IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: 2012 / 1474

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
*Section 67 of the **Coroners Act 2008***

Inquest into the Death of: AA

Delivered On:	16 March 2016
Delivered At:	Coroners Court of Victoria 65 Kavanagh Street, Southbank
Hearing Dates:	27, 28, 29 and 30 October 2015
Findings of:	JUDGE IAN L GRAY
Representation:	Ms Fiona Ellis, on behalf of The Royal Children's Hospital Ms Michelle Armstrong, on behalf of Ms A Ms Teresa Porritt, on behalf of Department of Health and Human Services Mr Michael Regos, on behalf of Moreland City Council Ms Erin Gardner, on behalf of Department of Education and Training Mr Sebastian Reid, on behalf of Dr Zagarella and Nurse Goodchild Mr Paul Haley, on behalf of Mr A
Police Coronial Support Unit	Senior Sergeant Jennette Brumby

I, JUDGE IAN L GRAY, having investigated the death of AA

AND having held an inquest in relation to this death on 27, 28, 29 and 30 October 2015

at Melbourne

find that the identity of the deceased was AA

born on 28 February 2012

and the death occurred 26 April 2012

at the Royal Children's Hospital, Flemington Road, Parkville, Victoria.

from:

1 (a) HEAD INJURIES

in the following circumstances:

Background

1. On 28 February 2012, Ms A gave birth by caesarean section to two female non identical twins, AA and BA at the Royal Women's Hospital.

2. Both twins were siblings to an older brother, CA who turned two a few weeks after their birth. Ms A and the father of the twins, Mr A and the three children all lived together in the privately owned family home in Coburg.

3. The twins were brought home 3 days after they were born, and over the following week were visited in the home four times by nurses from the Royal Women's Hospital domiciliary care service. Ms A had experienced problems breast feeding her son and made the decision to bottle feed the twins from the outset.

4. Both Ms A and Mr A took time away from their respective employment and provided the primary and essentially exclusive, care for both AA and BA They were also heavily supported by Ms A's mother, Ms M who visited the family home almost daily. Ms M essentially maintained primary care of CA whilst at the home.

5. Ms A and Mr A shared parental responsibilities for the twins by swapping each night as their sole carer. The nominated parent would care for the twins exclusively during the night with assistance from the other parent during the day. The nominated parent would sleep on the floor in the twins' bedroom overnight. The twins slept together in a crib in their bedroom.

6. The parent not responsible for the twins on any particular night would sleep in the master bedroom with CA

7. CA was somewhat sheltered from the twins, with Ms A keen to ensure that his routine was not significantly disrupted by the arrival of the twin girls.

8. Both twins were irritable, experienced difficulty with sleeping and feeding and were a challenge to settle. They would also cry a lot.

9. CA by contrast, had been an easy baby. He was a happy child and easy to manage. He was regarded highly by Ms A Mr A and Ms M .

Timeline of Contact with Health Services

10. In the eight weeks following the twins' birth, the family had a number of contacts with health service providers. It is important to set out the timeline of these appointments and consultations, which were the focus of my investigation into AA's death and consideration of whether or how it might have been foreseen and prevented.

11. On 7 **March 2012**, Ms Roslyn Monagle (Ms Monagle), a Maternal and Child Health (MCH) nurse with the Moreland City Council Maternal and Child Health Service (Moreland MCH Service), contacted the family by phone prior to attending for a planned home visit. She spoke to Ms A who advised that she was doing well, had lots of support and was very busy. Ms A advised that the domiciliary service from the Royal Women's Hospital were still visiting every two days and were also due to visit that day. She indicated that rather than have a home visit, she would be happy to come with the twins into the Moreland MCH service and a visit was booked for the following week.

12. On **11 March 2012**, both twins, now 12 days old, were taken to the Emergency Department of the Royal Children's Hospital (RCH) by their parents because of their concerns about the twins' increasingly unsettled behaviour after feeds. AA was physically examined and a history was taken from her parents. Both twins were referred to the RCH Unsettled Babies Clinic with the following notation: "*escalating unsettledness post feeds 1-2 hours. Gaining wt, feeding well, no fever or other symptoms, ?colic.*"[1]

13. On **15 March 2012**, accompanied by their father, the twins, at sixteen days old, attended their first assessment with the Moreland MCH Service. Ms A was reportedly unwell, or at least very tired, and remained at home to rest. The review was conducted by MCH nurse, Ms Monagle. Mr A relayed that both twins had been taken to the RCH a few days earlier because they were unsettled. According to the notes of the consultation, Mr A reported that the twins had been seen by a paediatrician and diagnosed with "colic". He advised that they were awaiting a review appointment with a paediatrician at the RCH. The twins were physically examined, weighed and measured and a possible hip breech was detected, with a hip scan flagged for May. No other matters of concern were recorded. No injuries or bruising were

[1] Coronial Brief, p 1317

observed. Ms Monagle recalled that the twins were settled and content and that Mr A undressed and redressed them both competently. It was noted that he had two months off work at this time.

14. On **19 March 2012** both parents attended an appointment with the Moreland MCH Service, again with Ms Monagle, but this time with their son for his two year old review. The twins were left at home in the care of family. No issues were identified with their son, who was observed to be happy and active and reported to be coping well with the arrival of twin sisters. Ms A was questioned about how she was feeling and coping following the birth. She reported that she was fine, that she was starting to feel better and less tired. Both parents indicated that the twins were also fine.

15. On **30 March 2012**, the twins attended their four week assessment with the Moreland MCH Service. Their review on this occasion was conducted by MCH nurse, Ms Anne Kingston (Ms Kingston). The twins attended accompanied by their mother and brother. The twins were undressed, weighed, measured and physically examined. At this assessment, AA was observed to have a small bruise measuring 6mm on her right cheek. Her twin sister BA was observed to have four small bruises measuring approximately 4 mm in a cluster on her left cheek. Ms A was questioned about the origin of the bruises, to which she replied "*I don't know what they are doing, they must be bashing each other/bashing themselves with the colic, they are like Houdini, they get out of their wraps no matter how tight I wrap them.*"[2] Ms A went on to explain that she placed the twins end to end in the cot for sleeping with their heads aligned, which explained how each twin's fist was sufficiently proximate and aligned with the others face. The safe placement of the babies was discussed and the possible need for future medical follow up and investigation if the twins proved to bruise easily. The bruising was noted in the Moreland MCH Service electronic notes of each twin, but was not noted in their "Green Books", a health and development record distributed to all Victorian parents following the birth of their child, and held by the parent.

16. At this appointment, Ms A completed an Edinburgh Post Natal Depression Scale questionnaire (EPDS) and received a score of 12. The EPDS is a validated tool for screening women for symptoms of depression in the perinatal period. It allows health professionals screening women for perinatal depression to identify most women who may need additional professional help including a referral for a full diagnostic mental health assessment.[3] A score of 12 is borderline and may or may not require referral to a general practitioner. Ms Kingston

[2] Coronial Brief p 183
[3] Coronial Brief p 1532

discussed Ms A 's mood with her and her available supports. Ms A reported that she was well supported by her husband and mother and that CA was coping well with his new sisters. Ms A was observed to be very upbeat with her management of the twins. She did disclose that she felt down sometimes because she couldn't help the twins with their colic and she felt sorry for them. Ms A presented as a caring and competent parent and was observed to interact in an appropriate and affectionate manner with her children throughout the consult. She appeared physically well and reported that she had been well since the day the twins were born. In the circumstances, Ms Kingston reviewed with Ms A what she was doing to help and comfort the twins. She also advised Ms A that it was important to follow up if she experienced any persistent low mood.

17. On **10 April 2012**, the twins were seen by the family General Practitioner (GP), Dr Sam Zagarella at the Niddrie Medical Centre. Both parents, the twins and their brother attended the consultation. The focus of the appointment was management of the twins feeding and colic. A history was taken, (which included that the twins had been treated for colic at the RCH), the twins were weighed and a brief physical examination was undertaken. In order to perform an abdominal examination, the twins' jumpsuits were unfastened, but they were not otherwise undressed. The examination revealed nothing of note and no injuries or bruises were observed. Dr Zagarella was not informed by either parent about the facial bruises that had been observed on both twins at the Moreland MCH Service consultation 11 days earlier. Dr Zagarella gave advice about different formula and anti-reflux medications that might be trialled. Although the appointment was for the twins, Dr Zagarella inquired about how Ms A was feeling. She reported that she was stressed, tired, and not sleeping well. Given her response, Dr Zagarella had Ms A complete the K10[4] and Depression Anxiety Stress Scales (DASS) screening tools in order to ascertain if there were issues with her mental health which might require follow up. Her responses to specific questions revealed that she self-reported as having poor attention, poor concentration, occasional confusion and a sense of worthlessness and hopelessness. She denied suicidal ideation. In view of her high scores on these screening tests, which are not diagnostic, a further appointment was made for Ms A to see Dr Zagarella and the practice's mental health nurse on 18 April 2012, for a mental health assessment and, if necessary, completion of a mental health plan. Notwithstanding the possible high levels of stress, anxiety and depression suggested by the screening tools, in a clinical context, Dr Zagarella observed Ms A on 10

[4] Kessler Psychological Distress Scale

April 2012 to be rationale, loving, caring, engaged, warm and concerned for the wellbeing of her children. He also noted that she was well supported by her family.[5]

18. On **18 April 2012**, Ms A attended an appointment with her GP, Dr Zagarella and a mental health nurse, Ms Sally Goodchild (Ms Goodchild). Mr A accompanied Ms A to the Medical Centre but did not sit in on the consultation. A mental health review was conducted, primarily by Ms Goodchild. Ms A reported that she was struggling with parenting the unsettling twins. Ms A was observed to be tired, but generally bright, calm and relaxed. She interacted appropriately, demonstrating an ability to discuss her needs and make reasoned decisions. When asked, she denied that she was at risk of harming herself or her children. She reported that she had good support with her husband and extended family providing assistance. Ms A reported some improvement in the twins' level of irritability since the previous consult on 10 April 2012, and Dr Zagarella recalled some improvement in Ms A too, with her presentation judged to be a bit brighter and more positive.[6] The possibility of a referral to the Tweedle Child and Family Health service (Tweedle) was discussed, to assist with strategies for parenting the unsettled twins. Ms A declined this, at least in part as a result of the fact that they were already seeing the Unsettled Babies Clinic at the RCH, and had an appointment the next day. A referral to a psychologist specialising in women's mental health was discussed. This was also declined because the psychologist's rooms were located some distance from her home. Ms A agreed instead to a referral to a psychologist operating from the same practice. An appointment was made for 1 May 2012, and a mental health plan was prepared accordingly, with a copy provided to Ms A When asked in general terms, Ms A indicated that she did not want to commence any medications related to her mood at that stage. Dr Zagarella considered this reasonable in all the circumstances, and was content that it was a matter which could remain under review.[7]

19. On **19 April 2012**, the twins were seen at the Unsettled Babies Clinic at the RCH Centre for Community Child Health. They attended the appointment with both parents and were seen by Dr Anne Dawson, who at that time was in the third year of her advanced training in General Paediatrics. Only one of the twins, BA in fact had an appointment on that day. However, at the request of their parents, both twins were seen together. Dr Dawson took a full history from the As encompassing antenatal, obstetric and postnatal history. Information was recorded about their feeding patterns, amount of formula tolerated, periods and time of irritable behaviour, vomiting, rashes, bowel patterns and strategies used (including medications) in

[5] Inquest transcript p 548
[6] Inquest transcript p 552
[7] Inquest transcript p 564 – 565 and p 592 – 593

response to their irritability. Dr Dawson was not informed by either parent about the facial bruises that had been observed on both twins at the Moreland MCH Service consultation 11 days earlier. The twins' parents reported that they appeared to be improving over the previous 48 hours. In addition to taking a history, Dr Dawson conducted a full physical examination of AA which revealed nothing remarkable. No evidence of injury or bruising was observed. BA was not examined at this time as she was asleep. Having found no organic cause for the twins' unsettled behaviour and in view of the history provided, Dr Dawson diagnosed colic and put in place a management plan to reflect this, which included providing the family with information about infant crying and response strategies, a diary to carefully record the twin's patterns and behaviours and a timetable for withdrawing from some of the medications they had commenced.

20. While at the clinic, Ms A completed another EPDS and provided this to Dr Dawson. Her score was 17, which is considered a positive screen for possible perinatal depression.[8] On question 10, which relates to thoughts of self-harm over the previous seven days, Ms A had ticked the box 'hardly ever', which is regarded as a positive answer, and cause for further inquiry.[9] Dr Dawson explored the results of the EPDS with Ms A She ascertained what supports Ms A had in place, including that her husband was currently off work and at home to assist with the twins, and that they were alternating nights caring for the twins. Dr Dawson recorded that Ms A had seen a mental health nurse the previous day and had been referred to a psychologist by her GP. She asked Ms A if she had thoughts of harming herself or her children, to which she replied "no". Dr Dawson's impression of the As during the consultation was that they were well engaged with the twins and appeared happy. Before the conclusion of the consultation, and while the family waited, Dr Dawson discussed the matter with her supervisor Associate Professor Harriet Hiscock (A/Prof Hiscock). There was consensus on the management plan for the twins and that the supports that were already in place for Ms A were appropriate at that time. A review appointment was made for 3 May 2012.

21. On **24 April 2012**, the twins attended their eight week assessment with the Moreland MCH Service. They were accompanied by both parents and their brother and were seen by Ms Monagle. Both twins had recorded poor weight gain, BA in particular, and their parents reported that they had been vomiting and that they were very concerned about their fussy feeding. Both parents were a little exasperated, or at least confused, because the twins had been commenced on the medication Zantac and then they had ceased this on the contrary advice of

[8] Coronial Brief p.1533
[9] Coronial Brief p 653 and p 656

the RCH. During this consultation, Ms Monagle observed a pea sized pale bluish bruise on the right side of BA's face and a small scratch also on her face. The As were questioned about this and were unable to explain how it had occurred. The possibility was discussed that CA may have caused the bruise and Ms Monagle discussed the need to carefully supervise him when around the twins. The possibility of a blood disorder was also discussed. Ms Monagle had not reviewed Ms Kingston's notes of the twins' four week assessment and was thus unaware that bruises had been observed and documented on both the twins' faces at that time. Ms Monagle recorded the bruise in BA's electronic Moreland MCH Service record and further noted it in her Green Book. Ms Monagle conducted a full physical examination of both the twins and observed nothing further of note, and certainly no further evidence of injury, including bruising. She observed both Ms A and Mr A to be attentive, confident and gentle parents as they each undressed and redressed a twin for examination and to have appropriate attachment with them. She observed both twins to be quiet but alert and engaged. Ms Monagle was concerned that the As were tired and struggling and may require additional support to help them deal with the large workload of three small children. Ms Monagle prepared a referral letter for BA to the family GP. She noted in the letter the unexplained bruise she had observed, BA's poor weight gain and her fussy feeding. She provided the letter to the As so that they might give it to their GP. She made arrangements with the family for a follow up visit the next week. Following the consultation she spoke to Nurse Joan Myers Braun of the Enhanced Maternal and Child Health Service (EMCH Service), with a view to exploring whether the EMCH Service might take on the family and provide them with some additional support. She was informed that although the EMCH Service was currently full, they would try to pick up the A Family as soon as possible and with some priority. Ms Monagle also discussed the possibility of a referral to Child First. Following this conversation, Ms Monagle resolved to conduct a home visit with the family later in the week in order to secure their agreement to a make referral to the EMCH Service and to Child First, and to formally commence that process.

Circumstances of fatal event

22. On 25 April 2012, Mr A was the nominated parent to care for the twins overnight. He fed them at 8.00pm and placed them into their crib. He then went to sleep on the floor. Ms A was in the master bedroom with CA At approximately 11.30pm, Mr A fed the twins again. AA was somewhat unsettled after this feed and at approximately 2am on 26 April 2012, Mr A became aware of AA making noises which sounded distressed and

seemed to be getting louder. He observed her to be limp and pale and shortly thereafter, while he was holding her, she stopped breathing.

23. Mr A then called out to Ms A told her that AA had stopped breathing and asked her to ring an ambulance. Ms A rang her mother, Ms M , and asked her to come to their house. She then made a phone call to "000". During the phone call Ms A relayed information to Mr A who was performing cardio pulmonary resuscitation (CPR) on instruction from the call-taker. Ambulance paramedics arrived at the house at approximately 2.11am. They found AA with pulseless electrical activity and not breathing. She was intubated with restoration of circulation following adrenaline administration, and conveyed to the RCH.

24. At the RCH, AA was extensively examined by attending medical staff, who found evidence of both old and new bleeding in the brain and multiple skull fractures. AA was intended for emergency surgery however was unable to be stabilised long enough for this to proceed. She died on the operating table at 7.55am on 26 April 2012.

25. The injuries suffered by AA were considered to have likely been caused by non-accidental trauma. Doctors questioned both Ms A and Mr A as to how these injuries could have occurred. Neither parent was able to provide an explanation.

26. In the circumstances, the Homicide Squad were notified of the death of AA and attended at the RCH. Both parents were interviewed under caution. AA siblings, CA and BA were taken that day to the Victorian Forensic Paediatric Medical Service (VFPMS), also at the RCH, and examined. CA's examination revealed no evidence of recent injury. BA's examination revealed injuries similar to those which had been sustained by her sister, including multiple skull fractures, multiple intracranial haemorrhages of differing ages, softening or loss of brain tissue, multiple rib fractures, fracture of the left clavicle, possible fracture of left radius and possible injury to her tibial shaft. Bruising was also observed on BA's right forehead, left leg, and labia. BA's complex constellation of injuries indicated that she had been subject to non-accidental trauma.

27. During her police interview on 26 April 2012, Ms A was questioned extensively about her mothering of the twins. She was confronted with the extent of the injuries to both girls. She initially stated that she did not cause the injuries.

28. From the outset she spoke of the colic that the girls suffered, of their unsettled behaviour and of the problems she and her husband had getting them to sleep. She acknowledged that neither twin was putting on as much weight as they should have and that this was the case at eight

weeks of age. She described her routines with the twins and emphasised the apparent pain the twins were in and that they would wake up screaming. She put it that "*colic just doesn't go away.*"[10] She did acknowledge however that children do grow out of colic. She spoke of the various visits to medical practitioners, including Dr Zagarella. She was adamant that the babies had never fallen off anything and that their injuries could not have been caused in that way.

29. Throughout the first part of interview, she was insistent for a lengthy period that she couldn't explain the injuries. She was consistently emphatic that her husband could not and would not have caused them.

30. At a later point in the interview she asserted that she did have post natal depression.[11]

31. In the context of post natal depression she was asked if she took out any frustration on the babies and said "*They were just crying all the time, I just didn't feel worthy of being a mother because I couldn't help them.*"[12] She said she "*Just cuddled them.*"[13] Then said "*...and rocked them and rocked them and rocked them and rocked them and rocked them and rocked them.*"[14] She was then asked if she ever got angry with them, she said that she screamed a bit and in relation to whether she grabbed "*them extra hard*"[15] or something similar, said that she didn't think so and that had that happened it would have been accidental. She then conceded that in the context of her post natal depression and her frustration, she was "*constant rocking all the time with them.*"[16] She went on to say that "*I mean now I'm worried about this postnatal depression if it made me flip...*"[17]

32. Further on in the interview, after being told how the hospital (RCH) staff were describing the various injuries to the twins, she was asked questions about the fact that given the arrangements with the children, the only persons who could have caused them were her and her husband. In that context she said "*The only thing I can think of is what if when I was that low that I just flipped and I don't even know that I flipped. Is that a possibility?*"[18] She went on to say "*They're always crying, they're always crying, you know, like, it's almost like – and then we rocked them and then we rocked and that's all I could do for them.*"[19] She referred to her own depression and the fact that she was awaiting an appointment to see a psychologist, she said that

[10] Coronial Brief - Transcript of video recorded interview with Ms A 26 April 2012– Appendices p 318
[11] Coronial Brief - Transcript of video recorded interview with Ms A – 26 April 2012– Appendices p 346
[12] Coronial Brief -Transcript of video recorded interview with Ms A – 26 April 2012 – Appendices p 347
[13] Coronial Brief -Transcript of video recorded interview with Ms A – 26 April 2012 – Appendices p 347
[14] Coronial Brief -Transcript of video recorded interview with Ms A – 26 April 2012 – Appendices p 347
[15] Coronial Brief -Transcript of video recorded interview with Ms A – 26 April 2012 – Appendices p 347
[16] Coronial Brief -Transcript of video recorded interview with Ms A – 26 April 2012 – Appendices p 350
[17] Coronial Brief -Transcript of video recorded interview with Ms A – 26 April 2012 – Appendices p 350
[18] Coronial Brief -Transcript of video recorded interview with Ms A – 26 April 2012 – Appendices p 358
[19] Coronial Brief -Transcript of video recorded interview with Ms A – 26 April 2012 – Appendices p 358

she had become aware that she wasn't well, she repeated that she and her husband were just "*rocking the babies because they wouldn't stop crying.*"[20]

33. She went on through the interview to express increasing acceptance that she must have been responsible for the injuries to the twins without having intended to cause them and without knowing exactly what she had done or when she had done it. She referred increasingly to "*losing my mind...*"[21]. She insisted that only she, not her husband, could have caused the injuries. She said from time to time "*I think I'm going crazy*".[22]

34. Later again in the interview, she said "*I remember I was thinking maybe when I was shaking them like this or maybe shook them too hard trying to settle them.*"[23] Asked "*Is that what happened?*" she said "*And I remember doing it like this and maybe I went too hard with that point and without realising the – just to try and settle them – I was just thinking...Maybe I went too fast and when I held them in my arms when I was rocking them.*"[24] She repeated this theme in a number of subsequent answers.

35. Later in the same interview she said that she was "*maybe holding them too tight*"[25] Throughout the description of her interaction with the twins, Ms A insisted that she was simply trying to settle them down and get them to stop crying. She repeated her emphatic denial of ever dropping the children. She was adamant that she did not intend to kill AA She went on to concede that she may have been shaking AA "*too hard*".[26] Later still she was asked "*You shook* AA Answer "*I shook her like that.*"[27]

36. It is not clear from the interview whether she demonstrated how she believed she had shaken AA or both twins. She was consistent in saying that she didn't know she was hurting them, "*...wasn't worried about hurting them, it was just when I got that frustrated and it just, sort of, happened I supposed 'cos when I'm – when I was sane I was okay.*"[28] Shortly afterwards she agreed that she might have shaken both of the twins and then stated that she in fact did so and that she may have done so more than once.[29]

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[20] Coronial Brief -Transcript of video recorded interview with Ms A – 26 April 2012 – Appendices p 362
[21] Coronial Brief -Transcript of video recorded interview with Ms A – 26 April 2012 – Appendices p 366
[22] Coronial Brief -Transcript of video recorded interview with Ms A – 26 April 2012 – Appendices p 370
[23] Coronial brief -Transcript of video recorded interview with Ms A – 26 April 2012– Appendices p 375
[24] Coronial brief -Transcript of video recorded interview with Ms A – 26 April 2012– Appendices p 376
[25] Coronial brief -Transcript of video recorded interview with Ms A – 26 April 2012 – Appendices p 378
[26] Coronial brief -Transcript of video recorded interview with Ms A – 26 April 2012 – Appendices p 382
[27] Coronial brief -Transcript of video recorded interview with Ms A – 26 April 2012 – Appendices p 388
[28] Coronial brief -Transcript of video recorded interview with Ms A – 26 April 2012 – Appendices p 390
[29] Coronial brief -Transcript of video recorded interview with Ms A – 26 April 2012 – Appendices p 391

37. She went on to repeat her explanation that the twins simply would "*scream and scream and scream*"[30] and not being able to help them. She later said "*I wish I'd taken the anger out on myself instead of shaking the girls.*"[31] Asked after that whether she believed she may have "*gripped them to tightly at times*?" she said "*I think I might have, yeah*" and agreed that she had "*shaken them more than once.*"[32]

Results of Autopsy

38. On 26 April 2012, Dr Linda Iles, Forensic Pathologist at the Victorian Institute of Forensic Medicine (VIFM) conducted an autopsy on AA

39. She was found to have the following injuries:-

a) Left temporal and left frontal skull bruises;

b) Three healing right parietal skull fractures

c) Four right parietal skull fractures, one recent, three healing

d) An acute on subacute left sided subdural haematoma with secondary ischaemic brain changes

e) Fresh right sided subdural haematoma

f) Healing contusional injuries to both sides of the brain

g) Bilateral intra-retinal haemorrhages

h) Multiple rib fractures both healing and recent

i) Left distal radial metaphyseal fracture

j) Liver fibrosis and siderosis, most likely of traumatic origin.

40. Dr Iles commented that "*the appearances of the skull fractures indicate both recent (no evidence of healing) and older blunt head trauma, i.e. at least two separate episodes of head trauma.*"[33] She noted that there was no accurate histological data in the literature that would allow her to accurately date the skull fractures, but that other changes observed in the brain would suggest an injury of several weeks duration. As to the origin of the skull fractures, Dr Iles commented:

> *"The presence of skull fractures of varying ages is indicative of blunt head trauma. The deceased was born via elective caesarean section. As far as I am aware there are no accounts of this infant sustaining accidental head trauma; regardless the extent and*

[30] Coronial brief -Transcript of video recorded interview with Ms A 26 April 2012 – Appendices p 393
[31] Coronial brief -Transcript of video recorded interview with Ms A 26 April 2012 – Appendices p 409
[32] Coronial brief -Transcript of video recorded interview with Ms A 26 April 2012 – Appendices p 414
[33] Coronial Brief p52

multiplicity of the skull fractures observed is not consistent with accidental injury. Whilst these fractures are consequent to the application of blunt trauma to the head on more than one occasion, I am unable to say whether these fractures are due to blows to the head, or more sustained blunt force to the head, i.e. forceful squeezing of the head."[34]

41. While Dr Iles noted a number of findings, such as subdural bleeding and retinal haemorrhages, which may be seen in instances of excessive, violent shaking of infants, she commented that in this instance the severity of the injury to the skull and underlying brain were such that she could not differentiate injury from blunt force trauma and more subtle injuries that might be observed in forceful shaking.

42. Dr Iles observed that the various rib fractures were in keeping with forceful squeezing of the chest. With respect to the metaphyseal fracture of the distal right radius, which showed minimal evidence of healing, Dr Iles opined that this may be consequent to a shaking type injury.

43. AA's cause of death was found to be head injuries.

Criminal Proceedings

44. On 21 August 2012, Ms A was arrested and re-interviewed. At the conclusion of the interview, Ms A was charged with the murder of AA and intentionally causing serious injury to BA

45. After a committal hearing, the Director of Public Prosecutions sought an expert opinion from Consultant Psychiatrist, Dr Grant Lester of the Victorian Institute of Forensic Mental Health. After reviewing Ms A's history and interviewing her, Dr Lester concluded that in his view, at the time of AA's death and for some weeks prior, Ms A was suffering from a depressive syndrome related to the post natal period.

46. The murder charge was not pursued and Ms A was subsequently indicted on one charge of infanticide in respect of AA's death, and one charge of recklessly causing serious injury in respect of BA Ms A pleaded guilty and was convicted on 28 March 2014. She was released on a Community Corrections Order for one year.

47. In his sentencing remarks[35], Justice Bongiorno indicated that this course, that is indictment on an infanticide charge as opposed to a murder charge, "*was entirely appropriate.*" His Honour questioned whether the '*recklessly causing injury*' charge was supported by the evidence given Ms A's mental state at the time, but accepted that Ms A plea meant the charge was established without the Crown being obliged to prove the facts supporting it.

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[34] Coronial Brief p53
[35] DPP v Q P X [2014] VSC 189 (28 March 2014)

48. Evidence was received at the plea hearing from a number of mental health practitioners who had reviewed Ms A some of whom were involved in her ongoing care. There was very little, if any, disagreement between them as to the psychiatric aspects to the case. Psychiatrist, Associate Professor Ruth Vine, gave evidence that at the time of the death, Ms A was "*sleep deprived, felt guilty and anxious at her inability to soothe and comfort the twins and developed a significant mood disorder.*"[36] They all attested to her ongoing depression, grief and despair as a result of what had happened.

49. In his sentencing remarks, Justice Bongiorno acknowledged that the exact mechanism of the infliction of AA's fatal injuries was difficult to determine, but stated that it was clear that they were inflicted by a loving mother suffering from significant emotional and psychological compromise. His Honour opined that Ms A's moral culpability with respect to the death was either non-existent or of such a low degree as to be negligible and that no Court could punish her more than she had been punished by the tragedy itself.

Issues for Coronial Investigation

50. AA's death occurred in Victoria and was unexpected, violent and the direct result of injury. For those reasons, her death was a reportable death pursuant to section 4 of the *Coroners Act 2008* (Vic) ("the Act") and one which a Coroner is required to investigate under section 15, for the purposes of finding the identity of the deceased, the cause of death and the circumstances of the death.

51. As is conventionally the case, the coronial investigation into AA's death was effectively suspended while related criminal proceedings were on foot. At the completion of those proceedings and the expiry of relevant appeal periods, a copy of the original Victoria Police criminal brief of evidence was provided to this Court so that the coronial investigation might resume.

52. Ordinarily, where a death is suspected to be the result of homicide, an inquest is mandated as part of the coronial investigation. However, sub-section 52(3)(b) of the Act provides that a coroner is not required to conduct an inquest into a suspected homicide where someone has been charged with an indictable offence in relation to the death. Section 71 further provides that no findings need be made where an inquest is not held for this reason and the making of findings would be inappropriate in the circumstances. Mindful of those sections, and the more general objective of avoiding duplication of investigations set out in section 7, I reviewed the criminal

[36] DPP v Q P X [2014] VSC 189 (28 March 2014)

brief provided by Victoria Police and considered the necessity and utility of further coronial investigation in this case.

53. There were issues relevant to the circumstances of AA's death which required further investigation. They were:

1. The timing and dating of the injuries to the twins in the context of considering whether such injuries could or should have been detected during any presentation of the twins to health care service providers, specifically the RCH Emergency Department on 11 March 2012; the RCH Unsettled Babies Clinic on 19 April 2012, the Moreland MCH Service on 15 March 2012, 30 March and 24 April 2012, and the General Practitioner visit on 10 April 2012.
2. The bruising detected by the two separate MCH nurses at Moreland City Council at the visits at four weeks of age, (30 March 2012) , and eight weeks of age, (24 April 2012), and whether:
    a. the detection of the bruising should have prompted notification to Department of Health and Human Services (DHHS) pursuant to mandatory reporting requirements or further action beyond that which was actually taken; and
    b. The arrangements for the recording and sharing of information and records within MCH Services and other health service providers are appropriate.
3. The assessment and management of Ms A in light of her presentation, comments and scores on post-natal depression screening test conducted by her GP on 10 April 2012, the MCH nurse on 30 March 2012 and the RCH Unsettled Babies Clinic on 19 April 2012, and whether:
    a. it is reasonable to suggest that the seriousness and immediacy of Ms A 's mental health crisis should have been identified at an earlier point; and
    b. the risk to the infant in the context of Ms A's mental ill health could or should have been identified and if so, what could or should have been done to address that risk.

54. With these matters in mind, I obtained further records and statements and at a mention hearing on 22 July 2015, these three issues were settled as the matters to be explored at inquest.

55. As it emerged, the two issues which were most directly in focus at the inquest itself were issues 2 and 3. Issue 1 (the dating of the injuries and the possibility of more timely detection on

examination of the twins) was not explored in detail at inquest given the thorough treatment of this subject in an Expert Report prepared for the Court by Dr Ciara Earley.[37]

56. For the purposes of the coronial investigation, and the inquest in particular, it was not in dispute that AA's death was caused by Ms A whatever the precise mechanism and timing of the injuries inflicted.

57. I formally find that AA's death was caused by her mother, Ms A

Overview of the Evidence

58. There was a comprehensive coronial brief compiled which included the materials from the original criminal brief; statements and records from health service providers with whom AA had come into contact; statements from both AA's parents; relevant policies and guidelines relating to the assessment and care of infants and the assessment and treatment of perinatal depression; and statements provided by representatives from the Department of Education and Training (DET) and the Department of Health and Human Services (DHHS) about the relevant policy context for the issues under consideration. All of the material included in the coronial brief forms part of my investigation and has been considered in the preparation of this Finding. In addition, the following witnesses were called to give oral evidence and answer questions at inquest:

- Dr Ciara Earley, Consultant in Forensic Paediatric Medicine
- Ms Anne Kinston, Maternal and Child Health Nurse, Moreland City Council
- Ms Roslyn Monagle, Maternal and Child Care Health, Moreland City Council
- Ms Joan Meyers-Braun, Maternal and Child Health Nurse, Moreland City Council
- Dr Anne Dawson, Unsettled Babies Clinic RCH
- Associate Professor Harriet Hiscock, Director Unsettled Babies Clinic RCH
- Dr Sam Zagarella, General Practitioner
- Ms Sally Goodchild, Mental Health Nurse
- Mr A father of AA

59. Witnesses called at the inquest gave evidence consistent with their statements

[37] Dr Ciara Earley, Consultant in Forensic Paediatric Medicine at the Victorian Forensic Paediatric Medical Service of the Royal Children's Hospital and Monash Medical Centre, report dated 1 May 2015

60. The representatives of the DET and the DHHS who had provided written statements for the coronial brief were not called to give evidence at inquest. However, further material was obtained from them by way of answers to written questions provided to them after the conclusion of the inquest.

61. I did not call AA's mother, Ms A to give evidence at inquest. After considering the matter and hearing submissions, I decided that it would not be appropriate for her to be called. I relied on the view of her psychiatrist, Dr Carol Harvey, which was conveyed to me via Ms A's legal representative. Dr Harvey's view was that it may have been damaging to Ms A's mental and emotional health if she was required to give evidence. Of equal importance was the fact that I did not expect that Ms A would be able to add anything at all to the information she had provided to the police at interview and referred to above at paragraphs 27 to 37 above, and to the statement, dated 7 October 2015, she made for the purposes of the coronial investigation. None of the interested parties pressed a submission that she ought to be called to give evidence.

Issue One: Timing, likely presentation and detectability of injuries

62. The issue of the dating of AA's injuries was covered by the expert witness, Dr Earley of the Victorian Forensic Paediatric Medical Service (VFPMS). Dr Earley gave evidence at inquest in terms consistent with her very detailed expert report.[38] She examined the entire medical record in respect of both AA and BA and statements provided by practitioners involved in their care. She noted the radiological surveys performed both anti-mortem and post-mortem in respect of AA She examined all the relevant specialist reports, including the post-mortem report authored by Dr Iles and referred to above.

63. Dr Earley catalogued AA's injuries consistently with Dr Iles, who had performed the autopsy. Based on the injuries documented, the evidence of healing and secondary ischaemic changes, Dr Earley also concluded that:

- The evidence indicated recent and previous blunt force trauma to the skull;
- The evidence indicated at least two, if not more, episodes of brain injury with evidence suggesting an acute haemorrhage may have happened within a few days of death and a more chronic haemorrhage may have occurred in the weeks prior.[39]

[38] Exhibit 3 and Coronial Brief, p. 522
[39] Coronial Brief p. 545

- Encephalomalacia, a term used to describe softening of brain parenchyma, was noted on the left cerebral hemisphere and indicates that it is possible that there may have been episodes of trauma up to three or four weeks before death.[40]
- Similar to the skull fractures, the rib fractures suggested more than one episode of trauma with both recent and older injury, with the rib fractures showing radiological evidence of healing likely to be at least 10 days old.[41]

64. In relation to causation of AA's injuries, Dr Earley was asked whether it was her conclusion that AA was subjected to shaking. She replied:

> *"Um, yes. I mean in terms of - as a mechanism of trauma, yes, certainly. The - the retinal haemorrhages found on post-mortem, the brain findings anti-mortem on CT and post-mortem, um and also the skeletal findings, would fit with the picture of shaking... yes, I would think, given that there were skull fractures and numerous skull fractures, probably an element of shaking plus impact."*[42]

65. Although Dr Earley was unable to comment more precisely on the timeframe within which AA sustained her injuries, in response to questioning, she agreed that in all likelihood AA did have underlying injuries when she was seen on 19 April 2012, a week prior to her death, at the Unsettled Babies Clinic and on 24 April 2012, two days before her death, at the Moreland MCH Service.[43] Given the challenges Dr Earley had outlined in accurately dating various injury types, she was appropriately not asked to speculate on whether injuries were likely present at earlier consultations, for example at the twins' GP visit 16 days prior to death or at their Moreland MCH service visit 26 days prior to death. In preparing her report, Dr Earley was aware of the bruising observed on both AA and BA on 30 March 2012 and on BA on 24 April 2012. As discussed in detail below, she gave evidence about the significance of these bruises as possible indicators of inflicted harm and underlying injury. In her Report, however, she did not attempt to draw a direct correlation between these documented bruises and any particular brain or skeletal injury to AA or BA which was later discovered. Likewise, she did not suggest that the occurrence of these documented bruises ante-mortem could be particularly relied upon in dating the brain or skeletal injuries observed post mortem. Dr Earley was not asked about this directly. However, given that the timing, number, nature and relative severity of episodes of trauma which occurred prior to death remains entirely unknown, I do not expect that she would have been able to draw any such connection.

[40] Coronial Brief p 544 – 545 and Inquest transcript p 97 – 98
[41] Coronial Brief p 544
[42] Inquest transcript p115 – 116
[43] Inquest transcript p 121

66. At inquest, and given the evidence regarding both acute and chronic injuries, Dr Earley was asked to comment specifically on the timing of the injuries which ultimately caused AA's death. Dr Earley gave evidence that "*the ultimate injury that led to her death would reasonably have been expected to have occurred close to the time of her death.*"[44] She went on to explain that by this she meant a matter of days.[45] However, Dr Earley also later explained that there are difficulties in pinpointing whether a particular event or injury led to death and when it occurred. She stated:

> *"The forensic feeling would be, in cases of fatal head injury, that the insult has happened relatively soon, close to the time of collapse. But again that is – is – is relatively controversial. And we're not sure about the degree that the previous injuries have contributed to her as well. Because sometimes as well it –it – it's difficult. And again for research to work out what has led to the final demise; is it shaking that's caused cervical spine injury and led to respiratory arrest, or is it the brain injury itself? So sometimes that it quite difficult to figure out."*[46]

67. Dr Earley gave evidence that the fact that no bruising or other evidence of injury was observed on AA when examined on 19 April 2012 and again on 24 April 2012 did not necessarily lead to a conclusion that the ultimate injury that caused her demise, more likely than not occurred after the first, if not both, these consultations.[47]

68. Importantly for the purposes of the coronial investigation, Dr Earley gave evidence, both in her written report and at inquest, that regardless of whether particular injuries were already present at any consultation, there may have been no clear clinical signs and symptoms. Further, she gave evidence that such signs and symptoms as were present may easily, and in the absence of any relevant history of abuse or trauma, reasonably, be assumed to be indicative of common childhood illness.[48] In her Report she stated:

> *"Abusive head trauma in infants may have very few clinical symptoms or signs. There is a wide range of ways in which infants may present. In severe case they can present with cardiovascular or respiratory collapse and in an encephalopathic state which can have fatal results. Other symptoms may include irritability, poor feeding, vomiting, and occasional seizures. Other cases, in particular those with subacute and chronic subdural haemorrhages may present with more chronic symptoms such as enlarging head circumference. Due to the varied presentation of abusive head trauma and symptoms that overlap with other common childhood illnesses, the diagnosis of abusive head trauma may be missed by medical professional or others.*
>
> *In cases where skull fractures are sustained, some studies have shown that there may not be external signs of trauma such as bruising or swelling. Therefore, in the absence of a history*

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[44] Inquest transcript p 118
[45] Inquest transcript p 118
[46] Inquest transcript p 134
[47] Inquest transcript p 119- 120 and p 133- 134
[48] Inquest transcript p 98 -99

of trauma, medical professionals may not be aware or investigate for possible skull fractures. Rib fractures may be seen in association with abusive head trauma. Although occasionally they may be found in combination with bruising to the thorax, in the majority of cases no external injuries are found. It is more common that rib fractures are found during the course of subsequent investigations for example the skeletal survey or bone scan."[49]

69. Consistently, at inquest when Dr Earley was asked whether any of the injuries would have been evident to those examining the twins, she said:

> *In relation to all the other injuries, the skeletal injuries and the brain injuries, based on your report, is it fair to say that it is quite possible that healthcare providers examining the children in terms of - and I'm not talking about X-raying, but certainly in a normal physical examination - is it quite possible - and I would ask you assessment on the reasonableness of this, that those bony injuries and brain injuries would not have been identifiable in those examinations?---Yes, that is true, that they may - there may not have been physical signs on examination of particularly those bony injuries and head injuries."*[50]

70. Questioned further, Dr Earley continued as follows:

> *"And putting perhaps seizures to one side, but certainly in terms of irritability, poor feeding and vomiting, that those are symptoms that could certainly - and I use the word reasonably be associated with other childhood conditions or illnesses, including that of colic?---Yes. Um, that is true, and that's one of the difficulties in um, assessing children with potential abusive head trauma."*[51]

She noted that this was the case in the context where there is no information known to the medical practitioner of potential abuse or no information about the possibility or risk of physical abuse.

71. I heard evidence from Ms Kingston about the physical examination she conducted on both twins on 30 March 2012;[52] from Ms Monagle about the physical examination she conducted on both twins on 15 March 2012 [53] and 24 April 2012;[54] from Dr Zagarella about the physical examination he conducted on the twins on 10 April 2012;[55] and from Dr Dawson about the physical examination she conducted on AA on 19 April 2012.[56] I accept the evidence of each about the nature of the physical examination conducted by them. I do not consider that there is any basis to suggest that the physical examination was not appropriately thorough, on each occasion, given the varying nature and purpose of each consultation.

72. With the exception of the bruises detected on 30 March 2012 and 24 April 2012, and discussed in considerably more detail below, I accept that on each occasion no physical signs of injury

[49] Coronial Brief p 546 – 547
[50] Inquest transcript p 99
[51] Inquest transcript p 99
[52] Inquest transcript p 302 – 303.
[53] Inquest transcript p407 – 409
[54] Coronial Brief p 558 – 559
[55] Inquest transcript p 541.
[56] Coronial Brief p 1313- 1314 and p 1328; Inquest transcript p 84.

were observed and no other clinical signs were present which, on their own, ought to have led the various practitioners to suspect underlying head trauma, rib or skull fracture. On that basis, and again leaving to one side the bruising observed by the MCH nurses and not known to the other practitioners, I consider that, regardless of the precise timing of AA's injuries, there is no basis for concluding that those injuries could or should have been detected by the practitioners who examined AA prior to her death on 26 April 2012.

73. It was reasonable, given the history disclosed of fussy feeding, irritability and vomiting, and in the absence of anything remarkable discovered upon examination or in their family history, that the twins would be diagnosed with colic. Even with the benefit of hindsight it does not automatically follow that this diagnosis was incorrect. In that regard, I accept the following submissions, made on behalf of the RCH, but which may also be considered relevant to other practitioners:

> *"Following her examination of* AA *and having regard to the history provided by* Ms A *and* Mr A *in respect of both* AA *and* BA *Dr Dawson formed the view that the likely cause of the twins unsettled behaviour was colic. The fact that colic is not a diagnosis but a descriptor of symptoms does not take away from the reasonableness or appropriateness of this conclusion with respect to the twins having regard to the history provided and examination of* AA *that was undertaken. Dr Dawson made a contemporaneous note in the medical record to the same effect.*
>
> ... ...
>
> *Overall, it is submitted, there is no evidence to suggest that the diagnosis of colic was in fact incorrect regardless of whether or not either of the twins was injured at the time of consultation on 19 April 2012. Symptoms such as vomiting and irritability are present in common infant illnesses such as colic and are not specific to or diagnostic of neurological injury. Further, colic, characterised by crying classically in the evening or late afternoon, is a common presentation in babies under the age of four months where no organic cause of their unsettled behaviour has been identified."*[57]

74. There are two further matters which require specific mention in relation to this issue.

75. When the twins attended the Unsettled Babies Clinic on 19 April 2012, only AA was physically examined by Dr Dawson. BA in whose name the appointment had actually been made, was asleep and was not examined. There were essentially two reasons provided for the decision not to physically examine BA The first was that the appointment had originally been made for one twin, but at the request of the parents it was agreed to see them both. The second was that BA was asleep for the bulk of the appointment. Given the nature of the clinic, and the fact that her history and presenting complaint were in effect the same as AA's , it was considered preferable not to disturb her. There was a plan to follow up with the family in two weeks, which, according to Dr Dawon would have provided an opportunity for examination.

[57] Submission on behalf of The Royal Children's Hospital p 9

A/Prof Hiscock, the Director of the Clinic, gave evidence that there was nothing particularly unusual in the scenario where an awake twin is examined and the sleeping twin is not woken.[58] Dr Earley concurred that the decision not to examine BA in all the circumstances, was very reasonable.[59]

76. The submission made on behalf of Mr A on this point was as follows:

> *"Although it is the position of* Mr A *that both* AA *and* BA *should have been examined on their attendance at the Royal Children's Hospital Unsettled Babies Clinic, it is accepted that a plausible explanation was provided for the failure to examine both twins."*[60]

77. I accept Dr Dawson's rationale for her decision to only examine AA at the consultation on 19 April 2012 and do not consider that her decision attracts any criticism. In the circumstances, it is unnecessary to speculate whether a physical examination of BA might have revealed anything to alert Dr Dawson to the injuries the twins had likely already suffered at that time.

78. The second discrete matter which warrants mention is the comparison between the bruising that was noted on BA on 26 April 2012, and that which was noted by Ms Monagle two days earlier on 24 April 2012 at the Moreland MCH Service. Ms Monagle recorded in her contemporaneous notes of the consultation on 24 April 2012 just one bruise on the right side of BA's face. In subsequent written statements and at inquest, Ms Monagle clarified that what she observed was a pea sized bruise on BA's right cheek. No bruise was located in this position when BA was examined on 26 April 2012 at the VFPMS, however, bruises were noted above the middle of her right eyebrow, another bruise just to the outer of this, three bruises on her right lower abdomen, four small circular bruises on her left knee, and a bruise on her labia.[61] In her Report, Dr Earley commented that:

> *"It is difficult to comment whether the injuries noted by VFPMS staff on* BA *which appear not to have been documented by her Maternal and Child Health Nurse when she was examined on 24th April 2012 may have been present. .... It is not possible to accurately date these bruises and therefore it is possible that these may have occurred in the two days prior to* BA's *examination at VFPMS."*[62]

79. At inquest, Dr Earley again gave evidence that it is "*notoriously difficult to age bruises*"[63] and that they can resolve quite quickly, possibly explaining the fact that no bruise was observed on BA's right check on 26 April 2012. For that reason, and consistent with my finding above, I do not think that the bruises that were documented on BA on 26 April 2012, but not on 24 April 2012, suggest any shortcoming in the thoroughness of the examination conducted by Ms

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[58] Inquest transcript p 143
[59] Inquest transcript p 135.
[60] Submission on behalf of Mr Mr A p 2
[61] Coronial Brie, p 147 – 148.
[62] Coronial Brief p 548
[63] Inquest transcript p 125.

Monagle, or support the conclusion that areas of bruising were missed or inaccurately documented on that day.

Issue 2: Response to bruising on the twins

80. In her written report, Dr Earley explained that a bruise results from haemorrhage into the soft tissues and skin, usually as a result of blunt force trauma. She stated that the presence of bruising on non-mobile infants raises concern about the possibility of non-accidental injury. Dr Earley referenced a Welsh review which highlighted that bruising in non-mobile infants was very uncommon and that accidental bruising was not commonly seen on the backs, buttocks, forearms, face, abdomen or hip, upper arm, posterior leg or foot. She referenced a second study that reportedly concluded that bruising in any region for an infant less than four months was thought to be suggestive of abuse.[64]

81. Dr Earley stated that the presence of bruising in infants may also raise the possibility of an underlying bleeding disorder. She noted that there may be other features in the history, such as a family history of bleeding disorders, which may prompt investigation. She suggested that initial blood tests for example a full blood count or a coagulations screen may help in differentiating a bleeding disorder as a cause of the bruising.[65]

82. At inquest, Dr Earley reiterated what she had stated in her written report. She agreed that bruising immobile infants under four months of age is of considerable concern. She was asked whether the two general possibilities for that bruising were deliberate infliction of an injury or a blood disorder. Dr Earley replied:

> *"Yes, that is true. Very rarely and uncommonly accidental cause but certainly the first two that you mentioned would be the first two that you would reasonably consider."*[66]

83. Dr Earley went on to explain why bruising in immobile babies is of particular concern. She said:

> *"You mentioned that it's particularly concerning about bruising on babies that aren't mobile. Why is it more concerning about a baby that's not mobile than a baby that is mobile?---So there have been further studies leading on from the ones that I have um mentioned and referenced. So once babies start to crawl, obviously, they are – or possibly roll but certainly crawling is more of a defining moment, that they are able to bang into things, fall on things, whereas when very young they can't move from where they're placed. So they - they don't tend to injure themselves accidentally."*[67]

84. Dr Earley's evidence about the significance of bruising in non-mobile infants was not in contest at the inquest, and indeed was echoed by other health professionals who gave evidence.

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[64] Coronial Brief p 547 – 548.
[65] Coronial Brief p 548
[66] Inquest transcript p 100
[67] Inquest transcript p 126 - 127

85. Dr Dawson gave evidence that it was a rarity to find a bruise on an immobile infant, that you have to be alert to it and that, where there is bruising on an infant less than four months of age, a concern may arise as to whether it is an inflicted or non-accidental injury.[68] A/Prof Hiscock concurred that bruising in an immobile baby would at least raise the prospect of non-accidental injury such that questions would need to be asked.[69]

86. Ms Kingston agreed that unexplained bruising in a child is a red flag and that unexplained bruising in an immobile child is an "*even greater red flag.*"[70] Ms Kingston agreed also that bruising in an immobile infant raises concern about the possibility of non-accidental injury.[71] When asked if any bruising or injury on an infant of four weeks is of considerable concern, she said "*I would agree that it's evident that the child has had a knock. Um, it would depend on the reasoning as to how the bruise was there as to what level of concern it would raise in me.*"[72]

87. Ms Monagle gave evidence that bruising on a non-mobile infant constituted a "*red flag straight away.*"[73] She agreed that one possible explanation was a blood disorder and that the other was deliberate infliction of an injury or abuse.[74]

88. Dr Zagarella also agreed that bruising on an immobile infant is absolutely a red flag for a practitioner.[75] Specifically, he agreed that it is a red flag for possible intentional injury or, an underlying blood disorder.

89. With respect to how bruising observed on an immobile infant ought to be followed up by health professionals, the evidence was somewhat more varied. There was clear consensus that questions should be asked as to the origins of the bruising. However, there was some divergence of view as to whether, depending on the explanation received, further investigation should be undertaken or referral made, and in what timeframe.

90. Dr Earley's evidence was as follows:

> *"Would you expect that if bruising was noted, facial bruising was noted on a child or children four weeks of age, that there will be some sort of follow-up done in relation to that?---Yes, I would expect that, some form of follow-up. I suppose it depends on who saw the bruising, in what context, what other information was available on what the follow-up should be, um but certainly I would expect the child to be followed up by someone, or if it was appropriate to referred on to somebody else."*[76]

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[68] Inquest transcript p 29
[69] Inquest transcript p 172 - 174
[70] Inquest transcript p 324
[71] Inquest transcript p 334
[72] Inquest transcript p 294
[73] Inquest transcript p 415
[74] Inquest transcript p 416
[75] Inquest transcript p 553
[76] Inquest transcript p 100 -101

91. However, in response to subsequent cross examination Dr Earley clarified how her response to bruising observed on an infant may depend on the explanation given for it. Her evidence was:

> *"So if you weren't satisfied with it, what would you do?---Well, I mean I - I have the benefit of being a specialised forensic paediatrician. Um, if I wasn't particularly happy with the reason given for the bruising, um, if I was concerned that there was anything else suggestive, or I was concerned about a bleeding disorder, I might start with some basic blood tests such as a full blood counter or coagulation screen. Um, but in a - such a young infant, if I had concerns, um, that there was abuse, um, would probably move to doing - to something like a skeletal survey and bone scan, um, which would be the next sort of - next - probably the next more reasonable step.*
> *And if you were satisfied with the explanation, would you do anything?---If there were - if I was satisfied and I was happy, I would probably bring the child back to myself again for further review within a short period of time, um, to follow up on their progress, and also look - ah, re-examine the child - children for further bruises; developmental progression."*[77]

92. Dr Earley indicated that, in her view, bruising on an immobile child would *mandate* action (for example, referral to an appropriate practitioner or service for review, skeletal survey or blood testing, and possibly mandatory reporting) at least on the second occasion, although not necessarily the first, where it would raise concerns to be assessed in the context.[78] I consider that this is consistent with Dr Earley's answer extracted above.

93. Dr Dawson's evidence was that if she was aware of a bruise she would seek an explanation from the parents, and discuss the information with her supervisor. She indicated that in most cases it would require follow up.[79] Her supervisor, A/Prof Hiscock, when questioned about this matter, indicated that it was difficult to speculate about the appropriate response:

> *"So would it be true to say that, if you see a baby with bruising, it's beyond your expertise to really say what's caused the bruising?---Yes. I - I think it, ah, in a - an immobile baby, yes, I think that's - gets quite tricky.*
> *So really as a cautious practitioner, you would then - - -?---I'd be asking about "Have you harmed".*
> *You'd probably refer them off, or at least admit them to the hospital?---Or I - I would be, if I was in - in doubt at all, then I'd be trying to admit them to the hospital.*
> *Yes. Because you'd have a low index of suspicion, and you'd want to - - -?---It's very hard to say. It's really hard to say."*[80]

94. In response to subsequent questioning, A/Prof Hiscock agreed that what, if any further steps she would take in response to documented bruising would depend on the answers she received to questions about the origins of the bruise(s) and whether she accepted those as providing a reasonable explanation.[81]

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[77] Inquest transcript p 129
[78] Inquest transcript p 111
[79] Inquest transcript p 23 – 24
[80] Inquest transcript p 174
[81] Inquest transcript p 130

95. Dr Zagarella, having agreed that bruising raised both the possibility of intentional injury and an underlying blood disorder, gave evidence that both possibilities would require investigation. However, it was unclear whether his answer assumed that the bruising was not otherwise satisfactorily explained or whether his answer would have remained the same in any case. The follow up question which was put to him, and in response to which he discussed the tests and imagining he would routinely order, was premised on the hypothetical assumption that an infant had been referred to him by an MCH nurse for investigation of bruising.[82] The further questions put to him assumed bruising had been observed on two separate occasions, in which case, consistent with Dr Earley, his answer indicated that, regardless of the explanation given, he would order further investigations and make an referral to the appropriate service for review.

96. Ms Monagle's evidence was that, as an MCH nurse, if she observed bruising in an immobile infant the least she would do would be to write a letter to the GP and refer off for him or her to consider further investigations.[83] Ms Kinston's evidence was that her response would depend on her assessment of the explanation given for the bruising and whether, in the context of the broader family presentation, it was plausible. In the event that she did not accept the explanation provided, her evidence was that she would follow up with a plan of action with direct communication with other health professionals.[84]

97. Based on all the evidence above, I conclude that bruising in an immobile infant is rare, in large part because the opportunity for accidental injury is limited. As a result, where bruising is observed on an immobile infant it raises a significant concern that the infant may have been subject to non-accidental injury. Such a concern requires careful questioning of caregivers in order to ascertain the origin of the bruise(s). Absent the provision of a credible and plausible explanation, upon which the interviewer might *reasonably* be satisfied that the infant has not been and/or is not at risk of intentional harm, further investigation must immediately be set in train. Even where such explanation is provided, I consider the cautious approach advocated by Dr Earley, which is to schedule a review of the infant within a short period of time, to be a sensible one.

98. It is in the context of those conclusions that I turn to consider the response to the bruising that was in fact observed on AA and BA on 30 March 2012 and on BA on 24 April 2012.

[82] Inquest transcript p 553-554
[83] Inquest transcript p 434
[84] Inquest transcript p 296

Response to bruising observed on 30 March 2012

99. As summarised in the timeline above at paragraph 15, on 30 March 2012, the A twins presented at the Moreland MCH Service for their four week consultation and were seen by Ms Kingston. They attended with their mother and two year old brother. It was the first time that Ms Kingston had seen the twins and the first time that she had met the A family.

100. Ms Kingston has been a MCH nurse for twenty-four years having qualified in 1991. She is a registered midwife. She has a post graduate qualification from Melbourne University in Infant and Parent Mental Health. She obtained that qualification in 2006. She also has a Graduate Diploma in Child and Family Health.

101. Ms Kingston made two written statements in relation to the death of AA which were both included in the Coronial Brief, and she gave evidence at inquest along the lines of her two statements.

102. Based on that evidence it is established that at the consultation on 30 March 2012, Ms Kingston noted that AA had a "*small bruise, green in colour, 6mm in diameter on her right cheek. BA was noted to have four bruises – 4mm in diameter in a cluster on her left cheek. One of the bruises had grazed skin and was healing.*"[85] To assist at the inquest, Ms Kingston drew a representation of the bruises on the faces of the two twins. The bruise marks were all very faint.[86] Despite the faintness of the bruising, Ms Kingston said they were "*certainly detectable*"[87] with the naked eye.

103. Ms Kingston stated that she asked Ms A about the bruises. Ms A had said "*I don't know what they are doing, they must be bashing each other/bashing themselves with the colic, they are like Houdini, they get out of their wraps no matter how tight I wrap them.*"[88] She said that Ms A went on to say that she placed the twins end to end in the cot for sleeping with their heads adjacent in the middle of the cot. As Ms Kingston put it "*this would explain how their fists could align with the other's face*".[89] Ms A did not purport to have directly witnessed the twins injuring each other in the manner described.

104. Ms Kingston considered that Ms A's explanation for the bruising was plausible[90] and she accepted that the facial bruises could have occurred and had occurred as Ms A suggested,

[85] Coronial Brief p 182
[86] Exhibit 12
[87] Inquest transcript p 294
[88] Coronial Brief p 183
[89] Coronial Brief p 183
[90] Inquest transcript p 297

namely as a result of the children sleeping adjacent to each other and behaving in an unsettled manner with arms "*flailing about with clenched fists*".[91] Ms Kingston said that she "*gave consideration to the possibility of underlying blood disorder which might result in bruising easily*".[92] She said she discussed with Ms A that any further appearance of spontaneous bruising from incidental contact should be followed up with a GP and recalled that Ms A gave her an undertaking that she would do so.[93] Ms Kingston felt confident that, given Ms A's past engagement with health services, she would in fact do so.[94] Ms Kingston discussed safe placement of the babies for sleeping so they couldn't harm each other and reviewed strategies for managing the unsettled behaviours of the babies.[95] She noted that Ms A undertook to cease positioning the twins adjacent to each other in the way that she reportedly had been.[96]

105. Ms Kingston said she did not see the need to seek advice or support from a colleague or supervisor or to refer directly to policies or guidelines in considering her response to the bruises.[97] She did not form the opinion that the twins were in need of protection or that Ms A would not or could not protect them or that they were at risk of physical abuse.[98] Ms Kingston made a note of the bruises in the record of the Moreland MCH Service, but not in the Green Books. She did not make any referrals or notifications in relation to the bruises.

106. During the inquest, Ms Kingston was examined at length in relation to the explanation for the bruises given by Ms A and her reasons for accepting them. She presented as an extremely experienced and reasonable MCH nurse. Overall she was a credible witness.

107. It was clear that, whether it was reasonable to do so or not, Ms Kingston did, in fact, accept Ms A's explanation for the bruising as plausible[99] and that in the circumstance, and taking into account the family's broader history and what she observed herself at the consultation, she did not have any concerns that the twins had been or were at risk of intentional injury.

108. As explained by Ms Kingston, her view was informed by a number of factors. The twins appeared otherwise well and were developing normally; Ms A's record revealed no history of parenting concerns[100]; her engagement with the twins and her son was observed at the

[91] Coronial Brief p 554 and Inquest transcript 336
[92] Coronial Brief p 553
[93] Coronial Brief p 183 and 553
[94] Inquest transcript p 351
[95] Coronial Brief p 183
[96] Coronial Brief p 183 and 553
[97] Coronial Brief p 554
[98] Coronial Brief p 554
[99] Inquest transcript 336
[100] Coronial Brief p 553

consultation to be appropriate, caring, affectionate and capable;[101] she had good supports at home from her mother and partner,[102] and she had demonstrated positive health seeking behaviours in her prior and planned contact with both the MCH service and the RCH.[103]

109. In response to questioning, Ms Kingston accepted that two immobile twins presenting with bruising was a rare presentation, one which she had not previously encountered in her 18 years' experience.[104] She accepted that the sleeping configuration which Ms A had suggested had led to the twin injuring each other was also an unusual sleeping arrangement, and again one which she had not previously encountered.[105] However, in her view, the combined rarity of the presentation and the basis for the explanation did not diminish the plausibility of Ms A's response so as to demand further questioning. On the contrary, Ms Kingston's view was that the mechanism for the infliction of the bruising that was proffered was, given the alignment of the twins and the location and nature of the bruising, "*feasible*".[106] In her view it was not of great significance to her level of suspicion that she had not previously encountered bruising on immobile twins, since she had also not previously encountered twins placed in the cot in a manner which she accepted might expose them to injury from one another. In her view, the novelty of the sleeping arrangement was not, in itself, cause for incredulity because, in her experience parents never ceased to surprise with the things they thought to do.[107]

110. There was some variation in the evidence from other witnesses at inquest about the plausibility of the explanation offered for the twins' bruises by Ms A When A/Prof Hiscock was asked how she would consider Ms A's explanation for how the bruising occurred she said "*I would say that could be an explanation for how they occurred. It could be.*"[108]

111. Dr Earley's evidence in relation to the explanation provided by Ms A as to the facial bruising, was as follows:

> "*...certainly as a paediatrician but probably more so as a forensic paediatrician, my level of suspicion would be quite high and I'd certainly be, um, considering do I need to perform further investigation. But certainly any small child of that age, even though it's a single bruise, I certainly would - the - the thought of, you know, has there been potential injury inflicted on this child, would um - it would occur to me. Also the consideration of any medical problems: Bleeding disorders, family history, those kind of things...*
> *But just going back to the bruising, that you would consider you would need a greater level of force, perhaps greater than what you would expect an infant to be able to project onto*

[101] Coronial Brief p 553 – 554 and Inquest transcript p 300
[102] Coronial Brief p 554
[103] Coronial Brief p 554
[104] Inquest transcript p 332
[105] Inquest transcript p 297
[106] Inquest transcript p 297
[107] Inquest transcript p 331
[108] Inquest transcript p 180

another infant, to create a bruise?---Yeah, possibly and also it's - it's not as common. Scratching is something that is relatively common in infants causing themselves, whereas bruising is not."[109]

112. Asked specifically whether a baby sleeping with another baby and flailing about might injure the other, Dr Earley said *"Whilst it's not necessarily an impossible mechanism, it would be unusual."*[110] She was then asked whether she considered the explanation given by Ms A to be *"far-fetched"*[111], she said:

> *"It's - far-fetched is a bit difficult to, ah, quantify. It - well, to me as a paediatrician, but I have the benefit of being a forensic paediatrician, I would think it is unusual, because we do see lots of twins, and twins do sleep together. Even, you know, bigger multiples - triplets. But they don't tend to injure each other via bruising. Um, I would - if I was given that explanation, I would have to think about it. Um, I would be reluctant to accept it as, um, sort of on face value. I would have to consider it. You'd be reluctant to accept it on face value, but you might consider it?---Yes. Yeah."*[112]

113. Taking into account the available evidence, I accept that there is some limited room for clinical judgement in considering how to respond to bruises observed on an immobile infant, at least on the first such presentation. I do not consider that the occurrence of bruises, at least on first presentation, automatically mandates further investigation or referral, irrespective of the explanation given and the broader context within which it is observed.

114. In this case, I accept that there were a number of features in Ms A's history and presentation to both mitigate concerns raised by the bruises on the twins and to indicate that the information provided by her was likely to be honest and credible.

115. However, there were also matters, which Ms Kingston was aware of, which might be regarded as peaking, rather than tempering, the concern raised by the bruises. As Ms Kingston acknowledged, familial support or not, with infant twins and a two year old, Ms A had an enormous workload[113], the twins were both unsettled and Ms A had already sought medical assistance in that regard; Ms A did not attend on the last occasion because she was sick or tired, (although she appeared to indicate that this was an isolated event); and Ms A's EPDS score at the consultation was borderline. When the EPDS was followed up with further questioning, Ms A disclosed that she felt down sometimes because she couldn't help the twins with their colic and felt sorry for them.

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[109] Inquest transcript p 101-102
[110] Inquest transcript p 127
[111] Inquest transcript p 128
[112] Inquest transcript p 128
[113] Inquest transcript p 390

116. Even more significantly, in terms of assessing the concern raised by the bruises, was the fact that Ms A did not claim to have witnessed how it occurred, and instead was offering an explanation based on how she had deduced it must have occurred.

117. I do not consider that I need to make a finding about whether the explanation for the bruises offered by Ms A was possible or plausible. The uncontested evidence was that this explanation was no more than a speculative theory for how the bruising had occurred.[114] Even accepting that this theory appeared to be a confident, thoughtful one that Ms A had carefully pondered upon,[115] in the absence of Ms A actually being able to verify how the bruises had occurred, I consider that Ms Kingston should have questioned her further, including exploring the possibility that the bruises may have been intentionally inflicted.

118. It is not sufficiently rigorous to state that bruising in an immobile infant is unusual and requires explanation, and that whether or not it raises concern about non-accidental injury depends on the absence or availability of a *possible* plausible explanation. Bruising in an immobile infant automatically raises concern about the possibility of non-accidental injury. That being the case more than a theory (regardless of how feasible and credible it was considered) ought to have been required by Ms Kingston to dispel that concern. It follows that further action from Ms Kingston was warranted in response to the bruising. Ms A's undertaking that further episodes of bruising would be referred to her doctor was not enough.

119. As it was, Ms Kingston accepted Ms A's explanation for how she thought the bruises must have occurred as completely addressing any concern that the bruises might be the result of intentionally inflicted injury. And being satisfied in this way, Ms Kingston did not discuss the matter with a supervisor or colleague, as for example, both Dr Earley and Dr Dawson indicated that they would.[116] Ms Kingston did not make contact with or made a referral to any other health professionals or services in order that the bruises might be further investigated. She did not take any steps to put other health practitioners involved in the care of the twins on notice about the bruising so that it might be considered as part of the full clinical picture in future assessments. She did not give consideration to whether a notification should be made to Child Protection, as at no point did she form an opinion that the twins were in need of protection. She did not make arrangements to review the twins within a short period. Ms Kingston advised Ms A about the safe placement of the twins in the cot, secured an undertaking that Ms A

[114] Inquest transcript p 330
[115] Inquest transcript p 303
[116] Inquest transcript p 333

would follow up with her doctor if more bruising were to occur and made a booking for the twins to attend their next routine appointment in four weeks time.

120. I consider that Ms Kingston's decision not to follow up the bruising represented a potential lost opportunity for the more timely detection of the harm to which the twins were exposed and possibly the more timely detection of their underlying injuries, of which there were otherwise no physical signs.

121. I accept that Ms Kingston acted honestly and conscientiously and that as an MCH nurse of considerable experience she exercised and backed her own clinical judgement. However, her approach employed a decision making process that did not appropriately weigh the potential significance of bruising in an immobile infant as an indicator of intentionally inflicted harm. In that respect, I consider that there is a question about whether Ms Kingston's prior training in respect of bruises was appropriately updated and clear as to the level or type of response expected. In submissions made on Mr A's behalf it is noted that Ms Kingston had not availed herself, of "*any training or information in relation to bruising in the non-mobile infant until October 2012.*"[117]

122. I also note with some concern that Ms Kingston's evidence was that, faced with the same clinical scenario today, she would come to the same conclusion.[118] I consider that this reveals, at least to a degree, a lack of "*insightful reflective learning*"[119] as put in the submission made by Mr A

123. I do not accept the suggestion made in submissions by Mr A that I should refer Ms Kingston to the Australian Health Practitioner Agency in relation to her professional standards. I do however strongly agree that it is critical that she and other nurses in her role undertake training in relation to bruising on immobile infants. The DET have made submissions and provided information on this point which is addressed below.

124. In submissions made on behalf of Mr A it was asserted that "*But for Nurse Kingston's inaction it is likely that* AA *would be alive today and* BA *would not be suffering from her permanent significant injuries.*" I am not sure that the position is so clear.

125. I accept Dr Zagarella's evidence that, if the twins been referred to him to investigate the bruising after the four week visit then he would have responded as follows:

> I *would routinely do some radiology, looking for skeletal trauma, looking for fractures. I would base it - given that - if we look in particular with the twins here,* AA *and* BA

[117] Inquest transcript p 323 and Submissions on behalf of Mr Mr A p 10
[118] Inquest transcript p 338 – 339
[119] Submissions on behalf of Mr Mr A p 10

given that they were unsettled I would probably then make a direct and urgent referral to a paediatrician for formal assessment so that they have greater expertise than what I have clearly, because they're specialists in the field and then they could order the - the appropriate investigations looking for blood disorders which could cause bruising. But generally if that was the case there would be bruising elsewhere so if it was an isolated bruise and it was on two occasions, as obviously was the case in these, imaging and a direct referral would be the most appropriate thing to do.

Take away the second occasion, but on the first occasion was as twins - - -?---Yes.

There's bruising on both twins, four week - that scenario you would still say the thing to do there, because it is isolated, the important thing is to do imaging and referral?---Yes.
And it is actually less likely to be a blood disorder, more likely to be an intentional injury because of the isolation of bruising?---That would be the probabilities, yes.
The scenario would have been, if you had received that referral after the four week stage, that's what you would have done in this case?---Yes, I would have."[120]

126. Of course, as explored in some detail already, it is not known whether any more significant underlying injuries had been suffered at that time and thus would have been detected. Nonetheless, it is difficult to resist the conclusion that this level of focus on the physical health of the twins in light of the bruising and the concerns it raised would have changed the course of the matter.

127. Dr Dawson was also asked about whether, had she been aware of the facial bruising observed on both twins at four weeks that may have changed her considerations and approach, she said "*It may have, but I think the main thing would be examining the baby, you know, which was done, would have been the most important consideration.*"[121]

128. A/Prof Hiscock was asked a similar question and replied as follows:

> *"So you've got bruising in two children?---Mm.*
> *You've got irritability. Bruising at four weeks in two children?---Yep.*
> *You've got irritability; you've got twins; you've got a mother who's scored 17 on an EPDS; you've got a mother who scored positively on the question of thought of harm of herself in the last seven days. Under those circumstances, the whole picture, if you were given the whole picture yourself and Dr Dawson or yourself weren't given the whole picture, but if you were, that would sort of up the ante from the picture you were given, wouldn't it?---I would still ask, "Have you thought about harming yourself", and that was asked. And I would still ask about, "Have you thought about harming your baby", and that was asked. And I would still - I would ask, "How did these bruises happen", and it would depend on the responses. So there was a negative to the first two responses."*[122]

129. It is speculation as to what Dr Dawson would have in fact done in the event of being made aware of the facial bruising noted by Ms Kingston, but I accept that she would have asked the parents about it and discussed the explanation of it. She may have brought a more sceptical

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[120] Inquest transcript p 553-554
[121] Inquest transcript p 152
[122] Inquest transcript p 173-174

frame of mind to the explanation, although given all of the other factors which led her to accept that there was no risk of harm to the twins when she saw them on 19 April 2012, it is on balance unlikely that she would have considered further action was required, particularly bearing in mind that it was by this stage 19 days after the observations made by Ms Kingston of bruising on both twins.

Response to bruising on 24 April 2012

130. As summarised in the timeline above at paragraph 21, on 24 April 2012, the A twins presented at the Moreland MCH Service for their eight week consultation and were seen by Ms Monagle. They attended the appointment with both their parents and two year old brother. Ms Monagle had reviewed the twins at their two week assessment, and was also familiar with the family having conducted a number of routine assessments in relation to their son, CA including one on 19 March 2012.

131. Ms Roslyn Monagle is also a highly experienced MCH nurse. She was first registered in 1972, then registered as a midwife in 1974. She has subsequently completed various certificates and worked in maternal and child health nursing since 1977.

132. Ms Monagle made three written statements in relation to the death of AA which were both included in the Coronial Brief, and she gave evidence at inquest along the lines those statement statements.[123]

133. Based on that evidence it is established that, at the consultation on 24 April 2012, Ms Monagle observed injuries on BA described as pea sized bruising on the right cheek and a small scratch on the left cheek. The injury was "*like a pea shape*" on the "*right cheek bone*". It was "*very light in colour and there was a scratch in the area of the left cheek bone*". [124]

134. Ms Monagle stated that she did not think the parents were aware of the marks before she pointed them out. She said "*I don't think* Mr A *had noted*" and "*I remember* Ms A *saying that she thought it happened about two days earlier but ... I'm not too sure what – I don't know what* Mr A *had said.*"[125]

135. In describing the bruising and scratching, Ms Monagle said:

> *"From your recollection of looking at the scratch and what you described as a pale or a light bruise?---Yeah, it's own - it was only very pale. Um, yeah.*
> *Would it be something you would expect you would see with normal handling and bathing and feeding of the children; something you would notice?---Ah, yes, it was very noticeable,*

[123] Exhibits 13 and 14
[124] Inquest transcript p 413
[125] Inquest transcript p 415

because I stopped what I was doing - about to do, um, as soon as I saw it, and that gives me as a Maternal and Child Health nurse a red flag straight away. Um, and so then I had to do a risk assessment. So I actually stopped the conversation that I would've kept going on, to go into a risk assessment, and asking the parents."[126]

136. In relation to questioning the parents about what they thought had happened, her evidence was:

"I actually - I can't recall everything. I - I know that we talked about the bruise. I know we mentioned CA *and I asked specifically, "Do you think* CA *has caused this?" I - I'm unsure of - of how both* Ms A *and* Mr A *answered those questions.*
Is it fair to say, you didn't really get an explanation. No one really knew how that happened?---Mm. Yes."[127]

137. Ms Monagle's evidence was that a discussion ensued with the A's about the need to closely supervise toddlers around newborns.[128] She could not recall who first introduced CA into the conversation, however, she did recall asking the parents whether he might have inflicted the injury.[129]

138. Mr A's evidence was that he remembered being told of bruising above BA's eyebrow and the scratching on the cheek. He said that he thought that Ms Monagle showed the injuries to him. Asked his reaction, the evidence was:

"I was shocked, I was astounded. I had no - I had - I just couldn't comprehend how they got there, I was speechless...I remember Roz asking me about them and I was speechless, I didn't know how to answer her because I wasn't sure how they were there. She may have asked the question to Ms A *but I was in and out of that room all the time looking after* CA *"*[130]

139. Asked about Ms A's response at the time, he was vague but said *"I know she blamed* CA *for some of them."*[131]

140. At any rate, it was not in contest, that the As were not able to provide an explanation for how the bruise had occurred.

141. Prior to or during the consultation, Ms Monagle did not read Ms Kingston's notes from the four week assessment.[132] She was therefore not aware that the twins had both presented on that occasion with facial bruising, and that Ms A had explained it with a theory that the twins must have been hitting each other because of the way they were positioned in the cot. She was not aware that Ms A had undertaken to take them to the doctor if it occurred again. Neither of the As mentioned that the twins had had facial bruising before.

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[126] Inquest transcript p 132
[127] Inquest transcript p 415
[128] Inquest transcript p 416
[129] Inquest transcript p 414
[130] Inquest transcript p 241
[131] Inquest transcript p 242
[132] Coronial Brief p 558

142. Ms Monagle was also not aware that Ms A had undertaken an EPDS on 30 March 2012 and had a borderline score of 12.

143. At this consultation, Ms Monagle observed that the As were tired, frustrated with medical advice,[133] struggling with the unsettled twins and concerned about their poor feeding and how it might be compromising their growth.[134]

144. Ms Monagle determined that BA should be reviewed by her GP and prepared a referral letter to "GP" in which she referenced the bruise on the right side of BA's face and noted that the parents did not know how it had occurred but had noticed it the previous day. She also mentioned BA's fussy feeding, poor weight gain and the recent withdrawal of the medication 'zantac' on advice from the RCH.[135]

145. After hours, on 24 April 2012, having completed her other consultations, Ms Monagle also spoke to a colleague from the EMCH Service about the possibility of the A family being picked up by that Service, given the challenges they appeared to be facing (an active two year old and unsettled twins, one with a bruise on her face possibly caused by her older brother).[136] She discussed their need for some extra support, possibly in the home.[137] Ms Monagle also discussed with her colleague the merits of referring the family to the organisation Child First.[138]

146. The day after the consultation was a public holiday and the day thereafter AA died. In the circumstances, Ms Monagle did not have the opportunity to consult further with the family and pursue any of the plans she had in contemplation for assisting them.

147. Ms Monagle was clear that she approached her colleague in the EMCH Service, and began to consider and explore plans for further supporting the A family because of the A family's general presentation on 24 April 2012, of which the bruise on BA was just a part. The bruise, however, was not the sole reason for her concern and nascent plans.[139]

148. The text of the referral letter to the GP also indicates that the bruise was part of, but not the sole reason, that Ms Monagle considered that BA required review. [140]

149. Ms Monagle did give evidence that she considered bruising in an immobile infant to be, in itself, a red flag because the possible explanations for it included both a blood disorder and the

[133] Coronial Brief p 560
[134] Inquest transcript p 478
[135] Coronial Brief p 563
[136] Inquest transcript p 496 – 497 and p 518 - 519
[137] Coronial Brief p 560 – 562; Inquest transcript 489 - 491
[138] Coronial Brief p 560 – 561 and Inquest transcript p 521
[139] Inquest transcript p 496 – 497 and p 518 – 519
[140] Coronial Brief p 563

deliberate infliction of injury and abuse.[141] In Ms Monagle's opinion, the most appropriate course of action with bruising on an immobile infant was to send the child off, at the very least, to a GP for review of the causes of the bruising.[142] She did precisely that in this case by typing a letter for the As to take to their GP. Further, and I accept her evidence on this point, she made another appointment for the twins in one week's time, commenced a process for referring the family to the EMCH Service, and intended, timetable permitting, to try and visit the family at home in a couple of days.

150. The question is whether Ms Monagle responded adequately and with requisite urgency to the 'red flag' represented by the bruise on BA on 24 April 2012.

151. In approaching this question, it is necessary to say something about the fact that Ms Monagle omitted to read the notes from the previous session, where bruising had been documented on both twins' faces.

152. In my opinion, the appropriate response to the bruising on 24 April 2012, should be considered from the perspective of someone who was aware that this was the second time one or both the twins had a facial bruise, and the second time that the parents were unable to say precisely how it had occurred, (the explanation on the first occasion having been framed as a deductive theory).

153. The evidence was clear that as a matter of practicality it would have been very easy for Ms Monagle to access the notes of the previous consultation.[143] It was Ms Monagle's evidence that it was good practice to read the notes of the prior session and that it was her usual practice to do so, often while the parent(s) were present so that she could confirm with them any issues or plans.[144] Other witnesses confirmed that this was their standard practice.[145] Ms Monagle agreed that this is what she should have done[146] and that the four week notes contained information which would have been relevant to her assessment.[147]

154. The reason Ms Monagle offered for departing from her usual practice and not reading the previous notes on this occasion was that, essentially, she was overtaken by circumstances.[148] Even from the waiting room, the parents commenced talking immediately about their worries

[141] Inquest transcript p 416
[142] Inquest transcript p 447 – 448
[143] Inquest transcript p 437
[144] Inquest transcript p 418 – 419
[145] Inquest transcript p 298 and p 105
[146] Inquest transcript p 437- 438
[147] Inquest transcript p 419
[148] Inquest transcript 418 – 419

and concerns[149] and then Ms Monagle noticed the bruise on BA and went into a risk assessment.[150] I accept that Ms Monagle is sincere in offering this explanation but I find it unsatisfactory.

155. The very reason offered by Ms Monagle for not reading the notes was the very reason, if she had not already, she needed to do so. A review of the notes of the previous presentation and any issues or concerns noted therein would appear to be highly relevant to any risk assessment. Indeed, at the time, both the Moreland City Council Mandatory Child Protection Policy for MCH nurses[151] and the Maternal and Child Health Service Guidelines, published by the DET in February 2011, indicated that reviewing prior records was part of the process of assessing an identified concern.[152] Ms Monagle indicated that she was familiar with both these documents.[153]

156. I accept that as a matter of appropriate professional standards of practice, not reading the notes of the earlier consultation was an obligation that Ms Monagle failed to discharge.

157. Returning to the question of whether Ms Monagle's response to the bruising was sufficient in the context I have outlined, I note that a number of witnesses indicated that bruising in a non-mobile infant on a second occasion was, in their view, of particular significance.

158. Ms Myers- Braun, the Enhanced Maternal and Child Health nurse, with whom Ms Monagle consulted on 24 April 2012, gave the following evidence:

> *"Nurse Myers-Braun. Just in relation to the observation of facial bruising on immobile infants, if you were aware of a scenario where immobile infants of some four weeks were observed to have minor bruising on their face at the four week mark and then again on the eight week assessment there was minor bruising observed on a second twin, would you be alerted - would that - obviously we've heard this morning there's a lot of factors that are taken into account - -- ?*
> *---M'mm.*
> *....but would just the fact of bruising on two separate occasions in immobile twins, the first time on both faces, the second time on one twin, would that be something that would turn your mind to the possibility of abuse?---I think if you were aware of a second occasion it probably would, but you know, I've actually been in a home where I saw a toddler fling something at a baby and the bruise came up while I was sitting there. So I guess that explanation of possibly a toddler, you know, doing something, might justify it on one occasion, but I - I'm not sure. I - I think if I had a second occasion I'd be very alerted. It would be a red flag for sure.*
> *Would it be fair to say, would that red flag in itself be enough to make you take further action, or would there be other enquiries you'd make before that stage?---You're always*

[149] Coronial Brief p 558
[150] Inquest transcript p 418 – 419
[151] Coronial Brief p 570
[152] Coronial Brief p 570 and 582.
[153] Inquest Transcript p 459

assessing the whole view of the situation and certainly you would need to follow it up, yeah."[154]

159. This issue was returned to with Ms Myer-Braun in subsequent questioning:

> *"You've answered some questions that you've been asked by counsel assisting and you said that a sure bruise on the second occasion would be a red flag for sure, were your words?---M'mm.*
> *You remember giving that evidence just now?---Sorry?*
> *Do you remember being asked if you were aware of if how a professional was aware that there'd been bruising on two occasions in twins - - -?---M'mm. - - - one at four weeks and one at eight weeks, that that would be a red flag for sure? That was your answer? Yeah. I think if you saw - if you were aware that there had been a previous occasion, it may influence - that you would think, but that's - I mean, it's all good in retrospect, when, you know...*
> *Sure?-*
> *I think the judgment was made at the time on the information at the time."*[155]

160. Dr Zagarella also gave evidence that if he had a presentation with isolated bruising (which in his view was less likely to indicate a blood disorder) and it was on two occasions, imaging and a direct urgent paediatric referral would be the most appropriate thing to do. Dr Zagarella also said that in those circumstances he would try to take a very thorough history, and "*tease out and ask the question a number of different ways to be absolutely certain what the cause of that bruise was.*"[156]

161. Dr Earley's also gave evidence on this point which I consider particularly persuasive:

> *"Yes, I think - ah I mean if you're looking at the whole context, for example, we've got twins as opposed to singletons, two episodes of bruising plus in the context of unsettled, irritable infants, certainly I would be very concerned about that presentation and history and would um pursue further investigations. Blood investigations and radiological investigations."*[157]

162. She considered Ms A's score on the EPDS on 19 April 2012 to also indicate "*another level of concern.*"[158] She summarised by saying

> *"Ah so I think putting, obviously, with the benefit of hindsight and having all the information, in a child where, if we had that all - all that information I would think um for all to - to all service um on presentation to a hospital emergency department would have been um recommended."*[159]

163. Based on all the evidence, the submissions made on behalf of Mr A contended that

> *"...rather than handing the parents a letter to take to Dr Zagarella regarding further investigation of* BA's *bruising, Nurse Monagle should have made immediate contact with a supervisor, general practitioner, specialist paediatrician or hospital emergency*

[154] Inquest Transcript p 520 – 521 and Coronial Brief, p.561.
[155] Inquest transcript p 522
[156] Inquest transcript p 554 – 555
[157] Inquest transcript p 103
[158] Inquest transcript p 103
[159] Inquest transcript p 104

department to organise further investigation whilst the parents were still present at the clinic."[160]

164. Ms Monagle did not accept the suggestion that the situation necessarily required more immediate action.[161] She gave evidence that had she been aware of the earlier incident of bruising, she still would have regarded the referral letter to the GP and the approach to the EMCH Service as a sufficient direct response to the bruise observed on BA on 24 April 2012. This answer, to a hypothetical question, was given in a context where it was also assumed that Ms Monagle was aware of the other family medical consultations which had occurred in the interim, and of the examinations, assessments and plans that had been made.

165. In my view it is significant that Ms Monagle also gave evidence that, had she read the earlier notes, she would have asked more questions of both parents, explored whether the sleeping arrangements had changed and whether they had observed any other injuries in the interim.[162] She indicated that if she wasn't "*overly convinced*"[163] she would have involved her coordinator or the Unit Manager to go over it again with the parents and consider next steps.[164] The submission made on behalf of the Moreland City Council is essentially that had Ms Monagle been prompted to ask more questions in this context, it is likely that it would have revealed that no bruising had been observed on the twins in the interim by examining doctors, no bruising had ever been observed by Mr A and that health supports and plans were in place to address any post natal mental health concerns.[165] It was submitted that based on her evidence at inquest, this information would not have altered her course of action.

166. While we can now do no more than speculate, I find it difficult to accept this submission from the Moreland City Council. Mr A's evidence is that he was not aware of the earlier bruising nor that it had been discussed at the earlier consultation. Perhaps more critically, his evidence is that the twins were not placed in the cot in the sleeping configuration suggested by Ms A that they weren't escaping their wraps or within arm's length of each other in their big cot.[166] Therefore, the possibility is certainly raised that if Ms Monagle had read the four week notes and more rigorous questioning had followed, greater scepticism may have emerged about the origin of the bruises.

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[160] Submissions on behalf of Mr Mr A p 13
[161] Inquest transcript p 450 and p 499 - 500
[162] Inquest transcript p 420
[163] Inquest transcript p 420
[164] Inquest Transcript p 420
[165] Submissions on behalf of Moreland City Council p 15
[166] Inquest transcript p 222

167. At any rate, I accept that Ms Monagle was confronted by a complex clinical picture on 24 April 2012. She had unsettled twins, one twin with particularly poor weight gain[167]; tired, frazzled parents who felt frustrated that they did not have any answers as to the cause of the twins' unsettledness nor a clear plan for addressing it; and one twin with an unexplained bruise on her face. On the other hand, both the parents presented as appropriately caring, attentive and attached to the twins; they had demonstrated over her history with them that they were dedicated and capable parents, they had demonstrated positive help seeking behaviours; and there were no other signs upon physical examination of the twins to suggest that they were injured, requiring urgent medical treatment[168] or that they were not developing as expected.

168. I accept that Ms Monagle is clearly a highly experienced MCH nurse and that, in responding to this complex presentation, Ms Monagle conscientiously did all she believed she was professionally required to do in a caring and thorough manner. Consistently with the submissions made on behalf of the Moreland City Council, I accept that Ms Monagle was very confident that the As would pursue the referral she had given them to the GP[169] and the evidence suggests that Mr A did indeed make contact with the medical centre for that purpose.[170] I accept that Ms Monagle planned to make arrangements for the family, with their agreement, to be accepted into the EMCH program and that the timeliness with which she intended to pursue this plan was reasonable in view of the intervening public holiday.

169. However, as with Ms Kingston, I do not think Ms Monagle properly appreciated the significance of the bruise observed on BA's face as a potential indicator of intentionally inflicted injury. I do not think Ms Monagle's response to the bruise, as a discrete issue, was sufficiently proactive and urgent in the circumstances.

170. The parents had no explanation for the bruise. It was the second time that one or both the immobile twins had presented with a bruise, a rare and 'red flag' presentation. It was the second time that a parent could not definitively say how the bruise had occurred. The bruise corresponded with poor weight gain in BA and with both twins being very unsettled. Even so the As were not directly questioned about the possibility of physical abuse. Where Ms Kingston had accepted Ms A's theory for how the bruises had occurred on the last occasion, it appears that Ms Monagle may have offered possible theories on behalf of the parents. Notwithstanding that the bruise was unexplained, it appears that Ms Monagle did not

[167] Inquest transcript p 436
[168] Inquest transcript p 437- 438
[169] Inquest transcript p 449
[170] Inquest transcript p 215

seriously contemplate the possibility that it had been deliberately inflicted by either parent. She gave evidence as follows:

> *"The bruising was of a - a pale blue - blue colour. Very small, like a pea shape. So it wasn't actually a force - you know, forcefully hit. It was in a place where a toddler could poke at and I have seen a lot of bruising from toddlers onto infants in my 37 years and the scratch just looked like - and the nails were long of both* AA *and* BA *They - they were long and easily to be able to cause that."*[171]

171. The evidence of Ms Myers Braun also supports the conclusion that Ms Monagle, despite not having an explanation for the bruise, discounted the possibility that it may have been intentionally inflicted by anyone other than two year old CA

> *"And you say in your statement that you were told by Ms Monagle that the toddler had hit one of the babies on the head, as reported by the parents. Is that your recollection of what was told?---Yeah I - the impression that she had, certainly the way her belief had formed at that time was that it was a - you know, it was an accident related to the toddler, that it - she didn't seem to have any concern or belief that it was anything else."*[172]

172. Although Ms Monagle talked of BA's bruise as a 'red flag', I consider that her approach did not adequately reflect this. It was appropriate that her assessment might take into account what she knew and observed of the parents. However, it was a lapse in professional judgement that, armed with the objective evidence of a bruise on a non-mobile infant, and without an explanation for it, she did not seriously countenance the possibility that either parent or another caregiver had intentionally inflicted injury. She did not directly question the parents about the possibility of physical abuse, check the records available to her for evidence of earlier issues of concern, or consult with her supervisor or colleague *in relation to the unexplained bruise*. These are all steps that a person in her position should have considered in assessing a 'red flag'.

173. Ms Monagle did provide the parents with a referral for review in respect of BA which referenced the bruise. However, I accept the submission made on behalf of Mr A that more was required in the circumstances. Ms Monagle should have made direct contact with a GP, paediatrician or a hospital on that day to arrange for investigation of the bruise. This is particularly so given that it was the second presentation of the twins where a bruise had been observed, a matter which Ms Monagle should have been aware of.

174. Ms Monagle's decision not to make direct arrangements for the bruise to be urgently investigated represented a lost opportunity to detect the harm to which the twins were exposed, to protect them from further harm and to identify and treat their underlying injuries, prior to AA's collapse on 26 April 2012.

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[171] Inquest transcript p 489
[172] Inquest transcript p 520

175. As outlined above, the evidence strongly indicates that underlying injuries, including brain injury and rib fracture, were already present on 24 April 2012 in both twins, and I expect that these injuries would have been detected if, for example, a skeletal survey had been ordered on that day. Dr Zagarella's evidence was that if he had been contacted by Ms Monagle immediately upon her findings on the eight week assessment, he would have undertaken a skeletal survey and referred on to a paediatrician urgently. This would have led to both twins being treated for their injuries and placed in a protective environment. To be clear, I consider that this would have been the case even if investigations were initially only undertaken on BA given what the findings would likely have been.

176. I have discussed above the evidence regarding the timing of the injury which ultimately lead to AA's death. That evidence suggests that while the 'insult' leading to fatal head injury generally occurs close to the time of collapse, and while consistently with this AA had acute injuries suffered within days of her death, it is difficult to be sure about the degree to which previous injuries contributed to the progression and outcome of AA's case.

Mandatory Reporting

177. In the context of considering the response of the MCH nurses to the bruises observed on the A twins, particular consideration was given to whether either or both Ms Kingston or Ms Monagle, as mandatory reporters under the *Children, Youth and Families Act 2005 (Vic)* (CYF Act) should have made a report to Child Protection pursuant to section 184 of the CYFAct. Such a report would have been mandated if either nurse had formed a belief on reasonable grounds that the twins were in need of protection on the basis that they had suffered or were likely to suffer significant harm as a result of physical injury and that their parents had not protected or were unlikely to protect them from harm of that type.

178. Both Ms Monagle and Ms Kingston gave evidence, which I accept, that they were aware of and understood their obligations under the CYF Act. Both gave evidence that they had in the past made mandatory notification reports to Child Protection.

179. In light of the evidence, particularly from Dr Earley, I consider that bruising on a non-mobile infant, could in and of itself give rise to a belief on reasonable grounds that a child was in need of protection and thus require a mandatory report to Child Protection. In my view, such a view might particularly be formed where the origin of a bruise is unverified; a bruise has been observed more than once or on more than one child; or if parents are unwilling or cannot be relied upon to facilitate and cooperate in the investigation of the bruise.

180. Nonetheless, I accept that neither Ms Kingston nor Ms Monagle formed a belief on reasonable grounds that either of the A twins were in need of protection such that a report to Child Protection was mandated. I make no adverse comment on this particular point.

181. I do not consider this contradicts my earlier finding that both nurses should have been more rigorous in questioning the parent/s about the origins of the bruises and more proactive and direct in arranging for the bruises to be investigated.

182. Ms Beth Allen, the Assistant Director of the Child Protection Unit, Statutory and Forensic Services Design Branch, DHHS provided a statement and answered written questions posed by the Court relating to the Victorian Child Protection system, including about policies and guidelines for health professionals related to vulnerable infants. Ms Allen's written statement[173] referred in some detail to the '*Vulnerable babies, children and young people at risk of harm: best practice framework for acute health services'*, a resource developed in 2006 in collaboration between the DHHS's Child Protection program and Victorian health services. Ms Allen noted that the Framework was not created for use by MCH nurses but that, as the document itself states, much of the content is relevant to all health care services and can easily be adapted for health care environments beyond the public acute hospitals, to which it is directed.[174]

183. The Framework advises health professionals to always consider the possibility that harm to a baby, child or young person, may be non-accidental. It includes a table of signs and symptoms of possible harm and advises health professionals to act promptly and decisively to investigate any suspicions, and diagnose accurately to confirm or exclude possible neglect. [175] The Framework then sets out a guide to action which includes a number of steps that a health profession should consider undertaking.

184. Ms Allen's statement and the references to the Framework prompted me, in the context of the case, to inquire further about what is expected when a health professional is confronted with a presentation that raises the *possibility* of non-accidental harm, but in isolation does not found a belief on reasonable grounds that the child is in need of protection. I put to Ms Allen written questions about whether there is a direction or expectation that health professionals in that circumstance would make inquiries with other services and/or undertake investigations in order to substantiate or give context to a *suspicion* of non-accidental harm before reporting. I also

[173] Coronial Brief p. 1374
[174] Coronial Brief p 1383 – 1384
[175] Coronial Brief p 1387

asked whether, and to what extent the threshold for mandatory reporting assumed that some preliminary investigation would be undertaken.

185. Ms Allen's answers relevantly noted the following matters:

- Section 186 of the CYF Act provides that in the context of mandatory reporting obligations, the grounds for a belief that a child is in need of protection are matters of which a person ***has become aware*** and any opinions based on those matters. (My emphasis.)
- Child Protection's understanding is that it is the responsibility of health professionals to care for a child's health, safety and wellbeing by accurately diagnosing, or excluding a diagnosis of, abuse or neglect.
- There is no requirement that health professionals will make enquiries of other services/agencies about the context for a suspicious presentation, but based on the above there is an expectation that they would do so.
- There is no direction to health professionals to undertake preliminary investigations regarding a suspicion of non–accidental harm, prior to making a report to Child Protection.
- The mandatory reporting provisions in the CYF Act do not require health professionals to prove that a child is in need of protection before making a mandatory report.[176]

186. Health professionals have a particularly important role to play in ensuring children are safe in their families. The parameters of that role do not begin and end with mandatory reporting obligations. Health professionals will be confronted with signs and symptoms which enliven (or should enliven) suspicions of physical abuse without rising to the threshold of belief that mandates a report to Child Protection. The CYF Act does not require further action of health professionals in that context, but other professional obligation will arise to inquire or investigate further or to take steps to safeguard the safety and wellbeing of the child.

187. It is in the context of those professional obligations, rather than the statutory ones set out the CYF Act, that I have adversely commented upon above on Ms Kingston's and Ms Monagle's response to the bruises observed on the A twins.

[176] Further Statement of Beth Allen December 2015

Training and Guidance for MCH Nurses

188. Ms Jane Foy, the Unit Manager of the Moreland MCH Service provided a written statement which was included in the Coronial Brief.[177] She stated that nurses are required to comply with established best practice professional standards, and relevantly to the circumstances of this case, appended the following documents:

- the Moreland City Council Mandatory Reporting - Child Protection Policy for MCH nurses that was in force in April 2012 (Child Protection Policy) and the revised policy as published on 3 September 2014 (the new Child Protection Policy);[178] and
- the Maternal and Child Health Service Guidelines, published by the DET in February 2011, which include an appendix on child abuse and neglect (the MCH Guidelines).[179]

189. The purpose of the Child Protection Policy was framed as "*to ensure correct procedures are followed in reporting suspected cases of child abuse to protective services*". The listed responsibilities of MCH nurses commenced with the following:

> *"Concerns realised by MCH nurses, e.g. maybe a child has disclosed, or there are signs that may indicate physical injury or sexual assault."*

190. The policy then listed the steps that should be taken which included gathering information from the consultation, questioning parents, reviewing prior notes and, if appropriate, consulting with colleagues and known support agencies involved in the family. The Child Protection Policy stated that following these steps, if there was concern about a child's safety a report to made to Child Protection. The new Child Protection Policy is in similar terms, however, the purpose is stated more broadly as: to promote the safety and wellbeing of children in Moreland and ensure the staff have a clear process to follow when making notification to Child Protection. It is also more prescriptive about the process of making a notification and contemplates that a referral may be made to either Child Protection or Child First.

191. Further guidance was (and is) offered in the MCH Guidelines, published by the DET. Appendix 2 of that document is focussed on Child Abuse and Neglect and states that MCH nurses need to be able to recognise when children have been harmed or are at risk of harm and lists physical and behavioural indicators of different abuse types to assist professionals who work with children to identify potential areas of concern.[180] The MCH Guidelines list steps that should be followed where a concern is present and a MCH nurse is deciding whether to make a

[177] Coronial Brief p 566
[178] Coronial Brief p 570 and p 572
[179] Inquest transcript p 459
[180] Coronial Brief p 776

notification to Child Protection.[181] The MCH Guidelines acknowledge that deciding to make a notification can be difficult and give rises to anxiety about the adequacy of the grounds for concern and the risk of alienating parents from the MCH Service.[182] However, the MCH Guidelines emphasise "*it is important to work from the principle that children, particularly infants, are highly vulnerable and unable to protect themselves. Abuse and neglect of infants has the potential for life threatening injury, and serious impairment of brain development, attachment, and the development of trust and healthy relationships in later life.*"[183]

192. There is a specific section in the MCH Guidelines regarding indicators of concern for infants. It provides as follows:

> *Infants are highly vulnerable and cannot protect themselves. Their rapid body growth and brain development in the first two years makes them extremely susceptible to the effects of neglect and malnutrition. Their soft skull, lack of muscle development and unprotected body make them extremely vulnerable to head and other injuries from shaking or direct blows to the body.*
> *Where professionals who work with infants and young children identify the following indicators (particularly where several indicators are present), consultation with supervisors/colleagues should occur. Consideration should be given to a notification to Child Protection if there is a reasonable belief that the child is in need of protection.*
> ....
> *Indicators include:*
> - *Evidence of physical injury inconsistent with the child's age and stage of development*
> - *Child is listless and immobile*
> - *Child is emaciated and pale*
> - *Child is below expected birth weight*
> - *Child displays inconsistent weight gain*
> - *Child is born drug dependent*
> - *Child may sleep for longer periods than would normally be expected*
> - *Child appears depressed and unresponsive to social involvement*
> - *Child cries excessively or not at all*
> - *Child displays self-stimulatory behaviours, for example, rocking, head banging*
> - *Child does not seek comfort from the parent*
> - *Child has poor muscle tone and motor control*
> - *Child exhibits significant delays in gross and fine motor development and coordination*
> - *Parent is consistently impatient or unresponsive to infants cues*
> - *Parent does not respond to assistance from the MCH nurse*
> - *Parent misunderstands or fails to respond to the child's cues*
> - *Parent has part or current substance abuse issues*
> - *Parent had poor antenatal care*
> - *Parent was aged under 20 at birth of child*
> - *Parent is highly transient or homeless*

[181] Coronial Brief p 781
[182] Coronial Brief p 780
[183] Coronial Brief p 780

- *Parent is engaged in a violent relationship*
- *Parent has a mental illness.*[184]

193. Both Ms Kingston and Ms Monagle were questioned about the MCH Guidelines at inquest, including parts of the document excerpted above. They both indicated that they were familiar, at least in broad terms, with the MCH Guidelines.[185]

194. As I have already noted, Ms Kingston and Ms Monagle presented as conscientious, dedicated MCH nurses. Their evidence indicated that they certainly understood their role to encompass a general duty to monitor and safeguard the development, wellbeing and safety of the infants they reviewed. I do not think that the deficiencies in their approach in this case arose from a lack of familiarity with the above policies and guidelines or a deliberate departure from them. As I have already found, I consider that they did not fully appreciated the significance of bruising in an immobile infant as an indicator of abuse, and this impacted on the rigour of their follow up and their weighing up of risk.

195. Both Ms Kingston and Ms Monagle gave evidence about their professional development obligations and outlined the training that they had undertaken, on matters including mandatory reporting.[186] They gave evidence that they had not, prior to AA's death, undertaken training about bruising in immobile infants.[187] In her statement, Ms Foy indicated that on 29 October in 2010 there was a presentation given at the DET bi-annual MCH Conference about battered baby syndrome which was presented by Dr Ann Smith from the Victorian Forensic Paediatric Medical Service (VFPMS) and which focussed on recognising the different types of bruising of an infant or child which may be of concern. Ms Monagle was overseas at this time.[188]

196. In light of my findings about the response to bruising observed on the twins, and the evidence about current guidelines and training for MCH nurses, I have made a comment, pursuant to section 67(3) of the Coroners Act below.

Issue 3: Assessment of Maternal Mental Health and Associated Risk to Infant

197. At each of the appointments attended by the twins in March and April 2012, there was some screening and/or assessment undertaken of Ms A's postnatal mental health. Ms A also attended a dedicated appointment with her GP and a mental health nurse on 18 April 2012,

[184] Coronial Brief p 786
[185] Inquest transcript p 304, 361 and p 458 – 460
[186] Coronial Brief p 550 - 552 and p 555 – 557; Inquest transcript p 430 – 432 and p 452 – 458 and p 354
[187] Inquest transcript p 323
[188] Inquest transcript p 455 and Statement of Dr Anastasia Gabriel, paragraph 67

which led to referral to a psychologist. That appointment was scheduled for 1 May 2012, some 5 days after AA's death.

198. In written statements, and at inquest, the issue was explored whether each of these assessments was appropriately thorough, or appropriately responded to, and whether consideration was, or should have been, given to the risk Ms A might have posed to her twins in the circumstances.

199. A number of reference documents, relevant to the issue under consideration were included in the Coronial Brief, including the "Clinical practice guidelines for depression and related disorders – anxiety, bipolar disorder and puerperal psychosis – in the perinatal period" published by Beyond Blue in February 2011[189] and the "Perinatal Mental Health and Psychosocial Assessment: Practice Resource Manual for Victorian MCH Nurses"[190] published in June 2013. Witnesses from the DHHS and DET helpfully gave written evidence about the origins, purposes and use of these documents.

Assessment of maternal mental health and associated risk to infant 30 March 2012

200. As already set out in detail, Ms Kingston saw Ms A and the twins at the Moreland MCH Service on 30 March 2012 for their four week consultation. The MCH Service Practice Guidelines 2009[191], (MCH Practice Guidelines) set out the types of questions to be asked and issues to be discussed at this consultation and in particular direct that a maternal health and wellbeing assessment should be undertaken. This is a physical, social and emotional health check which includes consideration of the risk of family violence.[192]

201. At the inquest, Ms Kingston was asked about the MCH Practice Guidelines.[193] She agreed that it was the practice manual for MCH nurses at the time of her consultations with the A family. She agreed that it set out the key ages and stages consultations undertaken by MCH services and what is required by nurses at each. Ms Kingston stated that she used it every day and that it was on her desk.[194] It was apparent from her evidence and her record of the consultation, that she did in fact undertake a maternal health and wellbeing assessment in a manner consistent with that outlined in the MCH Practice Guidelines. The possible exception was that she could not recall whether she had inquired about whether Ms A had a history

[189] Coronial Brief p 609
[190] Coronial Brief p 803
[191] Coronial Brief p 1113
[192] Coronial Brief p 1142 - 1143
[193] Inquest transcript p 305
[194] Inquest transcript p 430

of depression.[195] I do not consider that anything critically turns on this. Ms A had suffered a brief episode of depression in her mid-twenties. At any rate, Ms Kingston did consider and discuss Ms A's mental health regardless.

202. As already outlined, Ms A was observed to be physically well and reported that she had been since the day the twins were born. Ms A reported that she was well supported at home by her husband who had taken time off work, and by her mother. Ms Kingston observed the interaction between Ms A and her children (CA and the twins) and noted it to be responsive, appropriate and affectionate.

203. Ms Kingston administered a post natal depression screen in the form of the EPDS.

204. A total score of greater than or equal to 13 is generally considered a positive screen for possible perinatal depression warranting consideration of referral to an appropriate health profession for a mental health assessment.[196]

205. The EPDS cannot diagnose depression – this was confirmed by all witnesses in the case.[197] Likewise, the EPDS should not replace a health professional's clinical judgement – despite its specificity and sensitivity as it has a low positive predictive value of "*slightly less than 50%*".[198]

206. Ms Kingston tallied Ms A's score as 12. Ms Kingston described that as "*borderline scoring which may or may not require referral to a General Practitioner*"[199] This description of the score is broadly consistent with advice given in the Beyond Blue Guidelines, which include the following Good Practice Point: "*For women who score 10, 11 or 12 on the EPDS, administration of the EPDS should be readministered within 2 - 4 weeks, and existing support services reviewed and increased if needed.*"[200]

207. Ms Kingston explored Ms A's answers with her and was informed by Ms A that she felt down sometimes because she couldn't help her babies with colic and that she "*feels sorry for them*".[201]

208. Ms Kingston discussed with her the methods she was using for settling the twins. She was aware that Ms A had been to the RCH as a result of the twins being unsettled and was awaiting a follow up paediatric appointment at the RCH in relation to that.

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[195] Inquest transcript p 368 – 371
[196] Coronial Brief p 650, 653
[197] Coronial Brief p 1533
[198] Coronial Brief p 1534
[199] Coronial Brief p 554
[200] Coronial Brief p 650
[201] Coronial Brief p 183

209. Ms Kingston noted that Ms A's score on question 10 of the EPDS was zero, indicating that she had not had thoughts of harming herself in the last ten days.[202] Ms Kingston did not consider, and I accept, that there was nothing in Ms A's presentation or responses to questions that indicated anything to the contrary.

210. The EPDS does not include a question about thoughts of harm to others and Ms Kingston did not directly question Ms A about this.[203] Ms Kingston did not consider that there was anything she observed or was told during the consultation that raised such a concern and invited direct questioning. I have already discussed this in the context of the bruises that were observed at that consultation. I accept that, bruises aside, there was nothing in Ms A's psychosocial assessment and, in particular, her interaction with the twins to clearly indicate that such direction questioning was warranted.

211. Ms Kingston was satisfied that Ms A had good supports and a good plan and specifically did not think that Ms A was suffering any form of post natal depression. She made an appointment for the eight week review, with a notation, which I accept was intended to mean that the family health should be reviewed at that time.[204]

212. She advised Ms A that if she had any persistent low mood then she should consult her GP. Ms A gave an undertaking to do so should any issues develop with her mental health or her coping ability.

213. I accept that Ms Kingston completed a maternal health and wellbeing check on Ms A and that, based on Ms A's presentation and her responses to the EPDS and general questioning, Ms Kingston's clinical assessment that no mental health follow up was required at that time was reasonable.

Assessment of Maternal Mental Health and Associated Risk to Infant on 10 April 2012

214. As summarised in the timeline above at paragraph 17, on 10 April 2012, the A twins attended at the Niddrie Medical Centre with their parents and brother and were seen by the family GP, Dr Sam Zagarella.

215. Dr Zagarella graduated in 1987 and became a Fellow of the Royal Australian College of General Practitioners (RACGP) in 1993. He completed a Diploma of the Royal Australian College of Obstetricians and Gynaecologists in 1992. Dr Zagarella provided two written statements and gave evidence at the inquest.

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[202] Inquest transcript p 322
[203] Inquest transcript 323
[204] Inquest transcript p 320

216. He first consulted with Ms A in approximately 1995 at the McNamara Clinic. He then moved to the Niddrie Medical Centre where she consulted him from December 1998. He became effectively the family doctor. He regularly saw the first child, CA He noted that Ms A did not experience any post natal complications and that in particular she did not experience any post natal depression or psychosis after the birth of CA

217. On 10 April 2012, Ms A and her husband brought AA and BA for advice *"regarding colic"*[205] His physical examination of them was unremarkable and he was not informed about the earlier incident of bruising.

218. In the context of assessing the twins and providing advice, Dr Zagarella inquired how Ms A was feeling. She told Dr Zagarella that she was feeling stressed and tired and was not sleeping well. Although the appointment was not in fact for Ms A given her answers, Dr Zagarella arranged for her to complete a DASS and a K10, screening tools for depression.

219. At the inquest, Dr Zagarella was questioned at some length about the screening tools that he used. He agreed that they are not designed specifically for use with post natal depression. As he said *"a tool is designed to alert a practitioner that further formal mental state examination needs to be assessed, and that's exactly what happened."*[206] In discussing the EPDS scale he stated that he considered the DASS to be *"far, far more comprehensive"*[207]. He described it as a *"validated and very useful tool"*[208].

220. He stated *"In her responses to specific questions, she revealed that she had poor attention, poor concentration, occasional confusion, a sense of worthlessness and hopelessness and outbursts of anger.*[209] *She denied suicidal ideation."*[210]

221. In his evidence, Dr Zagarella described the ratings received on application of the two screening tests as follows *"Yes the depression was extremely severe, anxiety severe, stress severe. Yes. ..... accepting, of course, that they're not diagnostic."*[211]

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[205] Statement of Dr Zagarella 2 July 2012
[206] Inquest transcript p 544
[207] Inquest transcript p 544
[208] Inquest transcript p 544
[209] There was some confusion and ambiguity explored at inquest as to whether Ms A's answers on the originally completed questionnaire had been incorrectly entered onto the electronic file record, so as to erroneously record that she had answered "Yes Often" to a question about outburst of anger, as opposed to "yes often" to a question about speeding and overspending. Ultimately, I do not consider that anything turns on this point.
[210] Statement of Dr Zagarella 2 July 2012
[211] Inquest transcript p 572-573

222. Dr Zagarella's evidence was, despite the high scores on the screening test, he did not consider immediate mental health intervention was required in Ms A's case on 10 April 2012. Significantly, Dr Zagarella said this about Ms A's observed state:

> *"But in the clinical context which is the most important part of a mental state examination, she appeared loving, caring, engaged, warm and concerned for the well-being of her children."*[212]

223. He did not believe that Ms A had major depression or post-partum psychosis. He formed this view because she was "*still engaged*",[213] was able to discuss and plan for the further and appeared to be concerned for the welfare and care of her children. Dr Zagarella described Ms A's results on the screening tests, which were not diagnostic, as suggesting that further action and follow up were required and he subsequently arranged for Ms A to see the mental health nurse, Ms Goodchild together with him at an appointment on 18 April 2012.

224. Dr Zagarella also ordered blood tests for Ms A to ascertain if there were any underlying processes at work that might provide an explanation for her presentation.

225. There was nothing in the twins or Ms A's presentation on that day which indicated to Dr Zagarella that Ms A was a risk to herself or the twins.

226. Dr Zagarella gave evidence of his extensive experience in dealing with mental health issues and managing referrals for people dealing with those issues. I accept that he has substantial experience in this regard. His experience appears to be somewhat above and beyond the normal.

227. I accept that there was nothing which ought to have alerted Dr Zagarella to the fact that Ms Teralato, as a result of her mental state on 10 April 2012, was at risk of harming the twins. Dr Zagarella proactively engaged Ms A in conversation about how she was feeling and coping following the birth of the twins and in view of their unsettledness. He administered a screening tool to help him identify any concerns. When the results indicated that Ms A's mental health required further assessment, he arranged for this occur within an appropriate timeframe. Ms A's general presentation at the consultation, the information he had about supports available to her and her willingness to return for a further appointment were all factors reasonably relied upon by Dr Zagarella, to conclude that Ms A was not an immediate risk to herself or the twins.

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[212] Inquest transcript p 548
[213] Statement of Dr Zagarella 2 July 2012

Assessment of Maternal Mental Health and Associate Risk to Infant on 18 April 2012

228. On 18 April 2012, Ms A returned to the Niddrie Clinic and was seen by both Dr Zagarella and Ms Goodchild, a Division 2 Mental Health Nurse. Ms Goodchild provided a written statement dated 27 February 2013[214] and gave evidence at the inquest.

229. Ms A was accompanied to the appointment by her husband and the twins, although they did not sit in on the consultation.

230. A mental health examination was conducted, in most part by Ms Goodchild. In her statement, Ms Goodchild reported that Ms A entered the room *"feeling tired and low in mood and anxious."*[215] She gave evidence that she had discussed the scores from the DASS and K10 testing on the 10 April with Dr Zagarella before the consultation and said that she *"...in fact I expected someone to walk in extremely depressed."*[216] In fact, Ms Goodchild's observation on the day was that Ms A was tired but that she *"didn't present in anyway depressed."*[217] She explained that by reference to eye contact, communication and the appropriate responses to questions. She described Ms A as *"very relaxed."*[218]

231. Ms A reported her daughters as being unsettled with colic and reported herself and her husband to be stressed. They discussed strategies that the RCH had mentioned. Ms A discussed the friends and family support she had, Ms Goodchild offered a referral to Tweedle Day residential care to assist in providing parenting strategies. As Ms A was already seeing the Unsettled Babies Clinic at the RCH, she declined that offer. She confirmed that Ms A believed she had strong supports.

232. Ms Goodchild gave evidence of the mental health care plan that she and Dr Zagarella then prepared for Ms A

> *"SENIOR SERGEANT BRUMBY: Just on the front page of that mental health care plan?---Yep. Under the title "presenting complaint"?---Yes.*
> *It indicates Ms A has seven-week-old twins with colic. She also has a two-year-old who is settled in behaviour. She has support, supportive family network, husband, to assist in their care. She is struggling with the tireless care required looking after her twins, and her anxiety and depressive symptoms are increasing to the point that she is just locked into the house. She reports she is struggling with having three children and life routine?---M'mm. Was that the picture, if you like, that she painted to you, in terms of your consult?---Yes. Um, when a person walks in to, um, start speaking to me, I always, ah, put forward to them, "So why are you here today? Why do you think you're here, and why are you here?" Um, so that's what she put forward to me. Um, again it was also when - when she said about*

[214] Exhibit 22
[215] Coronial Brief p1030
[216] Inquest transcript p 590
[217] Inquest transcript p 589
[218] Inquest transcript p 589

being locked into the house, um, that we also put the - um, I ventured into, well, what things do you do with the children, and she brought up about going to the park and doing those things, and having family support so she can provide individual care.
Now, in relation to Ms A *- her relationship with her husband?---M'mm.*
Did you explore that, in terms of how she felt in terms of being able to share her concerns with her husband?---She did express to me that, um, Mr A *was home on, um, paternity leave, and he was, um, actively looking after the twins and looking after* CA *and giving her rest times. Um, as far as - she didn't express any concerns about their relationships and if she had expressed concerns about their relationship, that's something we also investigate because that's also important as far as her care. But it wasn't something that she certainly put forward."*[219]

233. The next step under the mental health plan was for Ms A to attend a psychologist on 1 May 2012. Ms Goodchild was not concerned about any delay between 18 April 2012 and 1 May 2012. She knew an earlier appointment could be organised if absolutely necessary. She believed that Ms A felt comfortable with the plan that had been made. She had no immediate concerns for Ms A's safety at the end of the 18 April 2012 consultation.

234. Dr Zagarella's observations of Ms A were also that "*At all times during the appointment* Ms A *remained engaged and interactive and appeared calm and relaxed.*"[220] He noted also that she was able to discuss her difficulties "*appropriately*". He specifically asked how the twins were and she said they were "*better*".[221] His own impression was that Ms A herself also appeared improved, in terms of her mood and outlook.[222]

235. Ms A was specifically asked at this appointment whether she considered she was at risk of harming her children or herself and denied both[223]. As to a risk of harm to the infants, the evidence was:

> "*You have a recollection about specifically asking her a question about whether she may have felt she was at risk of harming the infant?---That is a standard question that we ask, correct, yes. And the answer was in the negative?---Yes. It was negative. There was no risk of harm.*"[224]

236. Ultimately, I agree with the submission that Dr Zagarella and Ms Goodchild conducted their consultations with the A family professionally and thoroughly. I accept on the basis of their evidence that they were careful and exercised sound clinical judgement. Dr Zagarella was, in my view, an impressive and highly concerned general practitioner.

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[219] Inquest transcript p 593 - 594
[220] Statement of Dr Zagarella 26 October 2015
[221] Statement of Dr Zagarella 26 October 2015
[222] Inquest transcript p 552
[223] Inquest transcript p 588, p 547
[224] Inquest transcript p 546-547

237. Ultimately I accept the submission that neither Dr Zagarella nor Ms Goodchild should have been aware, or had a proper basis to be aware that Ms A presented a risk to her children and in particular to AA

Assessment of Maternal Mental Health and Risk to Infant 19 April 2012

238. The twins, accompanied by both parents, attended the Unsettled Babies Clinic at the RCH on 19 April 2012. They had been referred following an earlier attendance at the RCH Emergency Department, where a possible diagnosis of colic had been mooted.

239. They were seen by Dr Anne Dawson, Paediatrician, who was in her third year of advanced training in General Paediatrics. Dr Dawson provided a written statement which was included in the Coronial Brief and gave evidence at the inquest.

240. A/Prof Hiscock was the Director of the Unsettled Babies Clinic at the time when Dr Dawson saw the A family on 19 April 2012. A/Prof Hiscock did not speak directly to the A family, but Dr Dawson discussed and reviewed her assessment and proposed plan with A/P Hiscock before the family left the clinic. A/P Hiscock provided a written statement which was included in the Coronial Brief and gave evidence at the inquest.

241. At the consultation, Dr Dawson took an antenatal, obstetric and postnatal history from the parents and conducted a physical examination of AA The EPDS is administered to all mothers who attend the Unsettled Babies Clinic.[225] Accordingly, Ms A completed an EPDS which was reviewed by Dr Dawson.

242. Ms A's score on the EPDS was 17. She had also given a positive answer to question 10, ticking "hardly ever" to the question about thoughts of self-harm over the preceding week. Anything other than an answer of "never" to this question is regarded as a positive answer.

243. Dr Dawson's evidence was that as Ms A had positive scores on a number of questions on the EPDS,[226] that raised in her mind whether Ms A might be suffering from post-natal depression. She followed up the EPDS with further questioning of Ms A

244. She had noted generally that as far as the parents were concerned "*things were improving*"[227] and she was reassured by the demeanour of the parents in the clinic. She made enquiries about the amount of support that was available to the parents. She noted that Mr A was home on paternity leave and that the parents were alternating nights in caring for the twins. She noted

[225] Inquest transcript p 44 and p 143
[226] Inquest transcript p 15
[227] Inquest transcript p 18

that the previous day, Ms A had seen a mental health nurse and a GP and that a referral to a psychologist was in place.

245. Dr Dawson discussed the case with her supervisor A/Prof Hiscock. The discussion included Ms A's EPDS score, positive answer to question 10, and the plans that were already in place to review and address any mental health concerns (i.e. the referral to the psychologist). They agreed a plan for the monitoring and management of the twins' colic which Dr Dawson then discussed with the As She understood that they were satisfied with this outcome. No further follow was organised or suggested in relation to Ms A's mental health.

246. A number of questions were explored at inquest in relation to Dr Dawson's response to the family's presentation as follows:

- Did Ms A's positive screen on the EPDS indicate that she was likely suffering from Post Natal Depression?
- Did her high score of 17 (4 above the cut off of 13) increase the likelihood that she was suffering from depression and/or indicate that any such depression was likely severe?
- Did Ms A's positive answer to question 10 (about self harm) indicate that further inquiry was warranted about risk of harm to the twins?
- In the absence of an organic cause for the twins' unsettledness, did Ms A's positive score on the EPDS, indicate that further investigation was warranted about the possibility that their irritability was secondary to intentionally inflicted injury?

247. These questions framed the broader consideration of whether Dr Dawson could or should have recognised the risk posed to the twins by Ms A at that time.

248. In relation to the first question, as noted earlier, I accept that the EPDS is not diagnostic. I accept that a positive score, that is one equal to or above thirteen, is best categorised as a positive screen for possible perinatal depression, rather than an indicator that a woman is likely suffering from a depressive illness of varying severity. This is consistent with expert evidence provided by Dr Jenny Proimos and with the Beyond Blue Guidelines, and in particular with the evidence that the positive predictive value of a score of 13 or more is around 50 percent.[228] This means that 50% of respondents who score 13 or above on question 10 are likely to be suffering from a depressive illness of varying severity and 50% are not likely to be.

[228] Coronial Brief p 1534

249. Therefore, although questions were put to Dr Dawson and accepted by her, on the basis that mothers who score 13 or above were likely to be suffering from a depressive illness,[229] I do not accept that proposition as having been established on the evidence.

250. With respect to the second question about whether any particular significance attached to a score on the EPDS as high as 17, I note the evidence of A/Prof Hiscock that there is no proven correlation between the EPDS score and the severity of the postnatal depression[230] On that basis A/Prof Hiscock gave evidence that it is not her practice to approach a score above 15, any differently to a score above 13.

251. The Beyond Blue Guidelines provide as follows:

> *"A score of 15 or more on the EPDS has a greater specificity for the detection of major depression both antenatally (with a supporting study cited) and postnatally (with a different supporting study cited). This score may indicate significant depression or may be associated with pre-existing personality dysfunction. Referral for comprehensive mental health assessment may be necessary."*[231]

252. To the extent that there might be any perceived conflict between these two positions, I do not think that I am in a position to, nor that I need to, resolve it.

253. Whatever the significance of a score of 17 - according to the Beyond Blue Guidelines, from a good practice perspective, at most such a score indicates that the administering health professional should ensure access to timely mental health assessment and management.

254. Dr Dawson was aware that such an assessment had already occurred the previous day with a follow up referral to a psychologist in place. There was no reason for her to second guess the adequacy or timeliness of this plan, based on the score of 17 alone.

255. Asked whether she got any sense from either parent that something needed to be put in place more immediately regarding psychological assessment and support for Ms A Dr Dawson stated that she did not think this was likely given the plan that had been outlined. Dr Dawson did not recall getting a sense from either Ms A or Mr A that there was any urgency regarding Ms A's psychological assessment.[232]

256. The third question explored was whether Ms A's positive answer to question 10, relating to self-harm, indicated a potential increased risk of harm to the twins that should be directly explored with Ms A

[229] Inquest transcript p 39-40
[230] Inquest transcript p 189
[231] Coronial Brief p 651.
[232] Inquest transcript p 20

257. The training at the Unsettled Babies Clinic was that where there was a score above 13 or where there was a positive answer to question 10, the information should be brought to the supervisor, in this case A/Prof Hiscock, for discussion.[233] A/Prof Hiscock's evidence was that where a person was frankly suicidal then urgent psychiatric care would be arranged. In other cases arrangement for appropriate assessment and support in the community would be organised.[234] In this case, that had occurred already.

258. A/Prof Hiscock gave further evidence about a positive score on question 10 as follows:

> *"There is nothing in the development of the EPDS or its use subsequently both in research and clinical practice that says if a mother scores high or if she scores positively on self-harm, that you must then go on and ask about harm to the baby. It's not ever been looked at in research or clinical practice or validated in any way."*[235]

259. Nonetheless, despite the lack of empirical evidence to support a nexus between a positive response to question 10 of the EPDS and likely risk of harm to a baby A/Prof Hiscock gave evidence that she teaches doctors to ask mothers who answer in the positive to question 10 whether or not they have thought of harming their baby.[236] She gave evidence as follows:

> *"Would that be a practice that you would do if you had a positive score to self-harm that you would also - that would trigger you to explore the issue of harm to a child?---That's something that I tend to do, yes, certainly, but I wouldn't say it's standard practice, because I don't think there is such a thing around the country associated with the EPDS."*[237]

260. A/Prof Hiscock was further asked whether it is "*fair to say that that seems like an inevitably appropriate question whenever this matter is at this point on the scale?*" She responded:

> *"Probably the vast majority of women who do score positively on item 10, the EPDS, have not thought about harming their baby and have not harmed their baby. So whether it's clinically appropriate or not is difficult because it's a very difficult question to ask. It's a confronting question in itself?---And it can alienate families from the healthcare professional when you're trying to establish at the very first meeting a trusted relationship with that family."* [238]

261. The Beyond Blue Guidelines state that risk of harm to the infant can be related to suicide risk in the mother[239] and that whenever assessing a woman for risk of suicide, enquiries should be made about her risk to the infant.[240] No research is cited in support of this particular point.

262. Again, to the extent that there is any conflict between these two positions, I do not think that I am in a position to, nor that I need to, resolve it.

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[233] Inquest transcript p 144
[234] Inquest transcript 144
[235] Inquest transcript 149
[236] Inquest transcript p 156 – 157
[237] Inquest transcript p 148-149
[238] Inquest transcript p 156, 158
[239] Coronial Brief p 655
[240] Coronial Brief p 657

263. Dr Dawson stated that she could specifically recall asking Ms A about thoughts of self-harm or harming the children and being told "No". She agreed that it was a positive response to question 10 that prompted her to ask those questions. She also agreed that whether it was question 10 or the score on the EPDS, there was enough for her to be concerned that Ms A might be at risk of causing harm to one of her twin babies and that was why she asked the question.[241]

264. She could not recall the precise manner in which she had put the question in relation to harming the children. Her best memory was that "*my usual practice will be to ask if things had um, ever been so overwhelming or difficult to manage with the baby crying that um, if she'd ever thought of hurting the baby in that situation.*"[242] She could not say that she asked that particular question but stated that to be her usual practice.[243]

265. Dr Dawson made a brief contemporaneous note of this exchange with Ms A in the medical record as follows: "*Not suicidal/homicidal*".[244]

266. Dr Dawson gave evidence that she had no reason to doubt the answers given by Ms A in response to her enquiries following up the answer of question 10. Moreover, Dr Dawson stated that "*both parents ah, seemed um, quite happy on that particular day and interacted well with* AA *... If you had noted any abnormality in the interaction between* Ms A *and her baby, given the Edinburgh Postnatal Depression Scale, is that a matter you would have noted?—Yes.*"[245]

267. I accept, that to the extent that Ms A's response to question 10 raised the possibility of risk of harm to the infants, this was directly and appropriately followed up by Dr Dawson. It was reasonable that she accepted the answers given by Ms A in this context, particularly given her broader observations of the parents' demeanour, their observed interaction with the twins and the plans and supports already in place. It was reasonable that Dr Dawson reached the conclusion that Ms A did not pose an immediate risk to herself or the twins.

268. The final question explored in relation to the 19 April 2012 consultation was whether, in view of Ms A's score on the EPDS, and the absence of any organic cause for the twins being unsettled, specific consideration should have been given to whether the twins had already suffered intentional harm.

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[241] Inquest transcript p 35
[242] Inquest transcript p 17
[243] Inquest transcript p 17
[244] Coronial Brief p 593
[245] Inquest transcript p 81

269. The evidence was that irritability and unsettledness in infants is a very non-specific presentation. I accept that there is a reasonably long list of differential diagnoses that should be explored. I accept that non-accidental injury might be one of these. However, I do not consider that, given the unremarkable physical examination of AA and the healthy parent infant interaction that was observed, Ms A's elevated EPDS score indicated that greater clinical investigation of this possibility was warranted.

270. In summary, I accept that it was reasonable that Dr Dawson's treatment plan would be focussed on managing the twins' colic. I accept that there was no evidence to support the conclusion that Dr Dawson should have organised more urgent mental health assessment and treatment for Ms A beyond that which was already in place. I accept that there was no evidence to support the conclusion that Dr Dawson should have assessed Ms A as a risk of harm to the twins, or that she should have made more inquiries in that regard.

Assessment of Maternal Mental Health and Risk to Infant 24 April 2012

271. As discussed in some detail above, Ms Monagle saw the twins at the eight week assessment on 24 April 2012.

272. At that appointment Ms Monagle examined both twins, listened carefully to the parents' concerns about the twin's unsettledness, fussy feeding and poor sleeping. She observed closely the parents' interactions with the twins, and found them to be caring and protective. In view of her observations that they were tired and struggling with their enormous workload, she discussed the possibility of additional support for them. After the consultation she began the process of exploring and putting in place such support.

273. In relation to the mental health of Ms A Ms Monagle stated that she didn't conduct any direct assessment of Ms A's mental health in terms of post natal depression screening on the day. [246]

274. Ms Monagle's focus on identifying the family's further needs for support, and attempting to secure this, were appropriate. However, it is concerning that in the context of the parent's markedly tired and worried presentation, Ms Monagle did not specifically turn her mind to Ms A's mental health and whether a screen or referral might be required.

275. The MCH Practice Guidelines 2009 set out the primary matters to be addressed at the 8 Week Key Ages and Stages Consultation.[247] Maternal health and wellbeing does not have the same focus at this consultation as at the four week assessment. Nonetheless MCH nurses are still

[246] Inquest transcript p 427
[247] Coronial Brief p 1147

directed to review the physical and emotional health and social wellbeing of the family and are directed to respond to concerns raised at previous consultations.[248]

276. I have already discussed Ms Monagle's failure to review the notes of the four week consultation. As a result of that failure, she was unaware that Ms A's EPDS score on that occasion was 12, which according to the Beyond Blue Guidelines indicated that it should be re-administered in two to four weeks. Ms Monagle was familiar with those Guidelines.[249]

277. Ms Monagle's evidence, as to the significance of her not being aware of the borderline EPDS score on 30 March 2012, was as follows:

> *"If you had read the previous notes, you would have taken it upon yourself to as well, on top of what you did do, do a further EPDS on* Ms A *or investigate her - - -?---I would probably investigate her um, a little bit further, but I thought that I had investigated her anyway.*
> *All right, but it would have prompted you to investigate her further?---I did that anyway"*[250]

278. Ms Monagle expanded on her position in the following evidence:

> *"Did you ask her whether she'd seen her GP in relation to any mental health issues in the preceding days?---No.*
> *Did you ask her whether she was feeling depressed?---No, she said that she was just tired.*
> *No, I understand. But did you ask her?---But she didn't say anything about depression.*
> *Did you ask her about depression?---No.*
> *If you knew that she had a positive or an EPDS of 12, would you have asked at least about feelings of sadness or depression on the - that's an EPDS previously?---I - I had asked her about how she was feeling and she said that she was tired, she was concerned about the babies, about their fussy - and she was very concerned about* BA *and the amount of milk that um, she had dropped quite a lot. I think it was only half her Formula or a bit below that, if I remember rightly, and she was really concerned that it was taking such a long time for* BA *to - to feed, and she was very unsettled. She'd - both parents have told me that at the Royal Children's Hospital, they took the baby of Zantac. So the babies have been off the reflux medication for five days. So for me, was this meaning that they really did need the Zantac? Because before that, the babies were okay. Well, within reason. So I'm - to me, I viewed this as removing the Zantac of a reflux baby and then the reflux had come back, and this is why they were unsettled, and the parents were - were tired.*
> *I understand that was your reasoning, but what you didn't do is you didn't have, at that stage, the knowledge of the score of 12 on the EPDS?---No.*
> *You didn't ask particular questions about that depression; that is your evidence?---No.... So um, we need to take in consideration what we're actually seeing. A lot of this is the non-verbal, so this is the body language, the body language a mother has to her child. Um, this shows us if there is an attachment or a non-attachment. What she's saying - so her verbal cues to this child. So all that has to be taken into consideration.*
> *Your practice with a woman with a score of 12, what would you do in that situation?---I would review what had been ah, said, what I reviewed with the - with the mother, what she*

[248] Coronial Brief p 1147 and p 1151
[249] Inquest transcript p 428
[250] Inquest transcript p 437- 438

was saying, how she was saying it, and then I would work out, "Do I need to see her in a week? Do I need to see her in two or do I need to see her in four?" [251]

279. I consider that Ms Monagle's answers confirm, rather than assuage, my concerns that she did not specifically turn her mind to Ms A's mental health on 24 April 2012 and whether a screen or referral might be required.

280. Ms Monagle was asked a serious of hypothetical questions by different counsel at the inquest about how she might have acted differently on 24 April 2012 if she had been variously aware of the borderline EPDS score on 30 March 2012, the EPDS score of 17 on 19 April 2012, the high scores on the DASS and K10 screens on 10 April 2012, and the mental health plan and psychologist referral in place as of 18 April 2012.[252]

281. Perhaps understandably, Ms Monagle's answers varied depending on how the questions were framed.

282. Ultimately, what emerged from that questioning was that had Ms Monagle appreciated that there had been several and recent indicators that Ms A may be suffering from post natal depression, this would have impacted on her assessment of the family's presentation and raised in her mind the possibility that both Ms A and the children were at risk of harm.[253] I understand that this was her position, even putting to one side the bruise observed on BA. [54]

283. I accept also that had she been additionally aware that Ms A had already been assessed by a mental health professional, already had a mental health plan and a psychologist referral for five days hence, she may have considered that Ms A's mental health was already being appropriately managed.[255]

284. She could not have reasonably reached this assessment, however, without making some inquiries of Ms A herself (and perhaps re-administering the EPDS, with particular attention to question 10) to satisfy herself, given the dynamic nature of such matters, that more immediate mental health review was not required on 24 April 2012.

285. Ideally, it would not have been necessary to pose so many hypothetical questions about how Ms Monagle would have responded if she was aware of Ms A's history of mental health screens, assessment and referral. I consider that, regardless of what information was shared, it was reasonable to expect that Ms Monagle would have made inquiries herself about Ms A's mental health on 24 April 2012, so that she was in a position to consider whether it

[251] Inquest transcript p 439, 440, 441
[252] Inquest transcript p 466 – 437 and p 499 -500
[253] Inquest transcript p 467
[254] Inquest transcript p 467
[255] Inquest transcript p 499 -500

required further follow up from her and whether it had any implications for her, immediate risk assessment.

Evidence of Mr A **and** Ms A

Mr A

286. Mr A gave a written statement which was included in the Coronial Brief and gave oral evidence at inquest. He was also represented by counsel who had the opportunity to cross examine other witnesses.

287. I have not referred extensively to Mr A's evidence in this Finding, although I have certainly read and taken account of it.

288. Mr A was home with Ms A and the twins from the time they were born and attended the majority of the medical consultations discussed above.

289. By way of background, in his statement, Mr A said that his wife struggled even before they got the twins home and handled them entirely differently from the way she handled CA who had been a relatively easy baby. He said she "*just didn't seem happy*"[256] and that he "*put it down to stress and having newborn babies to look after.*"[257] He stated that after the twins had been home "*for a bit, they were vomiting, not feeding properly, crying all the time and not falling in to a regular sleeping pattern.*"[258] His wife told him that the twins had colic. He presumed that she had been told that by a doctor and simply accepted it. He stated though that he had never himself heard a doctor say they had colic. However he did remember "*professionals advising me that the girls were suffering from reflux and nothing more.*"[259]

290. He was highly critical of his wife for not reaching out for assistance and not saying anything to him to indicate that she needed help. He is entirely unable to account for the injuries sustained by the girls and could not understand how it had happened. He remains tragically perplexed as to the actions of his wife who ultimately admitted causing the injuries to the twins. Perhaps the cause of his greatest anguish is that neither his wife nor anyone else has ever told him what "*she actually did to my girls.*"[260]

291. Mr A spoke of the "*heaps of support*[261]" looking after the children and that his wife had ample opportunities to speak about her depression. He noticed no change in her behaviour to

[256] Statement of Mr Mr A 20 July 2015
[257] Statement of Mr Mr A 20 July 2015
[258] Statement of Mr Mr A 20 July 2015
[259] Statement of Mr Mr A 20 July 2015
[260] Statement of Mr Mr A 20 July 2015
[261] Statement of Mr Mr A 20 July 2015

suggest that she suffered from depression. He agreed that she was obviously stressed about the twins and that things were tense but asserted that he never saw her having an angry outbursts with the twins or with CA He went on to say:

> *"During the 8 weeks we had the girls home I was home all day with them. So unless she was having these 'angry outbursts' when she was alone (which would not be often), I never witnessed any of them. Also our house is not enormous so if she started yelling or was upset in another room, I would know. You would hear it in the house."*[262]

292. In his oral evidence at inquest, Mr A confirmed that his wife didn't give him any particular reasons to believe that she was struggling, apart from the general observations of the pressures of three children, lack of sleep and difficultly feeding the twins. He said there was "*only one angry outburst.*"[263] That was in relation to not being able to get the girls settled and the mother not knowing what to do. He said that was the only angry outburst he said he ever saw. At that point in time he took the girls from the mother and told her to go and get some sleep. He confirmed that his wife never discussed any concerns or worries about her emotional wellbeing with him. There was nothing that would have caused him to ask questions about that.

293. Mr A was clear that he didn't witness any actions on the part of the mother which concerned him or appeared to be placing the children at risk. He said "*If I had witnessed anything we wouldn't be in this situation right now.*"[264]

294. The surprising thing about this case is that Ms A clearly inflicted injuries on her daughters without her husband ever being aware of it, hearing anything or observing anything. However this all has to be seen in the context of parents of twins who were extremely tired and suffering the usual stresses experienced by parents of new babies.

295. Mr A went on to describe the medical appointments at which he attended and those which he didn't.

296. He recalled no conversations with his wife at these consultations about whether she may have had thoughts about harming the children. He was firm in saying that he believed he would remember such a thing.

297. In relation to the administration of the EPDS test or other mental health screens, Mr A had no recollection of his wife ever being tested.

298. He confirmed that he was never aware of an assessment that the underlying problem with the twins was colic and only had a memory of being told that it was reflux.

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[262] Statement of Mr Mr A 20 July 2015
[263] Inquest transcript p 202
[264] Inquest transcript p 221

299. He did recall his wife discussing with him plans to document feeding and sleeping routines. This flowed from the consultation with Dr Dawson at the Unsettled Babies Clinic.

300. He was unable to give specific answers to many questions at inquest relating to particular consultations with particular medical practitioners.

301. In relation to any direct conflict in the evidence between Mr A and doctors who made specific notes following their assessment and what they told the parents, I accept the evidence supported by the documentation of the medical practitioners. In saying this I in no sense criticise Mr A He was a conscientious, hands-on father providing exceptionally strong support for his wife, backed up by members of their extended families. A conclusion that he may not have heard, or may be mistaken about, what was said by particular medical practitioners at a series of consultations when both he and his wife were tired and stressed does not reflect adversely on him.

302. Mr A gave evidence that he was unaware Ms A had been given a mental health plan and referred to a psychologist.[265] However, he agreed that he had accompanied Ms A to the Niddrie Medical Centre and was in the waiting room with the twins when Ms A saw the mental health nurse and GP.[266] He did not seek to dispute that the Mental Health Plan prepared for Ms A was located, after AA's death, stuck to the fridge in the A home.[267]

303. In relation to the specific observations by nurses of bruises, Mr A's evidence was that he was not aware of the bruising being detected by Ms Kingston at the four week consultation. He said he did not see the bruising on the twins after that appointment. He said that when his wife came home from that appointment she did not discuss the bruising with him and he didn't see it.[268] Ultimately he had difficulty explaining why when a maternal child health nurse had seen bruises on both twin's faces he had not done so.[269] He confirmed under questioning that he observed no bruising on either AA or BA at the four week point or after – anywhere on their bodies.[270] He said that he only became aware of bruising when advised by the maternal child health nurse at the eight week assessment. He agreed that he was handling the babies every day and accepted that if there had been bruising he would have noted it.[271]

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[265] Inquest transcript p 212
[266] Inquest transcript p 211
[267] Coronial Brief p 203 and Inquest transcript p 578
[268] Inquest transcript p 238
[269] Inquest transcript p 238
[270] Inquest transcript p 239
[271] Inquest transcript p 218

304. Given the loss and trauma he has clearly suffered, Mr A probably did not do himself justice in the witness box. Mr A's evidence was clearly heavily effected by poor memory and vagueness. As stated above, I do not criticise him because of that. On all of the evidence he was a conscientious and good father. He has been traumatised by the events. He understandably has expressed great anguish about what occurred and in particular his wife's failure to tell him, at the time, what was happening. This is simply one aspect of the tragedy of the case.

Ms A

305. For the reasons noted above, Ms A was not called to give evidence at the inquest.

306. The key points made in her written statement for the inquest can be summarised as follows:

- She and her husband took the twins to the RCH Emergency Department when they were around 11 to 12 days old because the twins were crying all the time and difficult to settle.
- At 6 weeks of age they were taken to the Niddrie Medical Centre (Dr Zagarella). In the statement, Ms A says that she said to Dr Zagarella "*I need help I am not coping.*" She recalls doing the DASS and the K10 screen tests. She recalls being told that her scores were quite high and that she would need follow up appointments with both Dr Zagarella and mental health nurse Ms Goodchild. She said "*at that time I did not realise how serious the depression was.*"[272]
- She questioned why more immediate action was not taken given the scores. In this context I note the evidence already reviewed in relation to Dr Zagarella and Ms Goodchild, they did not consider that the scores themselves dictated an immediate and urgent mental health intervention for Ms A
- She recalled the referral to Dr David Collins, the psychologist.
- She referred to the visit the Unsettled Babies Clinic on 19 March 2012 and to the Maternal Child Health care nurse two days before AA's death.
- She described the support she had from her family and her husband.
- She referred to the police interview and her statements that she may have shaken the babies while they were in her arms, holding them and rocking them. In this statement she said "*Even now, that is all I remember doing with the girls. I did nothing deliberate*

[272] Statement of Ms Ms A 7 October 2015 p 6

to hurt them. I am not holding any information back. I have no memory of anything else I did that caused the injuries to the girls."[273]

- She was adamant that she did not know then that she was harming the girls and stated that she would have hospitalised herself if she had known that she could. She believed that she needed help in managing the girls but thought she was getting help appropriately. (I note that on the evidence, she was in fact receiving considerable help).
- Late in the statement she expresses her remorse and states that she can't remember what happened but is distraught at the consequences.

307. Ms A ultimately stated that she now understands how depressed she was but did not realise that at the time. She expressed a hope that the coronial inquest would *"improve thing for other parents who may face similar problems in the future."*[274]

COMMENTS

Pursuant to section 67(3) of the **Coroners Act 2008**, I make the following comment(s) connected with the death:

Response to Bruising

308. I was considering a formal recommendation arising out of my Findings above that the bruises observed on AA and BA were not responded to appropriately. However, in submissions to the Court, the DET has provided the following relevant information:

- In 2016, the Department will amend its MCH Guidelines to provide specific information to MCH nurses about identifying and responding to physical injury inconsistent with a child's age and stage of development, and in particular I relation to bruising on non-mobile infants.[275]
- The amended MCH Guidelines will emphasise that the presence of bruising on non-mobile infants is very uncommon and raises concerns about the possibility of non-accidental injury.[276]
- The amended MCH Guidelines will indicate that where bruising is noted on a non-mobile infant, there are reasonable grounds for forming the belief that the child is in

[273] Statement of Ms A 7 October 2015 p 10
[274] Statement of Ms A 7 October 2015 p 14
[275] Submissions in Reply on behalf of the DET, 15 February 2016, p 1
[276] Submissions in Reply on behalf of the DET, 15 February 2016, p 2

need of protection. As such a mandatory report to DHHS Child Protection is recommended.[277]

- Although the responsibility for ensuring registered nurses are abreast of relevant clinical issues primarily rests with the nurse, the Department has determined that it will provide further information, clinical updates and training to MCH nurses concerning the significance of bruising on non-mobile infants.[278]
- The Department envisages that it will seek to draw on the expertise of Child Protection, and the Victorian Institute of Forensic Medicine and other specialists to develop a new seminar regarding bruising on immobile infants. It is anticipated that this seminar will be presented to all MCH nurses at the Department's bi-annual conference in April or October 2016.[279]

309. The submission made on behalf of Mr A was that in all cases where there is bruising on a non-mobile infant that cannot be independently confirmed as having occurred as a result of accident in a public setting, a radiological screen for accidental injury is warranted. On that basis, it was further submitted that the Moreland City Council should promulgate protocols which mandate that a referral to a GP, specialist paediatric service or a hospital emergency department should be undertaken in all such cases.[280]

310. I have already indicated my view that there is some limited room for clinical judgment in considering how to respond to bruising observed on an immobile infant, at least on the first such presentation. In that respect I prefer the approach foreshadowed by the DET, which would emphasise the significance of bruising and then *recommend* rather than mandate a particular course. I think that a recommendation of this nature in the MCH Guidelines would adequately serve to highlight the scepticism or suspicion, and concern with which any presentation of bruising in a non-mobile infant should be approached.

311. I have stated that I consider bruising in a non-mobile infant sufficient in itself to found a belief on reasonable grounds that a child may be in need of protection. However, I have also indicated that I accept that health professionals may consider that bruising, in some cases, gives rise to a suspicion or concern that falls short of the reporting threshold, but which necessitates follow up referral and investigation. It would have been my intention, therefore, to recommend that MCH nurses be guided to pursue one or other of these paths – reporting to Child Protection or follow

[277] Submissions in Reply on behalf of the DET, 15 February 2016, p 2
[278] Submissions in Reply on behalf of the DET, 15 February 2016, p 2
[279] Submissions in Reply on behalf of the DET, 15 February 2016, p 2
[280] Submissions on behalf of Mr A p 15

up referral and investigation. However, I accept that such guidance may be confusing. It may introduce unnecessary complexities such as consideration of parental cooperation and likely follow through with referral and the availability and accessibility of appointments with other appropriate health services. On that basis the approach of the DET is to be preferred. In submissions, the DET notes that the result of a notification would be the same in any case, a Child Protection practitioner would conduct a visual check of the infant, and where injuries or symptoms of abuse are present, a paediatric forensic medical examination would be required.[281] I accept that.

312. The initiative being undertaken by the DET by way of an amendment to the MCH Guidelines, is a positive and appropriate response to the lessons learnt in this case. In the circumstances, I consider that it is no longer necessary to make a specific recommendation on this point.

Assessing risk

313. Reviewing AA's death, it is clear that none of the health professionals who encountered Ms A in the weeks leading up to 26 April 2012 concluded that she posed a risk of harm to her twins. With the exception of my findings in relation to the bruises, I have concluded that there is no basis for criticism in that regard. The primary indicators which might lead to concerns about risk of harm to an infant, such as difficulties in mother infant interaction, suicidal ideation or evidence of a serious mental health disorder, were not present in this case. On the contrary, the manner in which Ms A engaged with, responded to and spoke of her twins offered assurance to health professionals.

314. This led me to consider whether current screening frameworks are appropriately calibrated to recognise the risk to infants that may arise in more generic circumstances, for example, as a result of an infant being very unsettled, with exhausted but otherwise attentive parents.

315. It also led me to consider whether assessment of risk of harm to infants in the post natal period ought to be approached in a more routine, systematic way, irrespective of whether there are other possible indicators of concern.

316. For example, mothers are routinely encouraged to complete the EPDS as a matter of course in the weeks following birth, regardless of whether there is evidence of post natal depression. It is a broad screen and includes a question about thoughts of self-harm, which might otherwise not be broached. I raised the question, with two witnesses of considerable expertise in this area, Dr Jenny Proimos and A/Prof Hiscock (of the Unsettled Babies Clinic), whether there may be value

[281] Submissions in Reply on behalf of the DET 15 February 2016, p 3

in including in the EPDS an additional routine question for mothers about whether they have had thoughts about harming their baby.

317. Dr Proimos' statement[282] provided a helpful and authoritive explanation of the role, history and validation of the EPDS. Dr Proimos' expertise is considerable[283].

318. I accept the evidence that the EPDS is a "*completed validated screening tool*" and is therefore not readily amenable to modification or additions without "*requiring significant further research to test its validity.*"[284]

319. I accept that, Beyond Blue Guidelines aside, there is currently no uniform practice on whether, when and how questions about risk of harm to infants are posed to parents.[285] I consider that it would not be sound, based on AA's death alone, to suggest that the question should be routinely asked (verbally or in a written questionnaire) to every mother regardless of whether other indicators of concern are present.

320. In reaching that conclusion, I am mindful that, in any event, Ms A was twice asked the question (verbally) whether she had thought about, or was worried about, harming her children and denied any thoughts of harm. Her own evidence is that she was unaware that she was harming the twins or that she posed a risk to them.

321. In her response to written questions, Dr Proimos made two further pertinent points.

322. She was asked, "*would you agree that in the absence of these indicators, risk to infant is not routinely and directly explored in the context of screening for post natal depression or conducting a maternal psychosocial assessment*?"

323. In her answer she noted that the current screening framework employed by MCH nurses does recognise that risk to infant may arise in quite general circumstances. For example, she noted Appendix 2 of the MCH Guidelines dealing with Child Abuse and Neglect contains a long list of indicators of concern for infants which includes indicators such as excessive crying and poor weight gain.[286]

324. Dr Proimos also noted that risk to infant is routinely explored by MCH Nurses at all Key Ages and Stages (KAS) consultations and cited examples of how this occurs, which, in my view,

[282] Statement of Dr Jenny Proimos dated 8 October 2015
[283] Dr Jenny Proimos is the Principal Medical Advisor in Wellbeing and Engagement Division of the Victorian Department of Education and Training.
[284] Statement of Dr Jenny Proimos, p 14 and Inquest transcript p 150
[285] Inquest transcript p 154
[286] Statement of Dr Jenny Proimos, 22 December 2015 p 3

served to illustrate that it is not only through the asking of direct questions about potential or actual harm that risk is expected, explored or monitored.

325. Dr Proimos noted that the MCH Practice Guidelines prompt MCH Nurses to conduct a mental health and wellbeing check at the four week KAS consultation that includes the follow questions:

> *"Ask all mothers if they have experienced any of the following:*
> *Past history of depression/anxiety*
> *Anxiety/depression*
> *Fatigue/loss of energy*
> *Insomnia/hypersomnia*
> *Significant increases or decreases in appetite*
>
> *If the mother answers yes to any of the above questions discuss information in Emotional health during pregnancy and early parenthood, Beyond Blue.*
>
> *This included information in regard to the use of the Edinburgh Postnatal Depression Scale and support/referral options.*[287]"

326. In her statement, Dr Proimos made the point that there is no one risk assessment tool that can accurately predict whether a child is likely to be harmed by a parent or care giver.[288]

327. I note and accept that the "*primary trigger for shaking a baby is frustration and angry resulting from an infant's inconsolable crying.*"[289] This appears to be exactly what happened in this case.

328. I note also that the evidence is, that the generic nature of risk factors and triggers makes a screening tool or risk assessment tool with sufficient specificity in relation to Shaken Baby Syndrome (SBS), a considerable challenge to develop. It follows that prevention efforts must focus heavily on early engagement with parents about the risk of SBS. In this context I note the evidence of Dr Gabriel about the NAPCAN SBS pamphlet. (see paragraph 331) The NAPCAN SBS brochure is in very clear language.

329. Dr Anastasia Gabriel from the DET made a statement dated 4 September 2015. She also forwarded a letter dated 17 December 2015 answering a number of questions set out by the Court.

330. She outlined the policy documents that applied between January and April 2012. They were the Maternal and Child Health Service: Practice Guidelines (2009), and the Maternal and Child Health Service Guidelines (2011). She outlined the practice framework for consultations under the MCH Practice Guidelines. She noted that they are prescriptive as to activities nurses are to

[287] MCH Practice Guideline 2009, p 29
[288] Statement of Dr Jenny Proimos, p 14
[289] Statement of Dr Jenny Proimos, p 17

undertake at each KAS consultation.[290] The MCH Practice Guidelines specify data to be collected and other obligations.

331. She noted that the MCH Practice Guidelines "*act as a reminder to MCH nurses to turn their mind to the safety of the child at each KAS consultation.*" She noted that the MCH Practice Guideline prescribes that the MCH nurse is "*to provide and discuss each handout listed on the MCH framework – Promotion of Health and Development for the home visit KAS visit. (For the initial home visit these handouts include the NAPCAN pamphlet 'It's not ok to shake babies'.*"[291]

332. Finally Dr Gabriel noted that the Department of Education and Training provides $8000 - $10,000 annually to NAPCAN "*in order to purchase copies of its pamphlet "It's not ok of shake babies"*[292] to be distributed to every family at the initial MCH home visit.

333. I note the evidence of Dr Dawson that as part of explaining diagnosis of colic to the A's - she talked to parents about the "Purple Crying" website. No material from this website was tendered – but reviewing it myself, it appears to be a valuable resource for parents, especially those struggling with an unsettled infant. It includes the following explicit information:

> http://purplecrying.info/sub-pages/protecting/shaken-baby-syndrome-sbs.php
>
> *Did you know that nearly four times everyday an infant is shaken and abused? Shaken baby syndrome (SBS) is a form of child abuse that occurs when an infant is violently shaken by a much larger person. It is the most devastating form of child abuse as 30 percent of all infants who are shaken die and upwards of 80 percent who survive suffer permanent life-long brain abnormalities. In fact, shaken baby syndrome is the most common form of child abuse seen in children under one years of age. So now you are probably wondering, what does this have to do with me? I would never shake my baby. Would you believe that the number one reason a child is shaken is because a parent or caregiver becomes so frustrated with a baby's crying that they lose control and just shake them. Believe it! Research has shown that frustration with a child's crying is the number one reason a person shakes a baby. This can be hard to understand, unless you have been in a situation where no matter what you tried to calm your crying infant, nothing worked.*

334. On this topic Dr Proimos was asked "*do you believe the information provided to parents currently (eg. Pamphlet NAPCAN – It's not OK to shake babies) is sufficient to draw attention to parents/caregivers regarding the risks of SBS.*"

335. Her answer was:

> "*There is a place for additional evidence based information on unsettled infants, coping with infant crying, and the risks of shaken baby syndrome to be provided to parents by MCH Nurses and other health professionals (in addition to the NAPCAN pamphlet). Consideration should be given to:*

[290] Statement of Dr Anastasia Gabriel, 4 September 2015
[291] Statement of Dr Anastasia Gabriel, 4 September 2015
[292] Statement of Dr Anastasia Gabriel, 4 September 2015

(i) *Evidence based research projects that have been undertaken in other Australian States and Territories and overseas;*
(ii) *The effectiveness of these programs in education parents about infant crying and shaken baby syndrome via written materials, educational films, and online tools; and*
(iii) *The way in which parents and caregivers are engaged with this information...*"[293]

336. Dr Proimos also outlined projects which are being undertaken in Australia about the Cry Baby project. She said:

> *"The Cry Baby Project explored what methods were effective in engaging with vulnerable parents to access an interactive online program that provides them with information and strategies on how to cope with infant crying, and strategies to improve infant sleep. The Project explored whether online promotion, promotion by MCH nurses, and/or weekly emails prompts increased the level of engagement with this interactive online program.*
> *The preliminary findings suggest that promotion by MCH nurses and/or weekly emails prompts do increase parents' level of engagement with interactive online programs such as these.*
> *Once the findings have been finalised the Department will consider ways to integrate these findings regarding parent engagement methods into MCH practice."*[294]

Review of the Case by Moreland City Council

337. Ms Jane Foy was the Moreland MCH Unit manager at the time. She was not called to give evidence at the inquest. However she did make a statement in which she referred to the supervision of MCH nurses, in particular whether there is any routine audit of consultation records to check compliance with Guidelines and Practice Manuals and whether there are routine supervision meetings.

338. She referred to one focused desktop audit of certain notes that had been undertaken. It does appear that supervisors do not, as part of their supervision, review notes to consider compliance with policy and guidelines. I make no comment upon that matter. I note also that general MCH nurses have supervision meetings every two months.

339. As to whether there were briefings, de-briefings or reviews after the death of AA or whether there are in similar cases was canvassed in evidence. Ms Kingston was asked:

> *"Was this case debriefed or case conferenced, after the tragic outcome? No*
> *Would that have been helpful, to do that?---It's helpful to review any case.*
> *But you say there's been no review by Moreland City Council of this case?---That is correct.*
> *HIS HONOUR: I'll just ask you the obvious question. Do you think there should have been? For the benefit of yourself and other practitioners?---I think it would be very helpful.*
> *Mm.*
> *Yes.*
> *MR HALEY: Were any guidelines or protocols promulgated by Moreland City Council after this event in relation to bruising in immobile children?---No.*

[293] Letter from Dr Jenny Proimos, 22 December 2014
[294] Letter from Dr Jenny Proimos, 22 December 2014

HIS HONOUR: I'll ask you the same question again, Ms Kingston. Do you think that would be useful?---I think a review of, um, training on, um, signs of physical abuse would - is - is always helpful."[295]

340. I would agree with Ms Kingston that it would be "helpful" to regularly review training in respect of responding to signs of physical abuse. I note her view that it would have been helpful for there to have been a review of the case. I note also that no new guidelines or protocols were promulgated by Moreland City Council after this event in relation to bruising in immobile children.

341. There was no further evidence on this matter and more may have been done since then by Moreland City Council. Reviews of cases such as this leading to death or other significant incidents, are routinely undertaken by hospitals and other institutions. It is surprising that no review, as such, was conducted by the Moreland City Council but I make no further comment on the point.

Information Sharing – The Green Book

342. All health professionals involved with the family over the eight week period leading up to 26 April 2012 were engaged in a similar endeavour, that is, to ensure the health, safety and wellbeing of the twins and monitor and support maternal wellbeing. In approaching this task, they did not have the benefit of each other's observations and examinations, except to the extent that information was relayed via the parents.

343. Each practitioner would almost certainly have benefited from information from the others, about the bruising, mental health screens, diagnoses, treatment plans.

344. As a result, at inquest there were many hypothetical questions about how assessments and responses may have been different with a more complete picture.

345. In this context, there were a lot of questions about the Green Book - what was and wasn't recorded and why and whether the Green Book was taken to and checked by other practitioners anyway.

346. This prompted me to pose questions to the DET about the Green Book's intended use.

347. In her response to those questions Dr Gabriel of DET advised as follows:

"The Green Book is designed for use by parents and MCH nurses to record their child's milestones, health, growth, development and immunisation throughout their childhood. The Green Book also allows for parents to add in personalised details about their child's health and development and provides plastic sleeves for important documents.

[295] Inquest transcript p 340

Information is often added to a child's Green Book by MCH Nurses and the child's parent at each of the child's Maternal and Child Health consultations (Known as the Key Ages and Stages consultations).

...Parents are encouraged to take their child's Green Book along to their appointments with other health professionals in respect of their child. However, as far as the Department is aware (from anecdotal evidence), health professionals (other than MCH nurses) do not have the expectation nor do they require that parents will bring their child's Green Book to consultations.

The Department does not currently collect information regarding use of the Child Health Record by other health professionals....

Thus, a child's Green Book is very unlikely to contain all key health information about the child and therefore cannot and should not be relied upon by health professionals to collect complete, accurate and update to date health record of the child.

...it is not intended for use by health professionals as a way to disclose health information about a particular child to other health professionals.

In the circumstances where a MCH nurse makes a referral for a child or their parents to attend a consultation with another health professional (such as a General Practitioner) the MCH nurse will, in most instances, generate a referral letter/document that is provided in hard copy to the family to take along to the consultation with the health professional. This letter/documentation will ordinarily include all of the key health information that the health professional is likely to need, including the reasons for the referral by the MCH nurse. There is no expectation that the health professional will also review the child's Green Book in order to obtain the relevant information about why the child is being referred."[296]

348. I accept that the Green Book is not the intended, or preferred vehicle for sharing concerns about a child between health professionals or for apprising other health professionals of important health information.

Information Sharing - General

349. More generally on information sharing, the question to Dr Gabriel was:

> *"What are the options in terms of systems processes for health care providers responsible for the care of young infants and children to share information with other health care providers?"*

350. Dr Gabriel replied:

> *"My role at the Department is, amongst other duties, to lead a state-wide reform of Victoria's Maternal and Child Health Services including overseeing the update of program and service guidelines and standards for MCH Nurses.*
> *As such, my knowledge of information sharing systems and processes for health care providers is limited to those systems and processes available to MCH Nurses.*
> *To date, information share between MCH nurses and other health professionals has been predominantly one-sided. MCH nurses refer many children/families (with consent of the parent) to General Practitioners or other health professionals (such as early parenting centres, mother-baby units and dental services) but rarely receive any acknowledgement that a referral was received, or any information about how the referral was actioned, or what was the outcome of the referral.*

[296] Letter from Dr Anastasia Gabriel, 17 December 2015

MCH nurses will generally identify a need or form an opinion based on assessment frameworks or clinical judgement that a referral to an external health professional is required. An MCH nurse would normally document their concerns or rationale for the referral in the database used by the local appropriate health professional and provide this referral to the family to then hand to the health professional. On rare occasions, the MCH nurse may phone/email the referred health professional to express concerns about a family/child.

This process is consistent with the Maternal and Child Health Service Program Standards 2009, that state that a referral from MCH nurses to other health care professionals or community services/agencies should include, at a minimum, the child's name, date of birth, contact details, family details, the reason for the referral and any relevant health information."[297]

351. The final question posed by the Court was:

> *"Do you believe current options for information sharing between health care practitioners caring for infants, such as doctors, maternal child health services and specialists are sufficient?*

352. Dr Gabriel replied:

> *"As stated above, I am not in a position to comment on the sufficiency of the current options for information sharing between health care professionals caring for infants generally.*
>
> *In regards to the sharing of information between MCH nurses and other health care professionals caring for infants, it would be valuable for MCH nurses to receive a report or letter in reply from the health care professionals to whom they have referred a family or child.*
>
> *Collaboration and mutual communication between MCH nurses and other health professionals is important for the following reasons:*
>
> - *To ensure that each health professional is aware of their area of responsibility.*
> - ***To ensure that all health professionals involved in caring for, or supporting the child or family are aware of any progress or changes to the health or development of a child or a parent.*** (My emphasis).
> - *To clarify what services and health professionals are providing advice or support to the child and family at any given time.*
>
> *This is particularly important for MCH nurses because they are often the only health professionals to see a child and their family regularly over a lengthy period of time."*[298]

353. In my view this last statement of Dr Gabriel's is highly significant in the context of this case. Clearly systems of communication should support the purposes she lists – in particular the purpose of ensuring that "*all health professionals involved in caring for, or supporting the child or family are aware of any progress or* ***changes to the health or development of a child*** *or a parent.*" To the extent that they do not, they should be improved.

354. On the topic of information sharing I received a proposed recommendation from Moreland City Council. It related to the development of databases where information in respect of contacts for all services providers is established. The submission proposed:

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[297] Letter of Dr Anastasia Gabriel dated 17 December 2015 p 4
[298] Letter of Dr Anastasia Gabriel dated 17 December 2015 p 5

> *"That there be established an electronic database accessible by maternal and child health and other service providers. That database ought act like a telephone book of providers such that, with parental consent, a health care worker assisting the family can add their name to the list of workers assisting the family. That way all those workers registered on the database as working with that family become visible and contactable by telephone or email. The database should include an ability by any worker involved to notify all other service providers registered on the database if there is a change in a child's risk level."*[299]

355. The submission noted that there is already in use "*...by some Victorian Municipal Councils a website application connecting practitioners from local services with common clients within a geographic area.*"[300]

356. The submission encouraged me to recommend "*...that stakeholders, and particularly government funded stakeholders, involved in delivering maternal and child health services collaborate and consider joining and extending that database or creating a similar database, in respect of maternal and child health services.*"[301]

357. A proposal of this nature was not directly canvassed in evidence, although I did invite the parties to consider the issue of information sharing. It is important to point out that there was no suggestion in this case that the health professionals involved were unaware of each other's involvement. The problem was more that they were unaware of the content and outcomes of the actions of each other; the most stark example being the fact that Ms Monagle was not aware of the bruising findings of Ms Kingston.

358. However there is merit in the proposal by the Moreland City Council. Medical practitioners were unaware of the observations made by those who dealt with the A children before them and they did not have access to a shared or single medical record to assist them. Apart from the internal information within the Moreland MCH database, other practitioners following on were not in a position to access a single health record (shared database) to inform their knowledge and actions. Ms Monagle could have, but did not look, at Ms Kingston's note in the Moreland MCH database, but it may well have assisted other practitioners, dealing with the family after 30 March 2012, (when bruising was detected by Ms Kingston), to be aware of what she had seen and noted. Dr Zagarella saw the children on 10 April 2012, saw Ms A on 18 April 2012 with Ms Goodchild and Dr Dawson saw the family on 19 April 2012. A single health record, accessible by each of these practitioners at the point of their consultation with the family would have at least *enabled* them to see Ms Kingston's note and to take it into account in formulating their responses to the presentations on the day.

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[299] Submission on behalf of Moreland City Council, p 19
[300] Submission on behalf of Moreland City Council, p 19
[301] Submission on behalf of Moreland City Council, p 19

359. I note a second recommendation from Moreland City Council in respect of the need to review privacy legislation in this context. However there was no evidence in this case that practitioners believed they couldn't share information because of perceived privacy constraints. And it is not open to conclude that better information sharing would necessarily have altered the outcome.

360. I note also the information from Dr Gabriel of DET that information exchange is often one-sided and that MCH nurses often receive no information on outcomes of referrals. I agree that a letter to referring MCH nurses with information relating to the outcomes would be desirable. However, again the issue in this case not about method of referral and feedback to the referring health professional.

361. The development of a shared database, or a single health record, would undoubtedly be complex and expensive. It would involve policy and implementation/practical considerations – not the least of them being IT issues. In addition it cannot be concluded that a better sharing of information, let alone a single health record, would have made a difference to the outcome in this case. However in my opinion the issue remains important. It was not strictly in the original scope of the inquest but emerged during the course of the inquest. Towards the end of the inquest, I invited the parties to consider it. I posed questions on the issue and Dr Gabriel responded as above (see paragraph 352). The Moreland City Council made a submission on the issue, however there was no direct evidence about current developments, if any, on the issue.

362. The investigation of the circumstances of AA's death has crystallised information sharing as an issue warranting a recommendation. The experience of the case can usefully inform policy making. For these reasons I will make a recommendation intended to focus attention on the issues of information sharing and, if feasible, to do so by way of the development of a shared, single medical record applicable to infants/children, (and their mothers), being monitored and treated within the MCH system, and concurrently by other medical practitioners including GPs. The recommendation is necessarily cautious. I assume that this is a dynamic and complex policy area and in making this recommendation I do not presume the feasibility of what is recommended.

RECOMMENDATIONS

Pursuant to section 72(2) of the **Coroners Act 2008**, I make the following recommendation(s) connected with the death:

1. I recommend that relevant government departments (including the Department of Education and Training and the Department of Health and Human Services), in collaboration with the Municipal Association of Victoria and other stakeholders involved in delivering Maternal and Child Health services, examine the feasibility of the creation of a shared data base, being in effect a single

health record, of the monitoring and treatment of infants and children passing through the Maternal and Child Health system in Victoria. The purpose of the database would be to enable those monitoring and treating the infant/child to inform themselves, in real time, of progress and/or changes in the health or development of that infant/child by accessing the full medical record to that point in time.

Pursuant to section 73(1) of the **Coroners Act 2008** and section 18 of the **Open Courts Act 2013**, I order that the following not be published on the internet:

> Any material that identifies or tends to identify the deceased as the subject of this coronial investigation. This includes the deceased name and that of the parents and siblings.

I extend my condolences to the family of AA

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

Mr A C/- Mr Tom Ballantyne, Maurice Blackburn Lawyers

Ms A C/- Dowling McGregor Pty Ltd

Moreland City Council, C/- Mr Michael Regos, DLA Piper

Royal Children's Hospital, C/- Ms Jess Bayly, K & L Gates

Dr Sam Zagarella, C/- Ms Lara Larking, TressCox Lawyers

Ms Sally Goodchild, C/- Ms Lara Larking, TressCox Lawyers

Department Secretary, Department of Education and Training, C/- Ms Elena Totino, Children Families & Education Law Unit, Legal Division

Department Secretary, Department of Health and Human Services, C/- Ms Kirsty McIntyre, Legal Services Branch

Detective Senior Constable Jennifer Booth, Coroners Investigator

Senior Sergeant Jennette Brumby, Counsel Assisting

Professor Jeremy Oats, Consultative Council on Obstetric & Paediatric Mortality and Morbidity

Signature:

JUDGE IAN L GRAY

Date: 16/5/2016

Coroners Court of Victoria