IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 003672

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:	Lily Grace Arbuckle
Date of birth:	4 April 2021
Date of death:	11 July 2021
Cause of death:	1(a) Head injury
Place of death:	The Royal Children's Hospital Melbourne 50 Flemington Road, Parkville, Victoria, 3052
Keywords:	Family violence; Filicide; Infant death

BACKGROUND

1. On 11 July 2021, Lily Grace Arbuckle was 9 weeks old when she passed away at the Royal Children's Hospital in Victoria. At the time of her death, Lily lived with her parents, Melissa and Jed Arbuckle at 38 Deans Road, Upwey, Victoria, 3158.

2. Melissa met her partner Jed Arbuckle in 2015 when they were both students at Melbourne University. The couple got married in 2019 and bought a house together in the Upwey. Melissa qualified as a veterinarian and spent a few years in clinical practice before working in pet health sales with Blackmores.

3. During the course of the COVID-19 pandemic, the couple decided to try for a baby and Melissa became pregnant in July 2020. Lily was born on 4 April 2021.

4. Melissa had no reported history of alcohol or illicit substance abuse. There is no family history of mental illness. Prior to the birth of her daughter Lily, Melissa had no reported or known history of mental illness, suicidality or self-harm.

5. Melissa's pregnancy was uncomplicated but Lily's birth was by emergency caesarean due to a prolonged labour period.

6. From April to 11 July 2021, Melissa experienced a number of issues with breast-feeding Lily and significant post-natal depression. Melissa continued to raise lactation concerns with Dr Strybosch (Lactation Consultant) throughout June 2021[1] Melissa relocated to aunt-in-law's residence in Melbourne due to severe storms cutting power in the Upwey area. This caused Melissa more stress due to Lily being even more unsettled.

7. On 5 July 2021, Melissa became alarmed about a rash on Lily's leg and about her perception of Lily having lost condition in her leg and having a weaker cry. The couple took Lily to Angliss Hospital to be examined and were discharged with medical staff noting no remarkable findings. Melissa didn't accept this advice and became increasingly convinced that there was something wrong with Lily.

8. On 7 July 2021, Jed asked a neighbour to check on Melissa because of his concern about her mental state. On that same day, Melissa made a list of all the signs that she perceived in Lily

[1] Statement of J Strybosh dated 16 August 2022, 2

that indicated there was something wrong with her, such as weak muscle tone. Melissa became preoccupied with concerns that she had somehow injured Lily.

9. On 10 July 2021, Melissa told her husband that she had not been sleeping due to her concerns about what she might have done to Lily and that she was having suicidal thoughts. Duringthe period from 8 July to 11 July 2021, Melissa drafted and completed a suicide note and had numerous social media conversations with friends expressing anxiety about medical issues relating to herself and Lily, lactation issues, feeling stressed without electricity at home and feeling inadequately support and worried about Lily's wellbeing.

THE CORONIAL INVESTIGATION

10. Lily'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.

11. 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.

12. 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.

13. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Lily's death. The Coroner's 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.

14. This finding draws on the totality of the coronial investigation into the death of Lily Grace Arbuckle 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.[2]

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

Circumstances in which the death occurred

15. On 11 July 2021, Melissa took Lily for a walk at around 10.30am. Family members visited the house in the course of the day and later in the afternoon Jed left to play tennis. By 4.00pm all the family visitors had departed and Melissa left the house pushing Lily in her pram.

16. Melissa sent a message to Jed at 4.18pm saying that '*Muffin was losing it after a feed'*[3] and that she was intending to go for a walk with Lily as her mother and sister had left.

17. Whilst on the walk, Melissa searched for information about train timetables. At 4.53pm, Melissa took Lily from the pram and as a train approached she was seen by a train driver standing at the top of the Kumbada Avenue, holding Lily at chest height and using her hand to wave at the train.[4]

18. At 5.06pm, Melissa was seen by a train driver holding Lily about six to ten metres from the track. The train driver activated his train whistle as a warning when he realised that her manner was suspicious when she was about five metres from the track.[5] He then activated the train's full emergency braking system.[6]

19. Melissa placed Lily on one of the train tracks in the path of the train. Then, Melissa attempted to lay down on her side on the train track. They were then both struck by the train. Lily was struck by the train and thrown underneath. Melissa was seriously injured and suffered multiple fractures to her shoulder, neck and other injuries to the right side of her body.

20. Emergency services were contacted and Ambulance paramedics transported Melissa to the Royal Melbourne Hospital and Lily to the Royal Children's Hospital. Lily was airlifted from

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[2] 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.

[3] *Coronial Brief*, Exhibit 7 – SMS history

[4] *Coronial Brief*, Statement of metro train driver dated 15 July 2021, 55-56; Exhibit 13 – CCTV footage 15 Kumbada Ave, Upwey

[5] Ibid

[6] Ibid

the scene and arrived at the Royal Children's Hospital at 7.17pm but attempts to resuscitate her were unsuccessful and she was pronounced deceased at 11.49pm.[7]

21. On 7 April 2022, in the Supreme Court of Victoria, Melissa was convicted of infanticide and released on an adjourned undertaking of good behaviour for three years and continual mental health treatment.

Identity of the deceased

22. On 11 July 2021, Lily Grace Arbuckle, born 4 April 2021, was visually identified by her father, Jed Arbuckle.

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

Medical cause of death

24. Forensic Pathologist Dr Linda Iles from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an autopsy on 12 July 2021 and provided a written report of her findings dated 27 October 2021.

25. The post-mortem examination revealed the following:

    a) Evidence of severe head injury and traumatic haem pneumatoceles within the lungs;

    b) In addition there was a complete displaced fracture to the proximal left humerus and multiple rib fractures; and

    c) No evidence of any natural diseases contributing to the death.

26. Toxicological analysis of post-mortem samples did not identify the presence of any alcohol or any commons drugs or poisons.

27. Dr Iles provided an opinion that the medical cause of death was 1 (a) Head injury.

28. I accept Dr Iles's opinion.

FURTHER INVESTIGATIONS AND CORONER'S PREVENTION UNIT REVIEW

[7] *Coronial Brief*, Exhibit 46 – Lily Arbuckle medical records from RCH, 20

29. For the purposes of the *Family Violence Protection Act 2008*, the relationship between Melissa and her daughter Lily was one that fell within the definition of '*family member*[8] under that Act. Moreover, Melissa's actions in placing Lily on dangerous train tracks constitutes '*family violence'*.[9]

30. In light of Lily's death occurring under circumstances of proximate family violence, I requested that the Coroners' Prevention Unit (**CPU**)[10] examine the circumstances of Lily's death as part of the Victorian Systemic Review of Family Violence Deaths (**VSRFVD**).[11]

Maternal child health services provided to Melissa and Lily prior to the fatal incident

31. Lily and Melissa were engaged with Yarra Ranges Maternal and Child Health Services (MCH), with their first appointment being 13 April 2021 during which Melissa, Jed and Lily were visited by a MCH Nurse at their home.[12]

32. At the 13 April 2021 consultation, Lily was 9 days old. Postnatal depression was discussed during this appointment and Melissa reported that Jed was supportive and that she was aware of the support services listed in Lily's Green Book.[13]

33. On 20 April 2021, Melissa, Jed and Lily attended MCH Centre for an appointment and a two week hearing screen and consultation was conducted.[14] During this appointment, Jed and Melissa were both noted to be '*well'*.[15]

34. On 27 April 2021, Melissa and Lily attended at MCH Centre for an appointment for a four week consult.[16] During this consultation a mental health and wellbeing screen was conducted and Melissa noted that she was not feeling '*down, depressed or hopeless'*.[17]

[8] Family Violence Protection Act 2008, section 8(1)(a)
[9] Family Violence Protection Act 2008, section 9
[10] The Coroners Prevention Unit is a specialist service for Coroners established to strengthen their prevention role and provide them with professional assistance on issues pertaining to public health and safety
[11] 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
[12] Coronial Brief, Exhibit 42 – Maternal and Child Health Records of Lily Arbuckle, 18-19.
[13] Coronial Brief, Exhibit 42 – Maternal and Child Health Records of Lily Arbuckle, 18-19.
[14] Coronial Brief, Exhibit 42 – Maternal and Child Health Records of Lily Arbuckle, 15-17.
[15] Coronial Brief, Exhibit 42 – Maternal and Child Health Records of Lily Arbuckle, 16.
[16] Coronial Brief, Exhibit 42 – Maternal and Child Health Records of Lily Arbuckle, 13-15.
[17] Coronial Brief, Exhibit 42 – Maternal and Child Health Records of Lily Arbuckle, 15.

35. On 18 May 2021, Melissa contacted MCH 24 Hour Hotline. Melissa was noted as being '*teary on and off*'[18] during the phone call and stating *'I feel like I'm missing something and I feel like I'm not coping'*.[19] Melissa stated that she had had an emergency lower uterine segment caesarean section for Lily's birth and felt '*disappointed'*[20] by this experience. Melissa also noted that she was feeling unwell and was '*anxious'*[21] about Lily also becoming sick. Melissa advised that she had attended her General Practitioner (**GP**) and scored 11 on the Edinburgh Postnatal Depression Scale (**EPDS**) and had a plan to be reviewed by her GP in two weeks time. Melissa reported that Jed was supportive and feels that she is '*struggling with parenting'*.[22] It was also noted that Melissa was seeing a lactation consultant that week to assist with breastfeeding. A discussion was had regarding a referral to a first time parenting group, Sleep and Settling Clinic and Enhanced MCH. Melissa was also advised she could access a Mental Health Care Plan from her GP.[23]

36. On 19 May 2021, the MCH practitioner who responded to Melissa's call on 19 May 2021, consulted with the MCH Nurse Coordinator at the Yarra Rangers Shire.[24] Melissa was referred to Sleep and Settling Service[25] and allocated an additional 45 minutes for Melissa and Lily's next MCH appointment to complete the EPDS and be offered a referral to Enhanced MCH services. This information was communicated to Melissa and Lily's MCH nurses on the same day, who acknowledged receipt of this information.[26]

37. On 25 May 2021, Melissa was contacted by MCH and informed that a referral had been made to the Sleep and Settling service. During this conversation, Melissa advised that she was '*still struggling, and needs a time frame to set herself some goals'*.[27]

38. On 26 May 2021, the Sleep and Settling service contacted Melissa to arrange a time to meet.[28]

39. On 1 June 2021, Melissa and Lily attended MCH Centre for an eight week consultation.[29] During this appointment, Melissa advised that she had had a *'rough past few weeks, but also identified that she was possibly unwell/rundown'*. An EPDS was undertaken on this occasion

[18] Coronial Brief, Exhibit 42 – Maternal and Child Health Records of Ms Arbuckle Arbuckle, 9.
[19] Coronial Brief, Exhibit 42 – Maternal and Child Health Records of Ms Arbuckle Arbuckle, 9.
[20] Coronial Brief, Exhibit 42 – Maternal and Child Health Records of Ms Arbuckle Arbuckle, 9.
[21] Coronial Brief, Exhibit 42 – Maternal and Child Health Records of Ms Arbuckle Arbuckle, 9.
[22] Coronial Brief, Exhibit 42 – Maternal and Child Health Records of Ms Arbuckle Arbuckle, 9.
[23] Coronial Brief, Exhibit 42 – Maternal and Child Health Records of Ms Arbuckle Arbuckle, 9.
[24] Coronial Brief, Exhibit 42 – Maternal and Child Health Records of Ms Arbuckle Arbuckle, 9.
[25] Coronial Brief, Exhibit 42 – Maternal and Child Health Records of Ms Arbuckle Arbuckle, 9.
[26] Coronial Brief, Exhibit 42 – Maternal and Child Health Records of Ms Arbuckle Arbuckle, 8.
[27] Coronial Brief, Exhibit 42 – Maternal and Child Health Records of Ms Arbuckle Arbuckle, 7.
[28] Coronial Brief, Exhibit 42 – Maternal and Child Health Records of Ms Arbuckle Arbuckle, 7.
[29] Coronial Brief, Exhibit 42 – Maternal and Child Health Records of Lily Arbuckle, 10-12.

with Melissa scoring 14.[30] This score was originally miscalculated as being 13 and later amended to 14 upon recalculation. Recalculation occurred at an unknown date by an unknown person.[31]

40. On 4 June 2021, Melissa had her first Sleep and Settling consultation occurred via phone. During this appointment, Melissa advised that she '*has felt better emotionally over the last week'*.[32]

41. On 9 June 2021, Melissa was contacted by MCH Nurse for a wellbeing check and advised that Lily's routine had improved and felt as though they *had 'turned a corner'*.[33]

42. On 11 June 2021, Melissa was contacted by MCH and was advised of the Upwey New Parents Group which she could attend.[34]

43. On 18 June 2021, Melissa had her second Sleep and Settling consultation. Melissa noted that their family had to leave the family home as their power had gone out and would not be back on for several days. Melissa advised that moving between people's houses had been '*very stressful'*[35] and that she had '*really struggled and become emotional at times'*.[36]

44. On 29 June 2021, MCH contacted Melissa for an additional consultation.[37] During this consultation Melissa noted that she '*remains anxious re sleep and routine with Lily'*[38] and that both Lily and Melissa had had continuous thrush for two months.

45. On 2 July 2021, Melissa had her third Sleep and Settling consultation.[39] No concerns were noted during this consultation, however Melissa mentioned that she had felt overwhelmed and distressed during Lily's birth due to the urgent caesarean section and was noted to be '*still teary around this'*.[40]

46. Between 6-8 July 2021, MCH made five unsuccessful attempts to contact Melissa by phone.[41]

[30] Coronial Brief, Exhibit 42 – Maternal and Child Health EPDS, 1.
[31] Yarra Ranges Maternal and Child Health Services, Statement of B Hounslow, 10.
[32] Coronial Brief, Exhibit 42 – Maternal and Child Health Records of Ms Arbuckle Arbuckle, 6.
[33] Coronial Brief, Exhibit 42 – Maternal and Child Health Records of Lily Arbuckle, 8.
[34] Coronial Brief, Exhibit 42 – Maternal and Child Health Records of Lily Arbuckle, 7.
[35] Coronial Brief, Exhibit 42 – Maternal and Child Health Records of Ms Arbuckle Arbuckle, 3.
[36] Coronial Brief, Exhibit 42 – Maternal and Child Health Records of Ms Arbuckle Arbuckle, 3.
[37] Coronial Brief, Exhibit 42 – Maternal and Child Health Records of Lily Arbuckle, 4-5.
[38] Coronial Brief, Exhibit 42 – Maternal and Child Health Records of Lily Arbuckle, 5.
[39] Coronial Brief, Exhibit 42 – Maternal and Child Health Records of Ms Arbuckle Arbuckle, 1-2.
[40] Ibid, 2.
[41] Coronial Brief, Exhibit 42 – Maternal and Child Health Records of Lily Arbuckle, 1-2

47. On 14 July 2021, following Lily's death, one of the MCH nurse's engaged with Melissa and Lily attended clinical supervision and discussed their engagement with Melissa and Lily.[42] During this conversation, the MCH nurse noted that Melissa had asked why there was not '*a question there asking me if I want to hurt my baby?'*[43] in reference to the EPDS. The nurse reportedly concurred with Melissa that this should be asked but '*did not ask Melissa whether it was something she wanted to talk about'*.[44]

Lactation consultant services provided to Melissa in the lead up to the fatal incident

48. Melissa and Lily were engaged with lactation consultant, Dr Joanna Strybosch, from 12 April 2021 until the fatal incident. Melissa and Lily were seen six times during this period.

49. During these appointments, Melissa made several references that could indicate she was experiencing difficulties with her mental health.

50. On 26 May 2021, Melissa and Lily attended an appointment with the lactation consultant. During this appointment Melissa advised that she felt as though she was '*out of control and unsure what the routine is anymore'*.[45]

51. When filling out a COVID-19 Questionnaire on 7 June 2021, Melissa advised that her '*mental health'* would be at risk if she was not able to attend the appointment face to face.[46] This response does not appear to have been queried by the lactation consultant during the appointment on the same day.

52. On 7 July 2021, Melissa presented to an appointment '*anxious tat [sic] she has "caused brain damage" by rocking [Lily] in the pram to sleep'*.[47] Melissa further reported feeling '*overwhelmed and anxious'*.[48] Melissa was reassured that Lily was not cognitively impaired and was provided with information regarding a sleep school she could attend.[49]

COMMENTS

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

[42] Yarra Ranges Maternal and Child Health Services, Statement of B Hounslow, 9.
[43] Yarra Ranges Maternal and Child Health Services, Statement of B Hounslow, 9.
[44] Ibid.
[45] Coronial Brief, Exhibit 41 – Folio 1, 39.
[46] Coronial Brief, Exhibit 41 – Folio 1, 20.
[47] Ibid, 43
[48] Ibid, 43.
[49] Ibid, 44.

Adequacy of Maternal Child Health services

53. In a statement to the Court, the MCH Nurse Coordinator at the Yarra Rangers Shire, Belinda Hounslow, advised that:

> *In my opinion, Melissa and Lily should have had the following care undertaken by the Yarra Ranges Shire MCH Service regarding Melissa's mental health:*
>
> *a) an EPDS score should have been undertaken at the 4-week consultation with the MCHN, and repeated as required, including after the 1 June 2021 MCHN consultation;*
>
> *b) from the 4-week consultation, including during the undertaking of the EPDS score on 1 June 2021, a discussion between the MCHN and Melissa regarding whether Melissa felt that she may harm her baby ought to have occurred;*
>
> *c) when Melissa's EPDS score was 14 on 1 June 2021, she ought to have been referred immediately to her general practitioner for a mental health review, and referred to the Enhanced MCH Care program with discussion with Susan McDonald and me;*
>
> *d) Melissa should have been referred through the Enhanced MCH Program to the Council's Maternal and Child Health service Mental Health Nurse Jackie Williams, who provides psychological care to women and parents; and*
>
> *e) on 6, 7 and 8 July 2021, MCHN Patricia Stevenson made several phone calls to Melissa, left messages, and received no response. Usual practice required that MCHN Stevenson discuss this lack of response with me as MCHN supervisor. Escalation with a home visit or requesting Victoria Police to undertake a welfare check for Melissa and Lily was not strictly required because Melissa and Lily were not in the EMCH program. However, Melissa and Lily should have been in the EMCH program, and if so, escalation consequent to Melissa not responding to phone calls would have been required.*[50]

54. I concur with the concerns outlined by Ms Hounslow and note that a EPDS score of above 13 or above 'can be used for seeing symptoms of major depression in the postnatal period'.[51] Under the MCH Perinatal mental health and psychosocial assessment practice resource, MCH nurses are required to 'consider referral for mental health assessment and local pathways to care'[52] when a mother scores 13 or more in the EPDS.

55. Ms Hounslow further advised that MCH nurses at Yarra Ranges Shire MCH Services are required to undertake a secondary consult with her, a team leader or and enhanced team leader to discuss next steps when a parent scores 13 or above on the EPDS.[53] MCH nurses at Yarra

[50] Yarra Ranges Maternal and Child Health Services, Statement of B Hounslow, 17.
[51] Victorian Government, *Perinatal mental health and psychosocial assessment,* 25.
[52] Victorian Government, *Perinatal mental health and psychosocial assessment, 8 & 62*.
[53] Yarra Ranges Maternal and Child Health Services, Statement of B Hounslow, 7-8.

Ranges Shire MCH Services are also required to refer the parent to a general practitioner or phone a general practitioner to discuss concerns and next steps, speak with a support services that may already be engaged with the parent, refer to Enhanced MCH as required, and follow up with the client within one week to assess progress and query need for additional supports.[54]

56. I note that Question 10 of the EPDS queries a mother's thoughts of self-harm. The MCH *Perinatal mental health and psychosocial assessment* practice resource requires workers to investigate this question further with consideration for the infant's safety.[55] Workers are prompted to query whether the parent has had thoughts of harming their baby and document the results of this assessment.[56]

57. The available evidence suggests that these steps were not actioned by the MCH nurses engaged with Melissa during or following the consultation on 1 June 2021 and as a result, Melissa was not queried in relation to the risk she posed to Lily and was not engaged with Enhanced MCH services or additional supports. I am particularly concerned given that this was the second time that Melissa had made reference to experiencing difficulties with her mental health and wellbeing and had made comments, at an unknown date, to suggest that further enquiry regarding her risk to Lily was warranted.

58. The available evidence also suggests that Melissa was experiencing a decline in the mental health months prior to the fatal incident that was observed by her partner, Jed. In his statement to the Court, Jed made repeat references to indicators that Melissa's may have been experiencing post-natal anxiety or depression following Lily's birth, such as:

- Melissa was '*very anxious to be the prefect mum [sic]*'.[57]
- '*she was always anxious about whether she was on the right thing. I don't think she was ever satisfied that she was doing it right and she was always trying to improve things'*.[58]
- '*she didn't give herself a break and she didn't have anything to fall onto to take her mind off it. She was a bit obsessive about it and stated to see things that weren't there'*.[59]

[54] Ibid.
[55] Victorian Government, *Perinatal mental health and psychosocial assessment, 32.*
[56] Ibid.
[57] Coronial Brief, Statement of J Arbuckle, 21.
[58] Ibid, 42.
[59] Ibid.

- '*she started to get stressed about things that weren't really important, about how Lily was developing and growing. She was just taking little things that didn't matter and really getting worried about them when everything was fine'*.[60]

- 'Melissa said "*nothing will convince me that she (Lily) is OK*"'.[61]

- '*Melissa was convinced she had hurt Lily…I was just frustrated because I knew there was nothing I could do to convince her it was OK. It was becoming clear to me she couldn't see clearly that everything was fine'*.[62]

- '*About two weeks ago, Melissa was really down. She was really worried she had been shaking the bassinet too vigorously…over the weekend Melissa was really worried about her'*.[63]

59. In addition to these observations, Melissa informed Jed on either 4 or 11 July 2022, that she had experienced suicidal thoughts and had not been able to sleep because '*of these thoughts I have been having about what I have done to Lily'*.[64] Melissa advised Jed that she would not carry through with these plans because of the consequences for Jed. In his statement, Jed advised that '*I took it a bit naively because I didn't think she would actually do anything, I was applying logic to it but it wasn't logical'*.[65]

60. Whilst the available evidence suggests that Jed appears to have observed behaviours that made him concerned for Melissa's wellbeing, Jed's statement suggests that he was unclear of the seriousness of the situation and the impact that these experiences were having on Melissa's wellbeing. Jed also appears to have been unclear as to how to assist Melissa as evidenced in his message to a neighbour who had been supporting Melissa, which noted; '*I don't really know the best way forward at this point, but I think it involves getting professional help for Melissa as you suggested the other day'*.[66]

[60] Ibid.
[61] Ibid,44.
[62] Ibid, 44.
[63] Ibid, 43.
[64] Ibid, 45.
[65] Ibid.
[66] Ibid, 44.

61. Research indicates that secondary carer involvement in parenting and supporting primary carers can assist in reducing the risk of poor maternal post-natal mental health.[67] The role of fathers in post-natal care is echoed in Victoria MCH practice tools and policy, which make reference to the importance of including fathers in post-natal care, noting that '*father-inclusive practice is integral to the health, wellbeing, safety, learning and development of the mother and child'*.[68]

62. I further note concern with the heteronormative language used throughout MCH policies and guidelines and note that despite the involvement of secondary carers in the post-natal period being evidenced as a protective factor for maternal mental health, MCH services focus heavily on maternal engagement and have no standardized practices for proactively involving secondary carers in the post-natal support period.

Lactation consultants and post-natal mental health

63. In a statement to the Court, Dr Strybosch, advised that she had not used or been trained to use '*any formal assessment tools of maternal wellbeing or mental health'*[69] and that it was her impression that Melissa's '*mental state was unremarkable'*.[70]

64. In a statement to the Court, Dr Strybosch advised that she:

- Has a Bachelor of Osteopathic Science
- Has a Graduate Diploma in Osteopathic Paediatrics
- Was titled as an Advanced Paediatric Osteopath by Osteopathy Australia
- Is an International Board Certified Lactation Consultant[71]

[67] Dinga, L. A. , Kiage, B. M. , & Kyallo, F. M. (2018). Effect of father involvement in infant feeding on nutritional status and morbidity in Kisumu, Kenya. Journal of Nutrition and Health Sciences, 5, 1. 10.15744/2393-9060.5.105; Maselko, J. , Hagaman, A. K. , Bates, L. M. , Bhalotra, S. , Biroli, P. , Gallis, J. A. , O'Donnell, K. , Sikander, S. , Turner, E. L. , & Rahman, A. (2019). Father involvement in the first year of life: Associations with maternal mental health and child development outcomes in rural Pakistan. Social Science & Medicine, 237, 11242; Dadi, A. F. , Miller, E. R. , Woodman, R. J. , Azale, T. , & Mwanri, L. (2020). Effect of antenatal depression on adverse birth outcomes in Gondar town, Ethiopia: A community-based cohort study. PLoS One, 15, e0234728. 10.1371/journal.pone.0234728; Drysdale RE, Slemming W, Makusha T, Richter LM. Father involvement, maternal depression and child nutritional outcomes in Soweto, South Africa. Matern Child Nutr. 2021 Jul;17 Suppl 1(Suppl 1):e13177. doi: 10.1111/mcn.13177. PMID: 34241955; PMCID: PMC8269140.

[68] Victorian Government, Maternal and Child Health Service guidelines, 12.

[69] Statement of J Strybosh, 2.

[70] Statement of J Strybosh, 2.

[71] Ibid, 1.

65. Despite holding expertise in paediatric and maternal care, Dr Strybosh advised that her '*formal education in perinatal mental health was scant at best*'[72] and did not '*recall learning about [postnatal psychosis] in any detail at all in either my training as an osteopath or as a lactation consultant*'.[73]

66. The Court received a statement from Dr Karolyn Vaughan, Regional Director, International Board of Lactation Consultant Examiners (**IBLCE**) for the Asia Pacific and Africa Region on 18 September 2023, confirming that Lactation Consultants accredited through the IBLCE are required to meet the following criteria:

    a) minimum of 95 hours of lactation specific education (of which five hours must be counselling), completed in the five years immediately prior to examination application.

    b) 1000 hours of lactation specific clinical practise in the five years immediately prior two examination application.

    c) Evidence of registration with AHPRA, or copy of their Health Science degree.

67. Whilst a review of the accreditation materials on the IBCLE's website and information provided to the Court confirms that Lactation Consultants will consider the mental health of a breastfeeding mother, there is no clarity regarding how mental health is assessed or what referrals are made when concerns arise in providing services to new mothers.

RECOMMENDATIONS

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

    a) With the aim of improving the public health and safety, I recommend that the **International Board of Lactation Consultant Examiners** review their requirements for lactation consultant accreditation and ensure that they must have undertaken education that includes a demonstrated understanding of postnatal mental health, how to identify mental health risks and making referrals for appropriate supports to qualify for accreditation.

    b) With the aim of improving the public health and safety, I recommend that the **Victorian Department of Health - Maternal and Child Health Services** introduce a process to

[72] Ibid, 1.
[73] Ibid.

ensure that Supervisors are automatically alerted if a primary caregiver scores 13 or above on a EPDS so that Supervisors can ensure that a plan is in place for managing the risk posed to the primary caregiver and their child.

c) With the aim of improving the public health and safety, I recommend that the **Victorian Department of Health - Maternal and Child Health Services** provide staff with regular training to ensure that they are familiar with the need to query infant safety following completion of question 10 of the EPDS. This education should be supported by ensuring that discussions of client responses to this question forms a part of regular clinical supervision.

d) With the aim of improving the public health and safety, I recommend that the **Victorian Department of Health - Maternal and Child Health Services** require health services to engage with secondary carers on at least one occasion in the pre-natal period for the purposes of providing education around signs and symptoms of post-natal depression, anxiety and psychosis and options for support, noting that this engagement should only occur after permission is sought from the primary carer to do so.

e) With the aim of improving the public health and safety, I recommend that the **Victorian Department of Health - Maternal and Child Health Services** introduce an additional consultation into the *Key ages and stages framework* that requires MCH Nurses to proactively engage with the secondary carer for the purposes of providing education around signs and symptoms of post-natal depression, anxiety and psychosis and options for support, noting that this engagement should only occur after permission is sought from the primary carer to do so.

FINDINGS AND CONCLUSION

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

a) the identity of the deceased was Lily Grace Arbuckle, born 04 April 2021;

b) the death occurred on 11 July 2021 at The Royal Children's Hospital Melbourne 50 Flemington Road, Parkville, Victoria, 3052, from a head injury; and

c) the death occurred in the circumstances described above.

25. I convey my sincere condolences to Lily’s family for their loss.

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

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

Jed Arbuckle, Senior Next of Kin

Chelsea Woodlock

Annabelle Mann, In-House Legal, Royal Children's Hospital

Liana Buchanan, Principal Commissioner, Commission for Children and Young People

Dr Joanna Strybosch, Melbourne Therapy Centre

Professor Euan Wallace, Secretary, Victorian Department of Health

Belinda Hounslow, Maternal & Child Health Services Coordinator, Yarra Ranges Council

Dr Karolyn Vaughan, Regional Director, International Board of Lactation Consultant Examiners for the Asia Pacific and Africa Region

Detective Sergeant Sean Campbell, Coroner's Investigator

Signature:

Judge John Cain, State Coroner

Date : 23 November 2023

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an 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.