IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 004603

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Judge Liberty Sanger, State Coroner
Deceased:	EGB
Date of birth:	[redacted]
Date of death:	31 August 2021
Cause of death:	1(a) Head injuries
Place of death:	The Royal Children's Hospital 50 Flemington Road Parkville Victoria 3052
Keywords:	Child homicide; support for new parents; multiple hospital presentations; unexplained injuries in infants

INTRODUCTION

1. On 31 August 2021, EGB was eight weeks old when he died from head injuries at the Royal Children's Hospital (**RCH**). At the time of his death, EGB lived in an outer suburb of Melbourne, Victoria, with his parents, AHQ and HVR, and his two older brothers.

2. AHQ and HVR met in about 2012 and were married in February 2015. Their first son was born in 2018, followed by their second son in 2019. AHQ and HVR were the co-directors of a company.

3. EGB was born a healthy baby boy on [redacted] at the Royal Women's Hospital, weighing 3.58kg. He was born via an emergency caesarean section, and he suffered no complications as a result of the birth. AHQ planned to have a natural birth with EGB, as she did with her first two sons. However, when clinicians found a knot in the umbilical cord, they expedited the birth via caesarean section. As a result of the emergency surgery, AHQ had a longer than expected recovery period. She had previously planned to resume working immediately after the birth; however, due to her healing surgical wound she was unable to lift heavy items and had to tend to her wound to prevent infection. This also occurred during one of the many COVID-19 related lockdowns in Victoria, so the family received limited visits from their wider familial and social network. Consequently, HVR was required to take on more of the parental responsibilities for the children, including changing, cleaning and feeding EGB.

THE CORONIAL INVESTIGATION

4. EGB's death 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.

5. 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.

6. 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.

7. Victoria Police assigned Detective Senior Constable Telen Stanfield to be the Coronial Investigator for the investigation of EGB's death. The Coronial Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

8. State Coroner, Judge John Cain (as his Honour then was) originally held carriage of this matter, prior to his retirement in August 2025. I assumed carriage of this investigation on 1 September 2025.

9. This finding draws on the totality of the coronial investigation into the death of EGB 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]

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

Identity of the deceased

10. On 31 August 2021, EGB, born [redacted], was visually identified by his mother, AHQ.

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

Medical cause of death

12. Forensic Pathology Registrar Dr Joanne Ho, supervised by Dr Judith Fronczek from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on 1 September 2021 and provided a written report of her findings dated 1 August 2022.

13. The post-mortem examination revealed a normally developed and well-nourished male infant. Analysis of the brain by neuropathologist, Dr Linda Iles, noted the presence of a subarachnoid haemorrhage and focal small collections of neutrophils in the subarachnoid space, predominantly about the base of the brain and around the spinal cord and brainstem. These were present in the setting of early ischaemic necrosis and compression of posterior fossa

[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.

structures and were considered to be a response to neurological ischaemic injury and early haemorrhagic necrosis.

14. Dr Iles further noted bAPP staining in the brainstem was present on a background of hypoxic ischaemic injury and early haemorrhagic necrosis and while traumatic axonal injury could not be excluded this staining could be accounted for by vascular axonal injury and compressive changes about the brainstem. There was venular and capillary congestion present, associated with multiple foci of microhaemorrhage. There was sparring of the thalami. This was considered to represent a reperfusion injury in the setting of hypoxic ischaemic injury following a period of cardiac arrest and subsequent period of hypotension. A microscopic focus of white matter necrosis associated with microscopic gliosis in the adjacent cortex was identified in the parasagittal brain tissue. While the precise cause of this finding could not be determined with certainty, given its isolated and microscopic nature, "*tissue tears*" can have this appearance. This injury had features that pre-dated the post-arrest hypoxic ischaemic injury.

15. Associate Professor Penny McKelvie examined the eyes and commented that although hemosiderin could be seen in orbital fat and extraocular muscles in infants dying of non-traumatic causes up to five months, optic nerve sheath haemorrhages, in the absence of coagulopathy and/or sepsis are usually associated with trauma.

16. The autopsy and neuropathological examination revealed evidence of extensive head and neck injury, including:

    a) Right-sided frontal scalp bruising

    b) Right-sided occipital subgaleal haematoma

    c) Subdural haemorrhage

    d) Subarachnoid haemorrhage

    e) Deficit bridging vein

    f) Brain swelling patchy infarction choroid plexus

    g) Necrosis of the brain stem, distal spinal cord and focally in the white matter

h) Subdural and subarachnoid haemorrhage about the thoracic and lumbosacral spinal cord

i) Foci of haemorrhage in nerve roots, ganglions and perineural fibroadipose tissue of the upper cervical spine

17. Dr Ho noted that no significant accidental trauma was reported in the circumstances of the child's death that could account for the spectrum of injuries present. She opined that these injuries could not be sustained due to the normal handling of a child or short falls, such as a fall from a change table.

18. At autopsy, there were multiple fractures including to the ribs, humeri, radii, tibiae, fibulae and ilium. These were consistent with the radiological findings. The fractures showed various stages of healing. There were no acute fractures. These fractures were the result of multiple severe blunt force impacts. Some of the fractures (metaphyseal corner fractures) could also be inflicted due to shaking of the infant with flailing of the limbs and are highly specific to non-accidental injury. Dr Ho noted that posterior rib fractures, as were seen in this case, are highly specific to non-accidental injury. These fractures can (for example) be inflicted by squeezing of the chest. It is noted that ilium (pelvic bone) fractures are caused by high energy blunt trauma. There was no radiological or pathological evidence of underlying, non-traumatic bone pathology.

19. There was fibrous tissue ('scarring') in the omentum (the fat layer on the surface of the abdominal organs). This typically occurs in the setting of repeated abdominal trauma or surgery. This child had not had abdominal surgery. Dr Ho noted that the small bowel diverticula raised the possibility of previous serosal trauma.

20. There was erosion under the tongue which was the result of previous (older) blunt force trauma to the soft palate/tongue frenulum, for example, due to inserting structures forcefully into the mouth. There was no acute injury of the tongue frenulum.

21. There were multiple bruises over various body planes and abrasions to the chin and anterior to the right ear. The pathological examination did not allow Dr Ho to precisely estimate the age of these injuries, whether they occurred before admission to hospital or as a consequence of medical treatment.

22. There was patchy bronchopneumonia, which is a known complication of hospitalisation, particularly when a patient is mechanically ventilated (as was the case here).

23. There was focal haemorrhage of the posterior mediastinum (central compartment of the thoracic cavity) which could have been the result of resuscitation. However, previous blunt force trauma to that area could not be excluded.

24. There was no natural disease or congenital abnormality detected by the autopsy examination or ancillary testing to account for this child's presentation and autopsy findings.

25. Ancillary testing, including toxicology, bacteriology, cytogenics and metabolic examinations did not show any lethal abnormalities.

26. Virology demonstrated multiple organisms, comprising of *Parechovirus* within the left lung, bowel, cerebrospinal fluid, nasopharynx and myocardium, *Enterovirus* within the bowel, and *Adenovirus* within the nasopharynx and myocardium. Despite the presence of these viruses across multiple samples, there was no histological evidence that they caused or contributed to the death. They may be encountered as 'normal' childhood infections. Furthermore, the virology findings did not suggest whether the results were due to past or current infection.

27. Dr Ho concluded that there were multiple and extensive traumatic injuries in this eight-week-old infant on multiple planes of the body. The combination of autopsy findings provides very strong support for the hypothesis that the injuries were caused by non-accidental trauma, as opposed to the hypothesis that the injuries were caused by accidental trauma. The combination of these injuries was *not consistent with a single event*; however, the total number of events could not be estimated with any certainty.

28. Toxicological analysis of ante-mortem samples identified the presence of flucloxacillin,[2] metronidazole[3] and phenobarbitone.[4] Toxicological analysis of post-mortem hair samples did not identify any common drugs or poisons.

29. Dr Ho provided an opinion that the medical cause of death was 1(a) Head injuries.

30. I accept Dr Ho's opinion as to the medical cause of death.

EGB's medical history

[2] Flucloxacillin is a semisynthetic penicillin derivative used as a narrow-spectrum antibiotic with activity against Gram-positive bacteria.
[3] Metronidazole is an antiprotozoal and anaerobic antibacterial agent.
[4] Phenobarbitone is an anti-convulsant barbiturate used in the treatment of epilepsy. It also used as a sedative.

31. On 7 July 2021, HVR told AHQ that EGB's nose "*looked very red*". AHQ reported that she agreed but was otherwise not alarmed.

32. On the morning of 11 July 2021, HVR was feeding EGB and alerted AHQ that his nose had started bleeding on the outside. AHQ called the Royal Women's Hospital's advice line to ask about the baby's nose. She was advised to take EGB to the hospital or to a general practitioner (**GP**). HVR drove AHQ and EGB to the RCH, as AHQ was unable to drive while recovering from her surgery.

33. AHQ and EGB were seen in the RCH emergency department (**ED**) by a Registrar and Consultant. The initial triage documentation suggested possible diagnoses of a blood vessel disorder, non-accidental injury and/or infection. Clinicians asked AHQ if an adult could have caused the injury and she declined same. AHQ recalled that they discussed whether her other children could have caused the injury, however the clinicians thought it would be unlikely that they were responsible for the injury given their young age. RCH clinicians diagnosed the injury as mechanical chafing, prescribed Bactroban to prevent an infection and advised to re-present if it worsened, or if further blisters developed. AHQ informed HVR that the clinicians asked if an adult could have caused the injury and his response was "*What made them think that?*"

34. On 14 July 2021, HVR alerted AHQ to bruising on EGB's groin area while changing his nappy. AHQ noted that the Maternal Child Health Nurse (**MCHN**) was due to visit later that day and she advised that she would ask the MCHN to look at the bruise. When the MCHN attended, she recommended AHQ attend their GP or a hospital for further review.

35. AHQ consulted with the Victorian Virtual Emergency Department (**VVED**) at about 5.30pm, and the VVED clinicians recommended that she attend the Northern Hospital ED for an in-person review. AHQ attended the Northern Hospital ED as directed, and EGB was admitted for observation. During conversations between AHQ and hospital staff, she "*denied episodes of trauma when asked, stating that he had not been dropped and that his brothers were always gentle with him. She denied family violence*".

36. Overnight and into 15 July 2021, EGB developed an increased work of breathing and increased heart rate. He underwent a scrotal ultrasound and chest x-ray, the latter of which noted possible right upper zone consolidation. No fractures were diagnosed on the chest x-ray at the time; however, these were retrospectively (on 15 September 2021) interpreted as

demonstrating bilateral anterior rib fractures with early signs of healing. Following a discussion with surgeons, EGB was transferred from the Northern Hospital to the RCH.

37. Upon arrival at the RCH, clinicians initially investigated him for testicular torsion, however an ultrasound did not show evidence of same. The advice from surgeons was for conservative management. EGB was monitored and treated with intravenous antibiotics for 48 hours for presumed sepsis, followed by one week of oral antibiotics. A nasopharyngeal aspirate was positive for adenovirus. Clinicians discussed these findings with the infectious diseases team who had other recent reports of epididymo-orchitis with adenovirus and considered this as a diagnosis for EGB. The final diagnosis was adenovirus pneumonitis and epididymo-orchitis. EGB was discharged home on 18 July 2021 with a plan for GP follow-up in one weeks' time.

38. On 22 July 2021, AHQ took EGB to his two-week MCHN appointment. This appointment was delayed as EGB was in hospital at the age of two weeks and therefore missed his appointment. The MCHN noted EGB had a bruised scrotum, however AHQ noted that this had been investigated at the RCH, who diagnose him with adenovirus. The MCHN also noted the lesion on the tip of the nose, which AHQ was advised was a rare complication of adenovirus and she was treating it with Bactroban as recommended. The MCHN further noted an asymmetrical gluteal crease and advised AHQ to have it reviewed by a GP at six weeks of age, to exclude hip dysplasia.

39. On 26 July 2021, AHQ took EGB to her GP to discuss the gluteal crease and was given a referral for an ultrasound. The GP documented no hip clicks during the appointment.

40. HVR took EGB for his hip ultrasound on 12 August 2021. Later that day, AHQ reported that she walked into the laundry where HVR was bathing EGB. She observed that her son's body was blue, and his legs were floppy, so she started yelling at HVR to call an ambulance. AHQ recalled that HVR did not move, and she assumed he was in shock, so she called Triple Zero herself. Meanwhile, HVR took EGB to the change table, where he was "*extremely white but breathing*". Paramedics attended, then transported EGB to the Northern Hospital ED, accompanied by AHQ.

41. Northern Hospital staff performed an ECG, chest x-ray and various other investigations. The results of the chest x-ray revealed a normal x-ray; however, this was revised on 29 August 2021 to confirm bilateral posterior rib fractures of varying ages. Clinicians at the Northern Hospital asked AHQ if it was possible that HVR could have done something to EGB in the bath and AHQ denied same. EGB was moved to the ward for observation overnight.

42. On the morning of 13 August 2021, AHQ called HVR and asked him if he was experiencing post-natal depression, following the clinicians' questions the night before. AHQ reported that she was concerned about EGB being discharged without a diagnosis. EGB was discharged that day for a follow-up blood test in one weeks' time. AHQ also asked HVR to purchase a breathing pad alarm, as she was concerned about the risk of Sudden Infant Death Syndrome (**SIDS**), given the child's recent breathing episode.

43. According to AHQ, HVR took EGB to the Northern Hospital on 16 August 2021 for a follow-up blood test. When they returned home, AHQ observed a cotton wool ball taped on the baby's head and asked what happened. HVR reportedly advised that when he entered the hospital, another woman was exiting and moved her handbag, so he tried to protect the child's head and accidentally scratched his head instead. AHQ reported that she was upset by this explanation and warned HVR to hold the child in a better position next time.

44. On 18 August 2021, AHQ presented EGB to their GP for a six-week checkup and for routine immunisations. AHQ reported that she told her GP that she observed the child becoming very pale at different times of the day. The GP noted EGB's blood tests showed a level of iron deficiency and suggested that AHQ and HVR consider testing for thalassemia.

45. On 19 August 2021, AHQ called the MCHN advice line regarding EGB's cry changing. She noted that he would cry but the sound was either non-existent or very low. She recalled that they asked her standard questions about his oral intake and wet nappies and AHQ noted that everything was normal, other than EGB consuming a smaller quantity when feeding.

46. On 24 August 2021, HVR advised AHQ that there was "*something wrong*" with EGB's tongue. AHQ recalled it looked like a "*hole/cut*" under his tongue. It was not red or inflamed and only had a small amount of blood (dots) on each end.

47. That day, AHQ presented to the MCHN office with EGB, however the MCHN advised that she could not review the child due to COVID-19 restrictions. AHQ described the tongue injury and asked the MCHN if she thought it was serious. The MCHN was unable to advise whether it was serious and asked AHQ to leave. AHQ reported that she was not given any guidance about where to seek help. When she returned home, she called the MCHN advice line and was advised that HVR previously called the advice line for the same issue.

48. On 25 August 2021, AHQ had a GP appointment booked for herself, so she decided to bring EGB and use the time for her son instead. The GP reviewed EGB's mouth and tongue and

while she was unsure of the cause, she suggested that AHQ raise the issue at their upcoming paediatrician's appointment in two weeks' time. The GP noted that EGB's ultrasound results were normal.

Circumstances in which the death occurred

49. On 26 August 2021, HVR left for work at about 9.00am. AHQ was not feeling well, due to ongoing healing from her recent caesarean section, and asked her mother to come over and help care for the children. When HVR returned home from work, he was particularly tired and wanted to go to bed early. HVR tended to the children; however, they were difficult to settle, making it challenging for HVR to go to sleep.

50. During the early hours of 27 August 2021, HVR awoke to give EGB his night-time feed, while the rest of the family remained asleep. EGB reportedly did not want his bottle, which frustrated HVR. HVR (later) reported that he shook EGB "*five or six times in frustration*" and while he did not state how hard he shook him, he stated that it "*wasn't vicious*". HVR later told police that after shaking his son, he spat up some vomit, however there was otherwise no obvious change in his demeanour, so he put him back to bed. He did not tell AHQ about this incident at the time.

51. Later that morning, the family awoke as normal, and HVR fed EGB throughout the day. HVR reported that EGB was only consuming about half of his usual oral intake, however he was not concerned because he was still feeding and otherwise appeared normal.

52. On 28 August 2021, HVR spent the day at home with his family. AHQ was still healing from her recent surgery, and HVR looked after the children. HVR reported that EGB still had a lower than usual oral intake but otherwise appeared normal.

53. That day, AHQ observed that the hole under EGB's tongue had increased in size, so she called the VVED for advice. The VVED clinician diagnosed the issue as a viral infection or a possible tongue tie. They advised AHQ to wait for the upcoming paediatrician's appointment on 10 September 2021, as previously arranged.

54. At about 4.30am on 29 August 2021, HVR awoke to give EGB his nightly feed. After feeding his son, he changed his nappy and waited for him to fall asleep. Once EGB was asleep, HVR used the bathroom then cleaned up the dirty nappy and used baby bottle.

55. About 10 minutes later, the sleep apnoea alarm in EGB's bassinet sounded, alerting HVR to the fact that EGB was not breathing. HVR ran into the bedroom where AHQ was sleeping to wake her and alert her to the alarm. HVR removed EGB from his bassinet and placed him on the change table. At the time, EGB was unresponsive and blue in colour.

56. AHQ immediately commenced cardiopulmonary resuscitation (**CPR**) while HVR called Triple Zero at 5.21am. The Triple Zero call-taker provided instructions on how to deliver CPR, while they awaited the arrival of paramedics. AHQ observed milky vomit over the right side of EGB's face and right eye. She continued CPR until paramedics arrived.

57. The first paramedics arrived at 5.31am and took over CPR from AHQ. Paramedics intubated EGB and achieved a return of spontaneous circulation (**ROSC**) at 5.58am. After achieving a ROSC, paramedics transported EGB via ambulance to the Northern Hospital.

58. At the Northern Hospital, clinicians performed a chest x-ray which demonstrated multiple healing rib fractures. Due to his critical state, EGB was transferred to the RCH by paramedics for specialist care.

59. At the RCH, EGB underwent a CT scan of his brain, which demonstrated bleeding around the brain and radiological signs suggestive of a hypoxic ischaemic injury. Due to concerns about EGB's presentation, RCH staff contacted the Victorian Forensic Paediatric Medical Service (**VFPMS**) to examine EGB and interview his parents. Dr Joanna Tully of the VFPMS completed an examination of EGB on the afternoon of 29 August 2021 and spoke to AHQ and HVR (separately and together) in the presence of another VFPMS clinician.

60. HVR provided a version of events as described above, however omitted that he had shaken EGB. AHQ stated that EGB was a very easy baby to care for and was usually settled. She reported that the day before, he was his "*normal self*" and she held no concerns about him, although noted he was "*slightly off*" in the week prior. AHQ explained that her son's cry was intermittently quieter than usual but thought this was due to a sore throat. She also noted his feeding had reduced slightly in volume; however, she was not immediately concerned because he otherwise seemed well, was gaining weight and was still wetting his nappies. AHQ also provided a detailed history of EGB's health, as outlined above.

61. During Dr Tully's conversation with HVR, he disclosed that he dropped EGB about two weeks earlier, after losing his grip while picking him up from the change table. HVR attributed

EGB's rib fractures to this incident. He also reported that he might have been a "*bit rough*" with his son, including "*bicycling*" his legs to relieve wind.

62. Dr Tully spoke to the parents together and explained the concerns regarding EGB's injuries. HVR admitted that he "*may have been a bit rough*" but advised that he never intended to harm the child. When Dr Tully asked the parents if either had ever shaken EGB, they both denied same.

63. Following a review of EGB's present condition, in combination with his history of other injuries, Dr Tulley formed the view that he "*suffered inflicted injury on a number of occasions as result of an adult handling him in an inappropriate manner, including by violent shaking with or without associated impact against a firm or soft surface*". Police were notified, attended the RCH and arrested HVR at about 7.30pm that evening.

64. Police interviewed HVR on the evening of 29 August 2021 and into the early hours of 30 August 2021. During the interview, he denied any traumatic event occurring on 29 August 2021, however admitted to dropping EGB from the change table about two weeks' earlier. He stated that the child fell onto carpeted floor and his head and ribs impacted the floor. At the conclusion of the interview, police released HVR from custody, pending further inquiries.

65. Meanwhile, EGB underwent an MRI which revealed a catastrophic brain injury. His condition was deemed incompatible with life, and a decision was made to withdraw his life support the next day.

66. At 8.07am, HVR called AHQ and she asked him if he shook their child. After a long pause, HVR admitted that he shook EGB, "*but only a little*" and denied causing the injuries to EGB's ribs. He advised that he would call the police to confess same. At 8.47am, HVR called the police and admitted that he shook EGB "*a little bit, not profusely, not hard but I did shake him a little bit*".

67. HVR participated in a second recorded police interview on 30 August 2021. He admitted that he shook his child and that he was very tired at the time. He explained that he awoke in the early hours of 27 August 2021 to feed EGB and because he was refusing to eat, he shook the child back and forth five to six times, which "*caused his head to jag back and forth*". After shaking EGB, HVR observed the child cried, spat up a bit of vomit but otherwise appeared normal. HVR reported he put the child back to bed and performed Google searches for signs of brain damage in babies that had been shaken. He denied any further traumatic events after

this incident and denied any traumatic events occurring on the morning of 29 August 2021. HVR was released by police without charge, pending further investigations. Police applied for a Family Violence Safety Notice (**FVSN**) against HVR, to protect AHQ and their children. The FVSN prohibited HVR from having any contact or communication with his family.

68. At 3.21pm on 31 August 2021, EGB passed away, surrounded by AHQ and his two older brothers.

69. Following HVR's arrest, his phone was seized by police and was forensically analysed. HVR reported he searched Google after the incident on 27 August 2021; however, police were unable to locate any searches at that time. Police did, however, locate the following Google searches performed in the minutes and hours after EGB's collapse on 29 August 2021:

    a) "*How long can a baby go without oxygen before brain damage*" at 5.57am.

    b) "*Signs of brain bleed in toddler after fall*" at 10.09am.

    c) "*How long till a baby gets brain damage*" between 10.10am and 11.34am.

    d) "*How long can a baby go without oxygen before brain damage*" at 10.55am.

70. Police also located numerous other Google searches, performed in the days and weeks prior to EGB's death:

    a) "*How long can a newborn take to suffocate*" at 5.06pm on 5 July 2021.

    b) "*Newborn bruises*" at 8.45pm on 8 July 2021.

    c) "*Blood in white of eye of newborn baby*" at 10.19am on 26 July 2021.

    d) "*Brain damage signs in newborn*" at 1.14pm on 27 July 2021.

    e) "*Baby with cold rapid breathing*" at 5.34pm on 31 July 2021.

    f) "*Voice boxnewborns' ways.tp damage.voice.box [sic]*" at 6.18am and 6.20am on 10 August 2021.

    g) "*My 2 year old keeps hitting the newborn*" at 8.22am on 11 August 2021.

    h) "*My newborn has suspicious scratches*" at 8.30am on 11 August 2021.

i) "*Baby stop breathing in bath*" at 7.29pm on 12 August 2021.

j) "*Brue baby*" at 7.38pm on 12 August 2021.

k) "*What can cause a baby to los consciousnessfast au [sic]*" from 5.21am on 13 August 2021.

l) "*Baby not crying loudly Australia*" at 9.24am on 19 August 2021.

m) "*Can chocking [sic] cause loss of voice*" at 9.44am on 19 August 2021.

n) "*Can a newborn voice box get damaged*" at 5.49pm on 19 August 2021.

o) "*How much do newborns remember*" at 9.56pm on 19 August 2021.

p) "*Baby doesn't cry loud and Sids*" at 2.27pm and 2.40pm on 21 August 2021.

q) "*Internal stomach bleeding symptoms*" at 2.04am on 23 August 2021.

r) "*My baby wont [sic] take bottle*" at 1.28am on 24 August 2021.

s) "*Baby has hole under tongue any ideas*" at 1.37am on 24 August 2021.

t) "*Baby has hile [sic] under tongue*" between 9.03am and 9.52am on 24 August 2021.

u) "*My baby threw up feed*" between 3.10am and 4.05am on 25 August 2021.

v) "*I accidently [sic] scratched my babys [sic] face*" between 8.09pm and 9.00pm on 25 August 2021.

w) "*Is it normal for babys [sic] to grunt while tryingtogo [sic] to sleep*" at 5.16am on 28 August 2021.

x) "*Blood in baby snot*" at 5.18am on 28 August 2021.

y) "*Baby has runny nose*" at 8.51am on 28 August 2021.

z) "*Split under baby tongue*" at 1.08pm on 28 August 2021.

71. Following receipt of the medical reports and evidence, police charged HVR on 10 August 2022. He pleaded guilty to child homicide and was sentenced on 11 July 2023. As part of the sentencing hearing, Justice Lasry noted that he was sentencing HVR on the basis that his only

action that caused injury and ultimately death was the shaking he admitted to on 27 August 2021. His Honour stated that notwithstanding this, he was also satisfied that HVR was also the cause of the non-accidental fractures that EGB suffered on occasions other than when he shook him.

72. His Honour stated, in his opinion, that HVR inflicted not only the brain injuries caused by shaking the child, but also caused the other injuries which were the result of blunt force trauma. His Honour noted that the other adults who had any physical contact with the child denied inflicting any blunt force trauma on the child and their evidence was not challenged. While counsel for HVR pointed to HVR's internet search "*my 2 year old keeps hitting the newborn*", his Honour was not satisfied that a child of that age could have been responsible for same. Justice Lasry sentenced HVR to a period of 11 years imprisonment, with a non-parole period of eight and a half years.

FAMILY CONCERNS

73. AHQ wrote to the Court, following HVR's sentencing, and provided a timeline of the various medical ailments and issues EGB experienced in his brief eight weeks of life. She queried why the various clinicians involved with EGB did not identify that he had been subject to abuse or mistreatment.

FURTHER INVESTIGATIONS AND CPU REVIEW

74. Given the circumstances of EGB's death and the healing injuries that were identified at the time of his collapse on 29 August 2021, this case was referred to the Coroner's Prevention Unit (**CPU**)[5] for an independent review of the medical treatment he received in the lead up to his passing. Furthermore, as EGB's death was the result of non-accidental injury inflicted by a family member, this case was also reviewed as part of the Victorian Systemic Review of Family Violence Deaths (**VSRFVD**).[6]

Family violence review

[5] 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.

[6] 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.

75. Given the suspicious nature of EGB's death, police and Child Protection became involved, the latter with the couple's elder sons. During her discussions with the VFPMS, AHQ disclosed an incident when HVR put a hole in the wall and kicked a vacuum cleaner, however this occurred prior to their children being born. She further reported that HVR never perpetrated family violence against her, although noted in the weeks prior to the fatal incident, his "*temper has been a bit short towards the other boys*" and she had to tell him to stop "*because he was scaring the kids when he was yelling*" at them. She also noted that he was rough with the children on occasions.

76. Other than these incidents, there was no reported or documented history of family violence occurring in the family.

Expert report of Dr Joanne Tully, 28 September 2021

77. As noted above, Dr Tully reviewed EGB in life, interviewed his parents and compiled a detailed expert report. She provided this report prior to the autopsy report authored by Dr Ho, but with the benefit of some post-mortem testing and imaging. As a result of the history provided, clinical examination, pathology tests and radiological investigations, Dr Tully identified the following injuries, abnormalities and concerns:

    a) Severe global hypoxic ischaemic brain injury and brain swelling.

    b) Bilateral, multicompartment subdural haemorrhages over the cerebral convexities and in the posterior fossa.

    c) Subarachnoid and intraparenchymal haemorrhages.

    d) Unilateral mild retinal haemorrhages.

    e) Extensive spinal subdural haemorrhages.

    f) Possible ligamentous/soft tissue injury to the neck.

    g) Multiple bilateral rib fractures in different stages of healing.

    h) A healing pelvic fracture.

    i) Metaphyseal fractures of the long bones (arms and legs).

    j) A possible splenic laceration reported on CT but not confirmed at autopsy.

k) A possible contused (bruised) pancreas.

l) Areas of likely bruising on the left forehead, behind the left ear and under the left arm.

m) An injury to the sublingual frenulum.

n) Abnormal liver function tests, an elevated lipase, anaemia and a mildly abnormal platelet function test.

o) A past history of abrasions to the nose, scratches to the face and bruising to the checks.

p) A history of bruising to the suprapubic area and scrotum at the age of 11 days at which time a chest x-ray demonstrated rib fractures (which was incorrectly reported as 'normal' at the time).

q) A diagnosis of a brief resolved unexplained event (**BRUE**) about two weeks prior to death at which time a second chest x-ray was taken and demonstrated healing and recent rib fractures (which was also incorrectly reported as 'normal' at the time).

78. Dr Tully noted that EGB presented for medical care on a number of occasions prior to his death. He sustained abrasions to his face, genital bruising, a BRUE and bleeding from his nose. Multiple rib fractures were present at the time of his presentation; however, these were retrospectively diagnosed and were considered normal at the time. In an infant of EGB's age, Dr Tully opined that these injuries and presentations generate a very high level of concern about inflicted mechanisms for his injuries. The different stages of healing rib fractures identified on chest x-rays when he was two and six weeks of age suggested multiple episodes of trauma to the ribs.

79. Dr Tully opined that EGB sustained multiple injuries during his life, including a pelvic fracture and possible intraabdominal injuries. Not all these injuries could be explained by shaking, and the precise mechanism by which some of the injuries occurred had not been determined.

80. As of September 2021, there was no evidence of any naturally occurring medical condition that would reasonably explain the child's clinical presentation or the constellation of his injuries.

Root Cause Analysis

81. A multiagency review was performed involving RCH, Northern Health and St Vincent's Private Hospital. The review identified four critical points in time when there was a possibility for clinicians to have recognised the signs of traumatic injury and intervened:

    a) 11 July 2021 presentation to RCH for nose lesion.

    b) 14 July 2021 presentation to the Northern Hospital and RCH for scrotal bruising.

    c) 12 August 2021 presentation to Northern Hospital for a BRUE in the bathtub.

    d) 28 August 2021 presentation to VVED for a torn frenulum.

82. The multidisciplinary review noted the following contributing factors that influenced the decision-making at the time of each admission:

    a) Failure to recognise inflicted trauma.

    b) Failure to act on suspicion of inflicted trauma.

    c) Potential cognitive and cultural bias.

    d) The chest x-ray taken during the 12 August 2021 was reported as normal.

83. The review noted that each presentation for EGB had clinical signs and symptoms that were attributed to other causes and were not recognised at the time as inflicted trauma.

Scrotal bruising

84. The review noted that a handover between the Northern Hospital staff and the RCH staff did not include the former's suspicion of inflicted trauma. The review opined that this was likely due to the transfer occurring overnight, and the potential reluctance of clinicians to document concerns for inflicted trauma.

85. The review explained that testicular torsion can cause scrotal swelling and discolouration, but it does not cause bruising of the scrotal skin. The Neonatal Intensive Care Unit (**NICU**) consultant at RCH reviewed the scrotal clinical practice guidelines (**CPGs**) upon EGB's admission and did not find any reference to inflicted trauma as a cause. Additional differential diagnoses were not considered when the nasopharyngeal aspirate tested positive for adenovirus.

X-rays and rib fractures

86. The review noted that the initial x-ray taken on 14 July 2021 showed anterior rib fractures that were "*very subtle*", while the x-ray taken on 12 August 2021 showed obvious rib fractures and new acute rib fractures that should have been detected by an adult or paediatric radiologist.

87. The panel further noted that there was no easy way to share images between the Northern Hospital and the RCH.

BRUE

88. The review noted that BRUE is not a diagnosis in of itself and that the COVID-19 related restrictions in place at the time may have reduced the ability to gather collateral information.

Torn frenulum

89. The review found that multiple health professionals either did not detect or document a concern about this being due to inflicted trauma. Furthermore, video telehealth (as used on this occasion) does not permit an adequate examination of a child. This was an unintended consequence of COVID-19. Northern Health reportedly changed their VVED policy for any child under three months to have a face-to-face review within 24 hours.

Communication between health services

90. The review noted that there was no easy way for hospitals to know the frequency that a baby presents to a range of health services across the state. The review thought that this was not considered to be a major factor, as the hospital discharge summaries were forwarded to the MCHN and the GP for review. The CPU noted that it is correct that discharge summaries are routinely sent to a GP, GPs do not always have the time to scrutinise all discharge summaries in detail and/or some medical record systems may not make it straightforward to review the discharge summary. The CPU opined that sending a discharge summary to a GP is not equivalent to having a shared Electronic Medical Record (**EMR**) between health services.

External contributing factors

91. The external contributing factors that were considered included:

    a) Links with external health services

    b) Policies/guidelines not current best practice

    c) Policies/guidelines were used but were not useful

d) Inadequate training

e) Patient factors including medical history, physical history and social history.

Findings and recommendations

92. The review identified three findings/lessons learnt:

e) Finding 1 - Clinicians had a cognitive bias resulting in a missed diagnosis of inflicted trauma. This infant presented to multiple practitioners and units within and out of the hospital and no clinician seriously considered inflicted trauma. This was an issue in all of the following presentations:

i. Presentation with nasal grazing.

ii. Presentation with BRUE.

iii. Interpretation of chest x-ray during BRUE admission.

iv. Transfer and admission for scrotal bruising.

v. Torn frenulum.

f) Finding 2 – The CPG for acute scrotum does not include information on the differences between bruising, inflammation or redness, resulting in a missed diagnosis of inflicted trauma. When reviewing the CPG at the time of admission, there was no further information about potential inflicted trauma or indications that scrotal bruising can be viewed as a sentinel injury.

g) Finding 3 – The current CPGs for BRUE do not include information on injuries as a differential diagnosis, resulting in a missed diagnosis of inflicted trauma. The current CPG for BRUE also does not have information regarding the possibility of inflicted trauma to explain the cause.

93. The review made the following recommendations:

h) Recommendation 1 – RCH to build the functionality in EMR to enable clinicians to identify the potential risk of inflicted trauma for infants under 12 months of age and trigger the appropriate response. The review noted that infants under the age of 12 months were identified as the highest risk group, whilst balancing the potential for

alert fatigue if all paediatric patients had the requirement to complete an algorithm. The algorithm would record the decision process regarding inflicted trauma for this group of patients.

i) Recommendation 2 – Ensure clinicians use this EMR functionality for all infants under 12 months of age at the time of ED presentation. The review noted that the majority of inflicted injuries are admitted through the ED and that the RCH intended to build the process into the ED first, then would assess feasibility of further roll-out to other areas of the hospital.

j) Recommendation 3 – Amend the existing CPG for an 'acute scrotum' to differentiate between an acute scrotum and a bruised scrotum.

k) Recommendation 4 – Amend the existing CPG for a BRUE to include an alert box to consider inflicted trauma as a possible cause of injury.

l) Recommendation 5 – Develop an e-learning module on 'inflicted trauma' that is required for all staff at the RCH. The module is to include further resources on sentinel injuries (accessible to all staff) and links to self-directed learning packages on inflicted trauma and recognising and responding to inflicted trauma.

94. With respect to the first recommendation, the CPU noted that while it was a positive initiative for RCH, it did not cover other health services in Victoria. The CPU opined that it would be appropriate to have a systemic approach to this issue, rather than each individual hospital having their own individual approach.

Statement of Dr Suzanne Miller, Acting Director of VVED

95. Dr Miller explained that VVED clinicians can access previous consultation notes and investigations performed at Northern Health when assessing a patient via the VVED. However, VVED clinicians cannot review a medical record from another health service. Patients can send clinical images and videos through the Health Direct video call program, or they can email them to a designated VVED email address. The VVED clinician can review materials submitted by patients via Health Direct or the VVED email address, however, still cannot access the full medical record of another health service.

96. Dr Miller noted that since 2024, through the VVED paediatric community of practice, a non-accidental injury CPG for the virtual setting has been developed to assist clinicians. Other

common paediatric presentation guidelines, with built-in, age-specific risk assessment tools have also been developed. These guidelines and tools have been developed in-line with the Paediatric Improvement Collaborative, the framework representing current best practice across most Australian states. These has not been developed and were not in place in August 2021.

Statement of Dr David Tran, Divisional Director of the Women's and Children's Division, Northern Health

Policies/guidelines

97. With respect to the detection and investigation of a possible non-accidental injury, Northern Health has a 'Paediatric – Child & Adolescent Safety & Wellbeing' policy. This was created on 22 February 2011 and was most recently updated on 29 April 2025. Dr Tran noted that Northern Health also routinely follows the RCH's CPGs and would refer to the RCH CPG on Child Abuse, if required.

Admission for BRUE on 12 August 2021

98. Regarding EGB's admission on 12 August 2021, Dr Tran stated that there "*was no overt physical trauma or injury to EGB that raised suspicion of any neurological injury that would warrant a cranial ultrasound*". The CPU opined that this response is precisely why BRUE in of itself needs to be considered a potential red flag for non-accidental injury, as a child may not present with an overt injury, as was the case with EGB.

Chest x-rays on 14 July and 12 August 2021

99. The CPU noted that the chest x-rays taken on 14 July and 12 August 2021 at Northern Hospital were initially reported as normal. Upon a retrospective review of these x-rays by a consultant radiologist at the RCH, rib irregularities and fractures were identified. Northern Health was asked to outline the process for review of paediatric radiology interventions and reporting at Northern Health, and whether this case was reviewed by the hospital's radiology team.

100. Dr Tran explained that in 2021, the Radiology service at Northern Health was run by an external company (Lumus Imaging). In October 2023, this was taken over by Northern Imaging Victoria, an in-house radiology service.

101. At the time of EGB's two chest x-rays on 14 July and 12 August 2021, they were reported as normal by a General Radiologist, employed by Lumus Imaging. When EGB returned to the

Northern Hospital on 29 August 2921, he underwent a routine chest x-ray which identified rib fractures of various ages. Staff then reviewed the previous two chest x-rays and discussed them with the Radiologist, and an amendment was made to the 12 August 2021 x-ray. Northern Health advised that it was unsure whether an overall review was performed by Lumus Imaging regarding paediatric radiology interventions.

102. Dr Tran explained that since transitioning to an in-house radiology team, Northern Imaging Victoria has employed an additional two paediatric radiologists for a total of three paediatric radiology consultants. The current practice at Northern Health is for paediatric radiology investigations to be reported by a mixture of subspecialty trained paediatric radiologists and general radiologists with an interest in paediatric radiology. For any complex or uncertain imaging results, or in cases that involve a suspected non-accidental injury, a paediatric radiologist will oversee the reporting. Double reads between two radiologists also now occur for suspected non-accidental injury.

Independent review by Northern Health

103. Dr Tran explained that this case was reviewed by the Paediatric and Paediatric Emergency units at Northern Health, as well as at the joint Morbidity and Mortality meetings. This was in addition to the multi-agency RCA, outlined above. The review acknowledged that there were missed opportunities to identify EGB as a child at risk earlier, however "*clinicians at multiple health services had been falsely reassured by a family unit that did not have any of the usual red flags such as financial or mental health risk factors, no drug or alcohol history. There was no known previous interaction with child protection and no previous history of domestic violence*".

Supplementary statement of Dr Joanne Tully, VFPMS

104. As noted above, Dr Tully medically reviewed EGB in life, interviewed his parents, and reviewed his medical history, while he was admitted to the RCH. She provided a comprehensive report on 28 September 2021, which was prior to the autopsy report authored by Dr Ho. Once the full autopsy report was available, the Court sent it to Dr Tully with further questions and Dr Tully provided a supplementary statement on 20 June 2025.

105. Dr Tully noted that the autopsy report of Dr Ho did not alter the opinions expressed in her 28 September 2021 report, namely, that she was of the view that EGB sustained injuries on multiple occasions throughout his life, that all or most of these injuries were inflicted, that the

mechanisms of injury almost certainly included (but were not limited to) shaking with or without associated head impact, and that no naturally occurring medical condition was identified that could reasonably explain his presentations. Dr Tully noted HVR's admission that he shook the child on 27 August 2021, however noted that there was likely to have been an additional intervening event that occurred just prior to the collapse on 29 August 2021.

106. Considering the information from Dr Ho's report, Dr Tully made the following additional comments:

a) Recent bilateral convexity and falcine subdural haemorrhage, and parafalcine subarachnoid haemorrhages, were documented at autopsy. Dr Ho also identified deficient bridging veins on either side of the falx cerebri as well as histological evidence suggesting disruption of a vein in the parasagittal subarachnoid space. She noted that these findings are strongly associated with the recent application of acceleration-deceleration and rotational forces to the head, and that support shaking as a mechanism of head trauma in EGB's case.

b) No retinal haemorrhages were identified at autopsy, although a few intraretinal haemorrhages in the right eye were observed by the ophthalmologist during clinical examination two days prior to EGB's death. Intraretinal haemorrhages resolve rapidly, and interval resolution could explain this discrepancy. Optic nerve sheath haemorrhage was identified at autopsy, and this finding is in keeping with trauma. Dr Tully's original opinion regarding the significance of retinal haemorrhages identified clinically remained unchanged.

c) A CT of EGB's abdomen performed prior to his death raised the possibility of an intra-abdominal injury (specifically, the presence of fluid with features of possible bruising or tearing of the spleen). A post-mortem CT scan raised the possibility of a bruised pancreas but did not find evidence of splenic injury. While the autopsy did not identify evidence of injury to the intra-abdominal organs, there was evidence suggesting previous blunt force abdominal injury (fibrous tissue in the omentum). Autopsy findings also included haemorrhage into the posterior mediastinum, and while this could be attributed to CPR, prior blunt force trauma to the chest could not be excluded as a cause. Given the finding of multiple rib fractures in different stages of healing, impact to and/or compression of the chest/upper abdomen were possible mechanisms for the child's chest and abdominal injuries.

d) Dr Ho reported multiple rib and limb fractures (including posterior rib fractures and classic metaphyseal fractures) all demonstrating features suggesting various stages of healing. None of the rib fractures had features suggesting they were recent. This is in keeping with rib injury occurring at least a week or so prior to death. A CT scan performed two days prior to EGB's death identified two posterior rib fractures (one definite, one possible) that were reported as recent (no radiological signs of healing). In her original report, Dr Tully opined that the presence of recent posterior rib fractures (as reported radiologically) in combination with intracranial and spinal subdural haemorrhage and retinal haemorrhages, supported a recent episode of shaking as a single unifying cause for this constellation of injuries. The information provided by the autopsy findings regarding rib fracture timing indicates that the rib fractures were unlikely to have occurred during the reported shaking episode on 27 August 2021 or during any event that might have occurred prior to the collapse on 29 August 2021.

e) Signs of impact to the head were identified at autopsy, including a right occipital subgaleal haematoma, bruises to the back of the neck, right frontal scalp bruising and bruising behind the right ear. This pattern of bruising indicated blunt force trauma to the head, with more than one impact site. Dr Tully noted that there is increasing evidence to suggest that impact to the back of the head may produce a spectrum of intracranial and eye injuries similar to that typically attributed to shaking (including bilateral subdural haemorrhage and retinal haemorrhages), likely due to the magnitude and rotational component of the forces generated by occipital impact. Dr Tully noted that the child was allegedly dropped a few weeks before his death, however she had no additional information that would allow her to date the occipital haematoma, so the alleged drop could not be excluded as a possible cause. More recent blunt force trauma to the back of the head was also possible.

Opportunities for intervention

107. Dr Tully opined that there were opportunities for healthcare providers to intervene in EGB's case, and had an intervention occurred, she opined that it was highly likely that outcome would have differed. Dr Tully noted there is a well-recognised association between the presence of seemingly minor injuries in an infant who is not yet mobile, and later, more serious or fatal trauma. To reflect this association, such injuries are termed 'sentinel injuries'. Important sentinel injuries including bruising and oral injury (e.g., frenulum tears). Unidentified or

unrecognised sentinel injuries leave children vulnerable to further injury and early detection has the potential to prevent serious or fatal child maltreatment.

108. However, infants rarely present to health professionals with a minor injury as the chief complaint, meaning that vigilance is required to detect sentinel injuries and (given that many infants may present as clinically well), the significance of the injury must be appreciated to ensure an appropriate response is undertaken to protect the child. Dr Tully noted that leading paediatric organisations recommend that infants with sentinel injuries undergo a comprehensive evaluation for abuse (which would typically involve radiological imaging to identify occult bony injury, an eye exam searching for signs of trauma, and head imaging searching for signs of intracranial injury). In many cases, Child Protection would be notified.

109. In the eight weeks prior to EGB's death, he presented to several healthcare providers on at least four occasions. On three of these occasions, he was examined, and abnormal findings were documented (facial abrasions, genital bruising, frenulum laceration), however the fact that these findings were injuries was not recognised. Therefore, the potential significance of the findings in relation to non-accidental trauma was not appreciated.

110. In addition to visible signs of injury, Dr Tully noted that there are other presentations in infancy that should prompt consideration of non-accidental injury, including BRUEs, unexplained vomiting without diarrhoea or fever, prolonged crying and irritability (which can be a sign of a head injury). In EGB's case, his BRUE was investigated, but important radiological evidence of bony injury that was present, was not detected.

111. Despite an increasing awareness of the importance of detecting infant injuries that is encouraging, there is good evidence that these injuries are still all too frequently missed. This is despite the availability of clinical decision aids such as the TEN-4-FACES clinical decision aid and applications such as LCAST and Child Protector, which can be freely installed on a smartphone. There are also various screening tools, checklists, flowcharts, protocols and the development of quality improvement initiatives to improve provider recognition and response (such as orders or prompts embedded into the EMR), local hospital-based education, written guidelines, and the use of reminder strategies. Dr Tully noted that there is evidence that the use of standardised screening in EDs combined with staff training can increase the recognition of suspected non-accidental injury.

112. Dr Tully opined that there are many factors that likely contribute to the inability of healthcare providers to reliably detect inflicted injury, and that contributed to the missed opportunities to

intervene in this case. When considering ways to improve recognition and response, these barriers are important to understand. Barriers may include:

a) Failure to detect infant injuries – not conducting a thorough top to toe examination of all infants presenting for healthcare, particularly those presenting to the ED.

    i. Dr Tully noted that EGB *was* thoroughly examined, and abnormal findings *were* detected, however their significance was not recognised.

    ii. Dr Tully explained that the ED is busy, there may be a high volume of sick children and through-put is rapid. Due to the increased demand for acute healthcare services, there has been an increase in "*waiting room medicine*" where infants may be seen quickly, not thoroughly examined, then discharged. The increasing use of telehealth and virtual consultations may compound this problem, due to the limitations imposed by telehealth that preclude adequate investigation.

b) Failure to recognise the significant of infant injuries – lack of specialised training or expertise in the recognition of child abuse.

    i. Gaps in knowledge, particularly for healthcare providers working in non-paediatric settings (such as adult EDs, some virtual EDs and GP practices) regarding infant development, the epidemiology of infant injuries and the significance of minor injuries can result in diagnostic error. An individual clinician may rarely encounter a suspicious injury, meaning that reliance on pattern recognition processes is unreliable. In addition, the carers of injured infants do not usually disclose abuse but may seek care for other problems or for symptoms related to injury (excessive crying, vomiting, BRUE). On occasions, information may be deliberately withheld or a false narrative provided.

c) Cognitive bias and institutional culture.

    i. Social stereotypes and cognitive bias can preclude consideration of child abuse and cause a clinician to accept a caregiver's explanation for an injury too readily. The false assumption that child abuse is rare, the perception of professional risk, and the perceived negative outcomes of making the diagnosis, may all affect a clinician's willingness to consider inflicted injury.

Child abuse is not palatable to public health messaging and is a source of institutional risk.

d) Barriers to communication and information sharing.

i. There is no integrated medical record system that allows easy visibility regarding presentations to different health services in Victoria. The approach to non-accidental injuries requires multidisciplinary collaboration. While efforts have been made to establish local healthcare networks, the limitations around information sharing within Victoria persists.

113. Considering the barriers identified above, in conjunction with Dr Tully's first-hand experience, she made the following suggestions for my consideration:

a) To improve the recognition and response to infant injury, a system that minimises the risk of diagnostic error is required. Relying solely on education of individual healthcare providers is insufficient.

b) Detection of sentinel injuries would improve if healthcare providers had to fully undress and conduct a thorough top-to-toe examination of all infants presenting to emergency departments. Using standardised tools mandates a search for signs and symptoms of infant injury in every healthcare interaction. The universal use of such tools, in conjunction with targeted education, would standardise practice and moderate the risks associated with cognitive bias.

c) The use of virtual EDs in young infants (the group most likely to present with sentinel injuries and the group that has the highest risk of fatal inflicted injuries) presents a risk. In Dr Tully's view, young infants could be deemed ineligible for evaluation in a virtual ED on most occasions, because physical examination is required.

d) The increasing use of technology in medicine presents an opportunity for innovative solutions. Clinical decision aids and screening tools can be embedded in the EMR. Emergency technologies such as artificial intelligence may aid detection and improve diagnostic accuracy. Opportunities exist in Victoria to develop a statewide strategy to introduce procedures and tools to improve the recognition and response to non-accidental injury.

e) Ongoing education and upskilling of health professions in the recognition and response to child abuse is important. Healthcare providers should have ready access to the necessary expertise, including specialist paediatric radiology expertise. Prompting the use of 'local champions' within health organisations is likely to improve organisational culture and the willingness to consider the diagnosis of non-accidental injury. The introduction of mandatory training for healthcare providers with paediatric clinical responsibilities should be considered.

114. The CPU indicated it was fully supportive of Dr Tully's suggestions, noting her significant expertise in this area.

Discussion and conclusion

115. The CPU summarised the contributing factors in this case as follows:

a) Failure to detect infant injuries – not conducting a thorough top-to-toe examination in all infants presenting for healthcare, particularly those presenting to the ED.

b) Failure to recognise the significance of infant injuries – lack of specialised training or expertise in the recognition of child abuse.

c) Cognitive bias and institutional culture.

d) Barriers to communication and information sharing.

116. The CPU reiterated Dr Tran's comment that "*clinicians at multiple health services had been falsely reassured by a family unit that did not have any of the usual red flags such as financial or mental health risk factors, no drug or alcohol history. There was no known previous interaction with child protection and no previous history of domestic violence*". The CPU similarly noted that clinicians can be affected by cognitive bias regarding people who perpetrate child abuse and people who do not. This again highlights the need for universally used screening and detection tools that are designed to overcome such cognitive bias.

117. While the CPU was supportive of the RCH creating functionality in its EMR to enable clinicians to identify the potential risk of inflicted trauma for infants under the age of 12 months, it noted that this only covers infants who present to the RCH. Clinicians reviewing children in metropolitan or rural hospitals do not have access to that functionality in their EMR and will therefore not have access to the same prompts and suggestions. The CPU

suggested a systemic approach to this issue, rather than an individual approach at each hospital, would be appropriate.

118. I agree with the CPU. The RCH is likely best placed to develop such functionality and guidelines, however, cannot implement it statewide. In those circumstances, I intend to recommend that Safer Care Victoria work with RCH to create statewide guidance that adopts the RCH's functionality. This can then be rolled out statewide by Safer Care Victoria, to all hospitals, regardless of location.

119. I also note the concerns raised by the CPU about a lack of a statewide EMR, which would permit information sharing between health services. While I acknowledge the enormity of such a task, cases like this one are tragic examples of situations in which a statewide EMR would have been beneficial. I therefore intend to recommend that the Department of Health conduct a feasibility study to determine whether a statewide EMR can be implemented, and if so, provide a roadmap for implementation.

Procedural fairness responses

120. As a matter of procedural fairness, the Court wrote to Northern Health, the RCH, the MCHN and Lumus Imaging to provide them with an opportunity to respond to the concerns identified above.

Northern Health

121. In their correspondence to the Court, Northern Health acknowledged the missed opportunities to escalate EGB as a child at risk earlier. On the instances that he presented to Northern Health, staff *did* consider non-accidental injury as a potential cause, however they were falsely reassured by AHQ's responses, who was similarly unaware of the abuse perpetrated by HVR.

122. Northern Health advised that it remained committed to strengthening education within its service on the recognition and response to infant injuries; to minimise the risk of non-accidental injury cases being missed. EGB's case has been incorporated into Northern Health's formal education program via a 'Learnings from the past – case studies from past sentinel events' program. This program is presented twice per year.

123. Northern Health supported my proposed recommendation to Safer Care Victoria regarding the development of statewide guidance for clinicians assessing infants for the potential risk of inflicted trauma.

124. Northern Health largely agreed with Dr Tully's recommendations, noting her significant expertise as a forensic paediatrician. While Northern Health acknowledged her view that young infants could be ineligible for evaluation in a virtual ED, Northern Health did not believe that virtual ED services should categorically exclude young infants from assessment.

125. Beyond the VVED, Northern Health noted a range of other virtual or telephone services such as 'Nurse on Call', which provide advice to parents about infants. Northern Health referred me to a paper published in the Journal of Paediatrics and Child Health, which reviewed the implementation of Paediatric VVED services in Victoria.[7] The paper noted that 26% of presentations to the VVED were infants (children less than one year old). This equated to 34,084 infants from a total of 130,821 patients who were seen in a two-year period. Northern Health contended that this would be a significant number of patients to limit access and would be a particular disadvantage for children in regional areas. Where a clinician determines that an in-person assessment is required, Northern Health submitted that this would be clearly discussed with the parents and appropriate arrangements could be made.

126. I acknowledge the differing positions between Dr Tully and Northern Health, and I am cognisant that any blanket ban/policy might have unintended consequences. This is particularly relevant for families in rural or regional locations, who might be heavily reliant on telehealth services like the VVED. Given the complexity of the issue, I am not minded to make a recommendation about this particular issue and note that the relevant authorities (Department of Health, Safer Care Victoria, VVED) are best placed to debate and resolve this issue.

MCHN

127. The Court wrote to the [redacted], who are responsible for the MCHN services in EGB's area. The [redacted] responded and advised that they did not wish to provide a response.

Royal Children's Hospital

128. The Court wrote to Lander & Rogers (**Landers**) who represent the RCH in this matter and provided them with an opportunity to respond to the potential adverse comments.

[7] Lawrence et al, *Implementation of a Paediatric Virtual Emergency Department: A Descriptive Analysis*, Journal of Paediatrics and Child Health, 16 December 2025.

129. Landers advised that they were instructed to make the following submissions about the RCA:

a) Of the various attendances where the RCA panel determined there was a possibility for the clinicians to identify non-accidental injury and intervene, EGB's attendances at RCH were two of the earliest in time, occurring on 11 and 15 July 2021.

b) RCH submitted that these two presentations should be considered within their specific context. The findings of the RCA were made with perspectives that were not available to the clinicians who were managing the EGB's at the time, including the benefit of hindsight, and with the input of various specialities, including forensic paediatric medical services.

c) The clinicians who reviewed EGB at the time of his RCH presentations were not specialists in forensic paediatric medicine. The clinicians at RCH did not have the benefit of hindsight and it is notable that, at the time of these presentations, EGB had very limited exposure to any other health services, and the family was not (to the clinicians' knowledge) involved with Child Protection.

d) When considering the context of these two early presentations to RCH and the information available to clinicians at the time and without the effect of hindsight, Landers submitted it was understandable why the clinicians who treated EGB did not have a higher degree of suspicion for non-accidental injury.

130. I acknowledge that the clinicians treating EGB were not specialist forensic paediatricians. I also acknowledge that the RCA is a review that is completed in hindsight, absent the competing priorities and time pressures facing frontline clinicians, with additional specialists who were not present at the time. While I acknowledge and appreciate the differing contexts, this does not diminish the findings of the RCA.

131. In relation to the proposed comment that "*all healthcare provides involved (including the RCH), had missed opportunities to intervene in EGB's case, and that an intervention is highly likely to have altered the fatal outcome*", Landers made the following submissions:

a) Any finding that healthcare providers could have prevented EGB's tragic death is highly speculative.

b) There is a great deal of uncertainty as to what would have eventuated if healthcare providers raised concerns regarding non-accidental trauma at an earlier time.

c) In particular, Landers noted that it was difficult to know what information would have been revealed, where the information would have been escalated to, and whether that information would have led to EGB being removed from the care of his family.

d) Further, Landers noted the removal of EGB from a parent would have likely required the involvement of the Department of Families, Fairness and Housing and potentially Victoria Police. Landers further noted that EGB's presentations occurred during the COVID-19 pandemic, when healthcare and government resources were under immense pressure. Landers submitted that it was therefore not clear what stakeholders would have been available to assess EGB's risk and determine the next steps.

e) Landers submitted that I consider and incorporate these inherent uncertainties when making any findings that intervention by healthcare providers would have altered EGB's tragic outcome.

132. I acknowledge the circumstances of EGB's presentations to RCH and other healthcare providers, namely the COVID-19 pandemic. This is particularly pertinent for the community-based presentations, for example, the MCHN and GP.

133. I also acknowledge there are some uncertainties about what might have occurred if healthcare providers identified or raised concerns about non-accidental injury. I accept that it would be speculative to attempt to determine what actions Child Protection and/or Victoria Police would have taken. However, in my view, that was not the purpose of the proposed comment. The point of the Court's correspondence to the RCH was not to attempt to determine what Child Protection and/or Victoria Police would have done. The purpose of the proposed comment was that there were multiple healthcare providers who did not identify the potential for non-accidental injury. If they *did* identify non-accidental injury, the missed opportunity is that the issue did not get escalated to the relevant authorities. Child Protection and/or Victoria Police did not have the *opportunity* to become involved with EGB, and in my view, that is the key missed opportunity.

Lumus Imaging and Radiologist

134. As noted above, Northern Health contracted its radiological services to Lumus Imaging at the time of EGB's presentations. The Court wrote to Lumus Imaging to provide them with an opportunity to respond to the proposed adverse comments. Lumus Imaging advised that they took my observations seriously and noted that they were reviewing the matters raised in the

Court's correspondence, including the supplementary statement of Dr Tully. The company advised it was considering opportunities to support continuous improvement in clinical governance and reporting. Lumus Imaging did not outline any specific actions or improvements that have been implemented following this case.

135. Lumus Imaging further noted that the radiologist who reported EGB's x-rays on 14 July and 12 August 2021 was not an employee but was engaged as an independent contractor at the relevant times.

136. The Court wrote to the radiologist, who is still be employed by Lumus Imaging as a contractor, to provide him with an opportunity to respond to the proposed adverse comments. The radiologist advised that he did not intend to file a response.

137. I accept that while Lumus Imaging was not *specifically* 'responsible' for interpretation of the x-rays at the relevant times, they were nevertheless contracted by Northern Health to provide radiological services. Lumus Imaging, in turn, contracted staff to perform this function. For the benefit of the organisation and their continuous improvement, in my view, it would have been prudent to for Lumus Imaging to undertake an internal review, involving the specific contractor. This is not to apportion blame but rather to allow the organisation to learn from the incident and make changes.

SUBMISSIONS ON BEHALF OF FAMILY

138. Pursuant to ordinary procedure, the Court wrote to AHQ and advised of my intention to close this case by way of written findings without holding an inquest. AHQ's solicitors wrote to the Court and provided submissions to the Court dated 27 July 2026.

139. AHQ's solicitors noted my intention to find that there were multiple missed opportunities for healthcare providers to intervene and prevent the fatal incident. Her solicitors noted that Northern Health and the RCH had various policies and procedures in place for detecting and reporting suspected cases of child abuse and non-accidental injury. Her solicitors also submitted that it was open for me to find that if the rib fractures had been reported correctly on 14 July and/or 12 August 2021, EGB would have likely:

    a) Undergone further medical examination and investigation;

    b) Been referred to the hospital Social Work team;

    c) Been reported to Child Protection;

d) Been linked with ongoing supports; and/or

e) Not been discharged home without a safe discharge plan.

140. I agree that if the rib fractures were reported correctly, then any of the above steps *may* have been taken. However, I cannot determine what would have happened with certainty. For example, I cannot determine if Child Protection would have progressed the report to an active investigation and intervention or closed the report at the intake stage. Similarly, I cannot determine what the additional medical examinations/investigations would have uncovered, and whether they would have confirmed the injuries were non-accidental in nature.

141. AHQ's solicitors noted that if any of the above steps had been taken, the following may have occurred:

a) Further fractures may have been identified, including long bone fractures and a pelvic fracture;

b) AHQ and her family would have been assessed by a hospital social worker, Child Protection and/or a community family support service.

c) HVR would have been put on alert that his behaviour was placing EGB at risk.

d) If, after the referral or reporting, EGB suffered the BRUE or the torn frenulum, the relevant hospital would have been aware of a history of non-accidental injury, and any Child Protection intervention would likely have escalated.

e) AHQ would also have likely taken protective steps for the benefit of her family.

142. AHQ's solicitors concluded that on the balance of probabilities, if the above steps had been taken, EGB would not have suffered shaking-related injuries in the days before his death.

143. I accept that if any of the above steps occurred, then the possibility that EGB would have suffered shaking-related injuries in the days before his death may have been reduced. However, it would be speculative to form such a view with absolute certainty on the available evidence.

144. Taking the evidence at its highest, I find that there were multiple missed opportunities for healthcare providers to intervene in EGB's case and potentially prevent the fatal outcome.

FINDINGS AND CONCLUSION

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

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

    b) the death occurred on 31 August 2021 at The Royal Children's Hospital, 50 Flemington Road, Parkville Victoria 3052, from head injuries; and

    c) the death occurred in the circumstances described above.

146. Having considered all the circumstances, I am satisfied that multiple healthcare providers missed opportunities to intervene in EGB's case. This intervention may have involved contact with Victoria Police, Child Protection and/or social workers or other clinicians, although I cannot determine what would have occurred had such interventions taken place. However, any intervention may have assisted in preventing the fatal outcome or reducing the likelihood of EGB sustaining the injuries that led to his death.

RECOMMENDATIONS

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

(i) That **Safer Care Victoria** work with RCH to create statewide guidance that adopts the functionality developed for the RCH's EMR, namely, to help clinicians identify the potential risk of inflicted trauma for infants under 12 months of age and trigger the appropriate response. The algorithm would record the decision-making process regarding inflicted trauma for this group of patients. This functionality/guidance should be rolled out statewide by Safer Care Victoria, to all hospitals, regardless of location.

(ii) That the **Department of Health** conduct a feasibility study to determine whether a statewide EMR can be implemented, and if so, provide a roadmap for implementation.

I convey my sincere condolences to EGB'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:

AHQ, Senior Next of Kin (C/- Slater & Gordon)

Commissioner for Children and Young People

Department of Families, Fairness and Housing

Department of Health

Lumus Imaging

Northern Health

Royal Children's Hospital (C/- Lander & Rogers)

Safer Care Victoria

Detective Senior Constable Telen Stanfield, Coronial Investigator

Signature:

Judge Liberty Sanger, State Coroner

Date: 07 September 2026

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.