IN THE CORONERS COURT

AT MELBOURNE

CORONIAL INVESTIGATION OF THE DEATH OF SHYRA LEE BLOOMFIELD[1]

RULING ON RELEASE OF THE CHILD DEATH INQUIRY REPORT ON THE DEATH OF SHYRA LEE BLOOMFIELD

Ruling

I make no order to compel the Department of Human Services or the Child Safety Commissioner to produce the Child Death Inquiry Report relating to Shyra Lee Bloomfield.

Background

Shyra Lee Bloomfield was 16 years old when she died. She lived with her mother and step-father, Tania and John McPhelim, and their three other children at 10 Tanilba Street in Werribee. Shyra's history included living out of home, failure to continue education and drug abuse, particularly cannabis use and chroming.

Shyra had been a client of the Department of Human Services Child Protection Unit since 9 July 2006. At the time of her death, she was subject to a Supervision Order which included special conditions relating to her living conditions, treatment, provision of supports, school attendance and a curfew. This Supervision Order expired on 8 February 2008. It was subject to an application to extend which was listed for hearing on18 February 2008.

Coroners Court Case Number 696/08.

On 15 February 2008, Shyra met two friends at a vacant house near her home in Werribee. They chromed at this house until about 12.00am on 16 February. The three young people then left to go to their separate homes.

At 6.30am on 16 February 2008, Mr McPhelim found Shyra unresponsive hanging in the garage at home. She was unable to be revived.

The forensic pathologist who inspected the body formed the opinion that, in the circumstances, a reasonable cause of death would appear to be hanging.

Coronial Investigation of Shyra's Death

I am the coroner responsible for investigating Shyra's death. As part of that investigation, I have been provided with all Shyra's Department of Human Services records as well as records and statements from her community-based service providers and further information about chroming.

On 8, 9 and 10 November 2010, I heard evidence from witnesses including Shyra's mother and sister, Lisa Cuckow who was Shyra's protection worker and other professionals who provided services to Shyra. This Inquest was part of my investigation of Shyra's death.

Application for access to the Child Death Inquiry Report

Section 33 (1) of the *Child Wellbeing and Safety Act* 2005 states:

> *"The Child Safety Commissioner must conduct an inquiry and prepare a report in relation to a child who has died and who was a child protection client at the time of his or her death …. ."*

This report prepared by the Child Safety Commissioner is the Child Death Inquiry Report.

On 9 November 2010, Counsel for Shyra's family sought access to the relevant Child Death Inquiry Report. Counsel for the Department of Human Services and the Child Safety Commissioner objected to public release of this report. Both parties asserted their applications were in the public interest. Both parties provided me with written submissions to support their applications.

On 10 November 2009, I indicated to the Court that I had decided not to call for the Child Death Inquiry Report on Shyra's death and gave oral reasons for my decision. This Ruling comprises

the written reasons for my decision not to call for the relevant Child Death Inquiry Report.

Reasons

Section 33(6) of the *Child Wellbeing and Safety Act* 2005 states:

> *"Nothing in this Division is intended to limit or affect any power or function of a coroner or a member of the police force to investigate the death of a child."*

Therefore, there is no statutory reason for the Child Safety Commissioner or the Department of Human Services to refuse to release the Child Death Inquiry Report to a coronial investigation.

Further, the Court of Appeal[2] continues to rely on *Sankey & Whitlam* in ruling that the test for granting public interest immunity is high and its limits must continue to be very strictly drawn:

> *"The general rule is that the court will not order the production of a document, although relevant and otherwise admissible, if it would be injurious to the public interest to disclose it. However the public interest has two aspects which may conflict. These were described by Lord Reid in Conway v Rimmer as follows:*
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> *'There is the public interest that harm shall not be done to the nation or the public service by disclosure of certain documents, and there is the public interest that the administration of justice shall not be frustrated by the withholding of documents which must be produced if justice is to be done.'*
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> *It is in all cases the duty of the court, and not the privilege of the executive government, to decide whether a document will be produced or may be withheld. The court must decide which aspect of the public interest predominates, or in other words whether the public interest which requires that the document should not be produced outweighs the public interest that a court of justice in performing its functions should not be denied access to relevant evidence. In some cases, therefore, the court must weigh the one competing aspect of the public interest against the other, and decide where the balance lies."*[3]

Section 33(2) of the *Child Wellbeing and Safety Act* 2005 relates to the Child Safety Commissioner's functions in relation to deaths of children who are child protection clients at the time of their death. It states:

> *"The object of an inquiry under this section is to promote continuous improvement and innovation in policies and practices relating to child protection and safety."*

An Affidavit of Mary McAlorum appended to the submissions of Counsel for the Department of Human Services and the Child Safety Commissioner states that another role of the Inquiries and Review Unit of the Office of the Child Safety Commissioner is to provide an independent

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[2] *State of Victoria v Brazel* (2008) 15 VR 512 at p. 563 citing *Royal Women's Hospital v Medical Practitioners Board* (2006) 15 VR 22 at p. 32.
[3] Gibbs A.C.J. in *Sankey v Whitlam* [1978] HCA 43; (1978) 142 CLR 1 at p. 38

review of Child Protection practice in relation to the child who has died. However, the Child Death Inquiry Report is prepared by the Child Safety Commissioner with assistance from and mandatory co-operation of Department of Human Services staff and other service providers. Therefore, in practice, the Child Safety Commissioner's inquiry does not act independently of the Department of Human Services. I note that his lack of independence is also underlined by his being represented in this Inquest by the Legal Services Branch of the Department of Human Services and the same Counsel as the Department of Human Services. The Child Safety Commissioner and the Department of Human Services also tendered a joint written submission in this application.

This means that the Child Death Inquiry appears to be more like an internal review that relies on full and open disclosure by Department of Human Services workers and other service providers. In that sense, the Child Death Inquiry Report is analogous to or in the same 'class' of documents as the reports of internal reviews undertaken prepared by public hospitals after medical adverse events.

In the context of the coronial jurisdiction, Deputy State Coroner Iain West addressed the issues which influence the decision to compel production of this 'class' of internal review documents in his Ruling in the Inquest into the Death of Adolf Hermann.[4] In that Inquest, the hospital relied on a statement by Professor Garry Jennings who explained that in order to promote 'robust and frank discussions' at the monthly audit meetings he had advised clinicians that any discussions or documents produced at the meeting would be confidential. Deputy State Coroner West accepted that Professor Jennings correctly reflected the adverse consequences that would flow from an order for production of the report of the relevant morbidity and mortality review.

Similarly, relying on Ms McAlorum's affidavit, I also accept that it is in the public interest for discussion within the Department of Human Services and with the people who assist the Department to be as open as possible in order to improve their processes. I also accept that the Child Safety Commissioner's on-going investigations may be compromised if the participants know the report may be called in evidence in a coronial inquiry.

However, to apply Deputy State Coroner West's further reasoning, the exercise for the court is one of balancing the respective interests to determine which should prevail:

[4] Coroners Case 3578/96.

> *"The claim of public interest immunity must nonetheless be weighed against the competing public interest of the proper administration of justice, which may be impaired by the denial to a court of access to relevant and otherwise admissible evidence."* [5]

In the Hermann Inquest, Deputy State Coroner West ruled against calling for the report of the morbidity and mortality review undertaken by the Alfred Hospital's cardiology department in relation to Mr Herrman's death.

In similarly balancing the competing interests and being mindful of the document's 'class' status, I am concerned that my assessment of the circumstances of Shyra's death may rely on 'facts' which differ from those relied on by the Child Safety Commissioner so that we determine a different outcome and make different recommendations. Therefore, a decision not to call for the Child Death Inquiry Report may frustrate the public interest in the administration of justice.

However, the Coroners Court differs from other jurisdictions because it is a specialist inquisitorial court which is responsible for investigating the cause and circumstances of reportable deaths and making comments and recommendations intended to promote public health and safety.[6]

Like the Child Safety Commissioner, I can compel Department of Human Services employees to produce documents, make statements and give oral evidence in the Inquest, whether or not they have been involved in their internal reviews. No one has objected to contributing to the coronial investigation of Shyra's death. No information has been refused except this Child Death Inquiry Report. Therefore, the coronial investigation is not hindered by failure to call for the Child Death Inquiry Report.

Like the Child Safety Commissioner, I can rely on hearsay. In determining the outcomes of our investigations, both of us must weigh the evidence taking these factors into account. Therefore, in the context of our different roles, our comments and recommendations are complementary and not necessarily the same.

Further, unlike public hospital reviews of adverse events, the Child Death Inquiry Report is reviewed by the Victorian Child Death Review Committee which is a multidisciplinary ministerial advisory committee that reviews the deaths of children who are current or recent clients of the Child Protection service in Victoria. The Recommendations from the Victorian Child Death Review Committee are published in the "Annual Report of inquiries into the deaths of children

[5] *The C/th v Northern Land Council* (1992-1993) 176 CLR 604 at 617, adopting Gibbs ACJ in *Sankey v Whitlam* (1978) 142 CLR 1 at p 43.
[6] Ss. 1, 4 & 5 *Coroners Act* 2008.

known to Child Protection" which is tabled in Parliament. The parties have also been told that Recommendations 20 to 23 of the "Annual Report of inquiries into the deaths of children known to Child Protection 2010" relate to the Child Safety Commissioner's investigation of Shyra's death so the outcomes of the Child Safety Commissioner's review are publicly available.

Therefore, in the context of this coronial inquiry[7], public interest in encouraging open and co-operative internal investigation of client deaths within the Department of Human Services by refusing to order production of the Child Death Inquiry Report displaces the public interest in administration of justice which is otherwise met by the Department's cooperation with the coronial investigation.[8]

Ruling

Accordingly, I make no order to compel the Department of Human Services or the Child Safety Commissioner to produce the Child Death Inquiry Report relating to Shyra Lee Bloomfield.

Dr Jane Hendtlass
Coroner

20 April 2011

[7] *Sankey v Whitlam* 1978) 142 CLR 1 at p 60.
[8] *State of Victoria v Brazel* (2008) 19 VR 533 at 560.