducted home visits, although TFC occasionally cancelled as she had forgotten. During one unannounced home visit, TFC did not allow the worker inside the house.

71. The current funding model for many services such as the regional NDIS service provider appears to be based on support periods based on goal identification and achievement, followed by closure when there are no tangible goals to address. In this case, TFC told the regional NDIS service provider that she intended to relocate closer to her family and therefore did not want to engage with services at her home.

Regional Family Violence Service

72. TFC engaged with a local regional Family Violence Service after experiencing family violence in her relationship with JUY. The service was engaged with TFC as recently as April 2021.

73. In January and February 2021, TFC repeatedly contacted the Family Violence Service and expressed that she was not doing well, felt isolated, had no support, and wanted to access counselling. She was advised that she was placed on a waitlist for counselling.

74. In February 2021, TFC told the Family Violence Service that she was stressed as GFD had croup and she was unable to get an appointment with her doctor. She was advised to take GFD to the emergency department at the local Hospital if she could not access a doctor.

75. In April 2021, TFC called the Family Violence Service again to ask about the waitlist to access counselling. They suggested that she should contact her general practitioner if she needed more urgent mental health support, or to contact her local emergency department or Lifeline in an emergency.

76. While not necessarily preventative, it is possible that if TFC had access to a counsellor, she *may* have disclosed information that indicated she was struggling to care for her children.

77. Access to mental health services during COVID-19 was extensively reported on and was not limited to Victoria. The Royal Commission into Victoria's Mental Health System (**RCVMHS**) found that demand for mental health services outstripped capacity, community-based services were under-resourced and getting help was difficult. Historically and separate to the impacts of the COVID-19 pandemic, specialist family violence counselling was subject to extensive waitlists and private counselling is unaffordable for many people.

78. The RCVMHS recommended the development of a Mental Health and Wellbeing Outcomes Framework to drive collective responsibility and accountability for mental health and wellbeing outcomes across government portfolios. The RCVMHS suggested that this should be used as a mechanism to inform government investment processes and assess the benefits, including the economic benefits, of early intervention, with public reporting on progress against outcomes at a service, system and population level, every year.

79. In the newly released Victorian Government Mental Health and Wellbeing Outcomes and Performance Framework, Domain 2 states that:

> *People are supported by mental health and wellbeing services to live the life they want, including that mental health and wellbeing services are accessible and equitable. It outlines that Victorians should have equal ability to access mental health and wellbeing services in a way that works for them, no matter who they are, or where they live, with key measures to increase people being able to access the care and support they want and increase people being able to access care and support where and when they want.*

80. This case highlights the importance of accessible and affordable mental health support, regardless of the person's location. While I cannot determine that mental health support would have prevented GFD's passing, it is clear that TFC was seeking help with counselling, which is interesting in the context of her being unwilling or unable to seek help for her children.

Perhaps she felt more comfortable engaging with a counsellor rather than a Child Protection worker. Nevertheless, it is critical that Victorian's who are seeking mental health support can access same.

Opportunities for preventative intervention

81. This case was complicated by the context in which it occurred, namely the COVID-19 lockdowns in Victoria, and TFC's limited interaction with voluntary services. Police did not conduct a formal police interview with TFC, and it remains unclear why a person who externally presented as caring and attentive, was failing to act in the ways she was describing to others.

82. TFC previously demonstrated her ability to engage with services and previously sought medical attention for her children when they were unwell. It appears that the state of TFC's house on 3 July 2021 did not occur due to one incident; rather it appeared to be the result of sustained inaction.

83. The only person who appeared to be aware of the extent of TFC's home and her ability to care for her children was ZXC. TFC repeatedly expressed concerns that she felt isolated in the area she lived, however the services involved were not aware of same. There appeared to be a significant disconnect between TFC's ability to care for her children and the assessments of Child Protection, the regional NDIS service provider and her parents, who also tried to help her.

84. Parents with intellectual disabilities and cognitive impairments can face barriers to engagement with services due to the experience of stigma and negative perceptions about their parenting capacity.[5] This can translate to a reluctance to engage with services, outline support needs or request assistance due to fear of judgement and dissatisfaction with the available services.[6] TFC *did* engage with services, but only to the extent required and she disengaged when possible. She immediately expressed fear that UHB would be taken away from her when she called 000 for GFD, which suggests that the reason she was concerned about asking for help may have been her fear of losing her children.

[5] Commission for Children and Young People, Inquiry into services provided to vulnerable children and young people with complex medical needs and/or disability, 2018.

[6] S Collings et al., '"She was there if I needed to talk or to try and get my point across": Specialist advocacy for parents with intellectual disability in the Australian child protection system', Australian Journal of Human Rights, 24 (2), 2018, 162- 181.

DATA REGARDING SIMILAR DEATHS

85. I requested data from the Victorian Homicide Register (**VHR**) regarding the frequency of deaths in circumstances similar to GFD. The VHR is a database maintained by the CPU that contains detailed information on the offender(s) and deceased(s) in all Victorian homicides reported to the Coroner since 2000. It comprises over 230 data fields which capture information such as socio-demographic characteristics, location information, presence and nature of physical and mental illness, service contact, and in cases where there was a history of family violence, information on the presence and nature of the violence.

86. Based on data extracted from the VHR on 17 December 2024, there are currently multiple matters before the Court where a child aged 12 years or younger have passed since 2019 in circumstances that may suggest potential neglect while in the care of their parent(s). While there are some distinct differences in these cases, there are some similarities in other cases that align to GFD's circumstances:

    a) Prior/current service involvement, including Child Protection, MCHN and/or education services.

    b) Parents who declined or avoided service involvement.

    c) Traces of illicit substances found in the medical examination that indicated environmental exposure.

    d) Homes being found in states of significant mess/squalor.

    e) Parents who may have struggled with the capacity to care for a young child, understanding their needs and how to attend to them.

87. The Consultative Council on Obstetric and Paediatric Mortality and Morbidity (**CCOPMM**) report *Victoria's mothers, babies and children 2021 report and presentation* the CCOPMM reported that between September 2020 and January 2022, five Victorian children died from complications of malnutrition and neglect. Two of those children were aged between 0 and 27 days old while the other three children were aged between 28 days and four years of age. CCOPMM made the following recommendation:

> *Malnutrition in children is a high-risk factor for morbidity and mortality. There is an urgent need to strengthen Primary Health care systems, including Maternity,*

Maternal and Child Health and General Practice services to detect, monitor and treat malnutrition, especially in vulnerable families.

88. CCOPMM also noted the following contributing factors:

    a) A lack of recognition of the seriousness of the condition by parents or caregivers;

    b) A delay in care seeking for infants and older children;

    c) Difficulty accessing in-person medical or maternal and child health services (due to COVID-19 restrictions, staff capacity and conversion to telehealth);

    d) Parental and family factors of intellectual disability, pervasive developmental disorders, mental health issues, substance abuse, family violence and poverty; and

    e) Inability to access medical care due to poverty and social issues.

89. CCOPMM stated that across all types of deaths and all age groups, it continued to observe an over-representation of children from vulnerable families. CCOPMM noted its concern that the recent increase in economic pressure of families will worsen this problem.

PROCEDURAL FAIRNESS

90. As in all matters where there may be adverse comments or findings against a party, the Court attempted to contact TFC several times and send correspondence to her, outlining my proposed findings. TFC did not respond to any of the Court's calls, however her family indicated that she did not wish to engage with the Court.

91. As such, TFC was unable to receive a copy of my proposed findings prior to the finalisation of this matter, and she was unable to put forward a response or any other submissions.

92. I note that section 77 of the Act allows a person to apply to the Court for an order that some or all findings of a coroner should be set aside. If new facts and circumstances became available, for example, material that TFC wished to convey to the Court, then she could apply to the Court for some or all of my finding to be set aside.

FINDINGS AND CONCLUSION

93. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

    a) the identity of the deceased was GFD, born [redacted]

b) the passing occurred on 3 July 2021 at [redacted], from *1(a) complications of malnutrition*; and

c) the passing occurred in the circumstances described above.

COMMENTS

Pursuant to section 67(3) of the Act, I make the following comments connected with the death.

94. I note the critical importance of the ability for all Victorians to access affordable mental health support, regardless of their location. Those who are isolated by family violence, and in this case, also COVID-19 lockdowns, may face various barriers unknown to services and their families, however the indication of a willingness or need to engage with mental health services or counselling may be the one opportunity to identify other needs and risks and offer support.

95. While the CCOPMM report indicates a need to strengthen primary healthcare systems to identify and respond to malnutrition and neglect of young children, this case highlights that is not always where people will seek assistance.

RECOMMENDATIONS

Pursuant to section 72(2) of the Act, I make the following recommendations:

(i) That the **Department of Health** work with the **Municipal Association of Victoria** (**MAV**) and all local councils and associated MCHNs to review their policies to ensure that they all have documented processes of follow-up and assessment where a family has previously been engaged with EMCHN and then disengages.

I convey my sincere condolences to GFD's family for their loss.

Pursuant to section 73(1A) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

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

JUY, Senior Next of Kin

TFC, Senior Next of Kin

GFD's Aunt

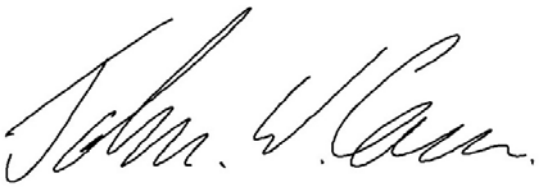
Department of Health

Mental Health and Wellbeing Commission

Municipal Association of Victoria

Detective Senior Constable Thomas Asciak, Coronial Investigator

Signature:



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Judge John Cain
State Coroner
Date: 20 August 2025

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 investigation. 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.