IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2015 0868

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 63(1)

Section 67 of the Coroners Act 2008

Amended pursuant to section 76 of the Coroners Act 2008 on 4 January 2022[1]

Findings of:	Caitlin English, Deputy State Coroner
Deceased:	Baby A
Delivered on:	13 December 2021
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Hearing dates:	6,7 & 8 April 2021
Assistant the Coroner:	Sergeant T Weir Instructed by N Ngai, Coroners Court In-House Legal Services
Counsel for the Royal Children's Hospital	M Fitzgerald of Counsel Instructed by S Pennington, HWL Ebsworth
Counsel for the Department of Families, Fairness and Housing	M Wilson of Counsel Instructed by B de Brouwer, Minter Ellison

[1] This document is an amended version of the Inquest Finding into Baby A's death dated 13 December 2021. Corrections to recommendations 1 and 3 and the distribution list have been made pursuant to section 76 of the *Coroners Act 2008* (Vic).

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INTRODUCTION

1. Baby A was 22 months old and lived in Pascoe Vale with his mother, JK and brother, three-year-old Child B, at the time of his death on 21 February 2015.

2. Baby A's parents, JK and KI, had separated in August 2014. Following separation, they shared custody of the two boys.[2] In September 2014, JK commenced a relationship with James Christoforou. About the time of Baby A's death, Mr Christoforou was staying nights at JK's house and he would supervise Baby A and Child B on his own.

3. On the evening of 19 February 2015, Mr Christoforou put Baby A and Child B to bed as JK was ill. When he returned 10 to 15 minutes later, Baby A was not breathing, blue in colour, and there was vomit on the pillow. He commenced cardiopulmonary resuscitation (**CPR**) and called 000. He woke JK and continued CPR.

4. An ambulance arrived, continued CPR, and later transported Baby A to hospital where he was admitted to Intensive Care Unit in a critically ill condition. He was found to have an unrecoverable hypoxic brain injury.

5. Two days after admission, in consultation with the family, treatment was withdrawn, and Baby A died at the Royal Children's Hospital (**RCH**).

THE PURPOSE OF A CORONIAL INVESTIGATION

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

7. The jurisdiction of the Coroners Court of Victoria is inquisitorial.[3] The Act provides for a system whereby reportable deaths are independently investigated to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[4]

[2] This was originally by mutual agreement and then as a result of a mediation.
[3] Section 89(4) *Coroners Act 2008* (Vic) (**the Act**).
[4] Preamble and section 67 of the Act.

8. It is not the role of the coroner to lay or apportion blame, but to establish the facts.[5] It is not the coroner's role to determine criminal or civil liability arising from the death under investigation,[6] or to determine disciplinary matters.

9. The expression '*cause of death*' refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

10. For coronial purposes, the phrase '*circumstances in which death occurred*',[7] refers to the context or background and surrounding circumstances of the death. Rather than being a consideration of all circumstances which might form part of a narrative culminating in the death, it is confined to those circumstances which are sufficiently proximate and causally relevant to the death.

11. The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through the observations made in the investigation findings and by the making of recommendations by coroners.

12. The investigation in this case was undertaken on my behalf by a member of Victoria Police who was appointed as the coroner's investigator, Detective Senior Constable Kim Cuccia. A coronial brief was prepared with witness statements taken from Baby A's family, persons who witnessed the circumstances leading to Baby A's death, and the forensic pathologist's medical examiners report. Other expert material was obtained from the RCH and other medical experts at the Victorian Institute of Forensic Medicine.

13. All coronial findings must be made based on proof of relevant facts on the balance of probabilities.[8] In determining these matters, I am guided by the principles enunciated in *Briginshaw* v *Briginshaw*.[9] The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about individuals, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

Victoria Police investigations

14. Detective Senior Constable (**DSC**) Kim Cuccia was the coroner's investigator, and she gave evidence at the Inquest.

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[5] *Keown v Khan* (1999) 1 VR 69.
[6] Section 69(1) of the Act.
[7] Section 67(1)(c) of the Act.
[8] *Re State Coroner; ex parte Minister for Health* (2009) 261 ALR 152.
[9] (1938) 60 CLR 336.

15. With respect to Baby A's death, a brief of evidence was submitted to the Homicide Squad and the Office of Public Prosecutions however charges were not authorised against Mr Christoforou on the basis there was insufficient evidence for a reasonable prospect of conviction.

16. DSC Cuccia was also the police informant for charges laid against Mr Christoforou with respect to a young child, BW. These charges concerned intentionally causing serious injury to BW in April 2016 by exposing him to methylamphetamine. The serious injury charges were ultimately withdrawn against Mr Christoforou and on 30 October 2020 in the County Court he was convicted and fined for two charges of possessing a drug of dependence.

17. DSC Cuccia did not believe that either BW or Baby A's mothers were aware that Mr Christoforou was using drugs during the period of his respective relationships with them.[10]

18. Prior to commencing his relationship with JK, on 30 April 2014, Mr Christoforou was sentenced to a community corrections order.

REQUEST FOR INQUEST

19. On 14 February 2020, Baby A's father, KI, filed a *Form 26 Request for Inquest into Death* requesting an inquest be held into the death of his son, Baby A. [11] His reasons included:

> *My child's death remains unexplained. My child, Baby A had numerous injuries including broken bones and bruising discovered at autopsy due to unknown reasons.*
>
> *My child was subject to several VFPMS attendances whilst in the care of his mother and her boyfriend. As joint custodial parent, I was not contacted by any authority regarding this life-threatening injury.*
>
> *My child Baby A presented 4 months before his death to the Royal Children's Hospital with a life threatening injury not dissimilar to the subsequent injuries resulting in death. He was once again in the care of the same boyfriend. This was not reported to me or the police.*

20. KI raised concerns regarding whether the steps taken by the RCH and the Department of Health and Human Services (**DHHS**)[12] were adequate, given Baby A's numerous presentations to the hospital in four months.

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[10] T 90.
[11] Coronial Brief (**CB**) 884.

21. KI also proposed coronial recommendations regarding notification to non-custodial parents by authorities when considering safety concerns about children.

22. On the basis of KI's request for inquest and the unexplained questions surrounding the cause and circumstances of Baby A's death, I determined to hold an inquest into his death.

23. A mention hearing was held on 15 October 2019. The inquest was delayed owing to legal proceedings against Mr Christoforou that the interests of justice required be concluded prior to commencement of the inquest. Those proceedings concluded on 30 October 2020.

24. A directions hearing was held on 20 March 2021 and the inquest was heard for three days commencing 6 April 2021.

25. The scope of the Inquest was as follows:

    (a) What is the medical cause of Baby A's death?

    (b) What were the circumstances leading to Baby A's death?

    (c) Was there a connection between the recent hospital attendances in the lead up to Baby A's death?

    (d) Was Child Protection engagement with Baby A and his family in the lead up to Baby A's death reasonable?

IDENTITY OF THE DECEASED PURSUANT TO SECTION 67(1)(a) OF THE ACT

26. On 20 February 2015, Baby A, born 12 April 2013, was visually identified by his mother, JK.

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

BACKGROUND

28. Over the four months prior to Baby A's death, there were a number of unusual events regarding his health and wellbeing, summarised as follows:

23 November 2014

29. On 23 November 2014, Mr Christoforou was with Baby A and Child B at breakfast time whilst JK slept. Mr Christoforou gave Baby A, a wet wipe to wipe his face with whilst he

[12] The Department of Health and Human Services is now the Department of Families, Fairness and Housing (**DFFH**).

went inside to dispose of a nappy. When Mr Christoforou returned, he noticed that Baby A had started choking on the wet wipe. Mr Christoforou flicked it out of his mouth. JK awoke and noted Baby A was in distress and called an ambulance. By the time the ambulance arrived, Baby A was behaving normally, however as a precaution he was taken to the RCH.

12 December 2014

30. On 12 December 2014 JK decided to end her relationship with Mr Christoforou. JK arrived at her home to find Mr Christoforou lying on her bed. She called police asking that Mr Christoforou be removed as he had broken in. Mr Christoforou left the house prior to the police arrival. He subsequently sent threatening text messages to JK and also returned to her house that night. Police applied for an intervention order against Mr Christoforou, however on 18 December 2014 JK no longer supported the application. A limited intervention order was made prohibiting Mr Christoforou from committing family violence however he was not excluded from attending JK's premises. On 22 December 2014 the intervention order was served on Mr Christoforou.

16 January 2015

31. On 16 January 2015, JK noticed Baby A's testicles were bruised and swollen. As he was due to spend the weekend with KI, she asked him to keep an eye on him.

32. On 18 January 2015, KI took Baby A to Melton Health Urgent Care after noticing bruising on Baby A's right testicle. Following doctors' advice, he took Baby A to RCH for review, meeting JK there.

33. At the RCH, Baby A was diagnosed with idiopathic scrotal oedema which was treated with anti-inflammatory and antihistamine medications for one week. The scrotal swelling subsided over the week and there was no follow up appointment.

12 February 2015

34. On 12 February 2015, JK noticed bruising on Baby A's testicles. He was due to spend the weekend with KI. On 15 February 2015, when KI returned Baby A to JK, he noted the bruising appeared to be worse.

16 February 2015

35. On 16 February 2016, JK took Baby A to Moonee Ponds Medical Centre and he was referred to the RCH. Baby A also had a swollen left thumb.

36. On 17 February 2015, at the RCH, the Victorian Forensic Paediatric Medical Service assessed Baby A and he underwent some tests. The exact cause of the scrotal bruising was not determined. An x-ray of Baby A's left thumb was taken. On 19 February 2015 radiology reported there was a possible abnormality, and a repeat x-ray was ordered.

17 and 18 February 2015

37. Baby A was with JK and became ill with vomiting and diarrhoea several times during the night.

19 February 2015

38. On 19 February 2016, JK became ill and went to bed. That evening, Mr Christoforou cared for Baby A and Child B. He gave them dinner however Baby A thereafter vomited again, and Mr Christoforou cleaned him up. He put the boys to bed with a DVD and stated Baby A fell straight to sleep. He returned 10 to 15 minutes later and could smell vomit. He noticed Baby A was lying in a different position, was not breathing and had turned blue. He commenced CPR and called 000.

39. An ambulance attended and continued CPR and then took Baby A to the RCH where he was admitted to the Intensive Care Unit.

MEDICAL CAUSE OF DEATH PURSUANT TO SECTION 67(1)(b) OF THE ACT

40. Three experts were called at Inquest to give evidence regarding Baby A's cause of death. They were Dr Yeliena Baber, a forensic pathologist at the Victorian Institute of Forensic Medicine, Dr Timothy Cain, specialist paediatric radiologist at the RCH, and Dr Dimitri Gerostamoulos, forensic toxicologist at the Victorian Institute of Forensic Medicine.

Autopsy findings

41. On 23 February 2015, Dr Baber conducted a post-mortem examination and provided a written report, dated 5 November 2015. In that report, Dr Baber concluded that a reasonable cause of death was '*1(a) Global cerebral ischaemic injury following cardiorespiratory arrest of unknown cause*'.

42. The precise cause of Baby A's cardiac arrest is unknown.

43. In her examination, Dr Baber found evidence of injuries, and in her report stated, '*Of concern, is the finding of mesentery haemorrhage and fibrosis*.' The mesentery is the membrane that attaches the intestine to the abdominal wall and holds it in place. The finding of fibrosis was evidence of a healing injury and the haemorrhage was evidence of acute recent injury, possibly the result of CPR. Dr Baber stated:

> *With the exclusion of possible natural disease, the main differential to be considered would be previous trauma to the abdomen to the extent that the bowel mesentery has been damaged. Similarly, as it has not been possible to pinpoint a natural disease process causing bruising to the scrotum, trauma is the other possibility that should be considered. Neither of these, however, have contributed to death*.[13]

Radiology findings

44. On 23 February 2015, Dr Cain performed a post-mortem skeletal radiograph, and he identified a partially healed fracture of the right radius (one of the bones in the forearm), and healing fractures on the right sixth rib, left seventh rib and the left eighth rib.

45. Dr Cain concluded:

> *The cause of the patient's death has not been demonstrated. However, there is evidence of bilateral 6-8th rib fractures and a fracture of the distal right radius. Suspicion of epigastric soft tissue trauma noted*.[14]

46. Dr Cain identified the following injuries:

> *Right forearm: healing distal diaphyseal fracture with periosteal new bone formation and transverse sclerosis in the distal ulna at the same level. Appearance of advanced healing and suggesting an age of at least many weeks.*
>
> *Right sixth rib: irregularity of the costo-chondral junction consistent with a healing fracture*
>
> *Right eighth rib: only subtle contour irregularity noted.*

[13] CB 17.
[14] CB 58.

Left seventh rib: irregularity of the costochondral junction consistent with a healing fracture.

Left eighth rib: subtle contour irregularity of the costochondral junction demonstrated consistent with a healing fracture.[15]

47. In a second statement Dr Cain opined the following about these injuries:

> *Whilst I am unable to reliably state the age of the fractures, it is my opinion, based on experience, that the stage of healing of the fractures seen indicates an age of between three weeks and three months, but most probably between three and five weeks.*[16]

48. In his evidence at Inquest Dr Cain confirmed:

> *… there was evidence of a previous radial fracture ... there's been some injury to the arm, ..., at some stage the bone integrity has been disrupted and there's now evidence of healing*.[17]

49. Dr Cain also noted at Inquest that the rib injuries were not caused by recent CPR as they were healing fractures. In his opinion:

> *... the explanation is that there's been report trauma to the epigastrium involved in damage to the soft tissues and probably fracture to the ribs at the same time*.[18]

50. Dr Baber in her evidence agreed, stating it was quite possible the age of the mesenteric injuries '*fits with the timing of the rib fractures*.'[19]

51. Dr Cain was of the opinion the multiplicity of injuries was very concerning and the words *'inflicted injury'* in his report meant it was not an accident: '*somehow a force was applied to the child intentionally by someone else*.'[20]

Discrepancy between autopsy and radiology reports

52. On 21 September 2017 Dr Baber prepared a supplementary report.[21] This report was prepared at the request of the coroner as there appeared to be discrepancies between the original

[15] CB 53.
[16] CB 1014; Statement Dr Timothy Cain dated 31 March 2021.
[17] Transcript (**T**) 11.
[18] T 20.
[19] T 33.
[20] T 23.
[21] CB 74.

autopsy findings and Dr Cain's radiology report. Although Dr Cain identified fractures to Baby A's right wrist and ribs, the histopathology performed on those bone samples did not disclose evidence of the fractures.

53. In her second report Dr Baber stated:

> *It would not be prudent to disregard the radiology opinion of Dr Cain, the possibility remains that despite meticulous dissection of the apparent fracture site, the portion of bone interpreted as a healing fracture on the x-ray may not have been sampled as there is no irregularity of the bones identified at autopsy. It should be noted that the distal right radius was not sampled at autopsy, therefore the radiology report should be regarded as diagnostic*.[22]

54. In evidence at the Inquest Dr Baber explained the challenges of the sampling process at autopsy without the benefit of the live imaging it is easy to miss, *'... in effect I'm sampling slightly blindly*.'[23]

55. The effect of the combined medical evidence of Dr Baber and Dr Cain is that although there were discrepancies in the findings at autopsy as compared to the post-mortem radiography, Dr Baber was of the view that Dr Cain's findings should not be discounted, that the fractures may have been missed during sampling at autopsy, and that the injury to Baby A's wrist identified by Dr Cain should be accepted as diagnostic. At inquest they both gave concurrent evidence on this point and Dr Cain stated: '*the findings of what isn't corroborated is trivial by comparison to what is corroborated*.'[24]

Neuropathology findings

56. On 27 February 2015 Dr Linda Iles, forensic pathologist at the Victorian Institute of Forensic Medicine, conducted an examination of Baby A's brain. She found no evidence of traumatic brain injury or subdural haemorrhage.

[22] CB 75.
[23] T 29.
[24] T 34.

Toxicology findings

57. The toxicology report by scientist Maria Pricone from the Victorian Institute of Forensic Medicine dated 13 May 2015 identified the presence of methylamphetamine (~3 ng/mg)[25] and amphetamine[26] (.4 ng/mg) in Baby A's hair and morphine (.5 mg/L) in his urine.[27]

58. Dr Dimitri Gerostamoulos, Head of Toxicology at the Victorian Institute of Forensic Medicine, prepared a report dated 6 January 2021[28] for the inquest.

59. He was asked to consider:

    (a) The physiological effects methylamphetamine/amphetamine could potentially have on an otherwise healthy 22 month old infant; and

    (b) Whether the levels of methylamphetamine/amphetamine are significant and what were the means of introduction into the body.

60. He reported:

> *Children may be harmed directly or indirectly from exposure to methylamphetamine.*
>
> *Depending on the amount of methylamphetamine ingested, adverse effects range from agitation, crying, vomiting, tachycardia, hyperthermia and rhabdomyolysis*.
>
> *The agitation from methylamphetamine results from an increase in circulating catecholamines within the CNS.*
>
> *Due to the lack of relevant pharmacological information, it is not possible to predict the toxic effects from a blood concentration for methylamphetamine in infants.*
>
> *The concentration of ~3ng /mg of methylamphetamine and ~0.4 ng/mg of amphetamine detected in Baby A could be due to environmental contamination where methylamphetamine is being used by adults in the vicinity of the child, exposure in-utero or as a result of previous ingestion of methylamphetamine.*

[25] Note - ng mg is nanogram per millilitre compared with mg/L which is milligrams per litre.
[26] Amphetamines is a collective word to describe central nervous system stimulants structurally related to dexamphetamine. One of these, methamphetamine, is often known as 'speed' or 'ice', which is a strong stimulant. Amphetamine is also a metabolite of methamphetamine, benzfetamine, and selegiline. Amphetamines stimulate the central nervous system, causing persons to become hyperactive and more aroused. Blood pressure and heart rate are also increased.
[27] The presence of morphine was explained as a result of the emergency administration of that drug.
[28] CB 80-6.

Blood and urine samples revealed the presence of a trace amount of methylamphetamines at concentrations below the limit of reporting. This is consistent with consumption of methyl amphetamine.

In general, infants and young children cannot metabolise drugs as efficiently as adults and as a result drugs have a greater potency. Methylamphetamine is predominantly metabolised by cytochrome p450 (CYP) enzymes mainly CYP 2D and CYP3A isoforms. These enzymes are not fully formed in children until 1-2 years of age. Hence the administration or consumption of a drug can have significant effects on an infant or child that cannot metabolise or clear a drug normally.

In summary there are significant risks for infants or children ingesting drugs such as methylamphetamine or amphetamine. These can result in adverse or toxic effects and death.[29]

61. Dr Gerostamoulos gave evidence at the inquest about the amount of methylamphetamine detected in Baby A's toxicology results. He stated: '*I can't quantitate whether its small … it's a significant drug that's found in a child that shouldn't be in a child*.'[30] He noted in general terms, it takes about seven to ten days for the drug to appear in the hair and for it to be able to be measured.

62. Dr Gerostamoulos explained that whilst laboratories set limits regarding the lowest level of drug concentrations they report, there were small amounts of methylamphetamine, less than these limits, detected in Baby A's urine and blood:

> *There are small amounts of methylamphetamine detected in the urine but less that the limit of reporting. And also a very, very small amount of methylamphetamine detected in one of the blood samples. So while the report indicates not detected, there are small amounts of methylamphetamine in urine and blood of Baby A*.[31]

63. Passive exposure to methylamphetamine such as by inhaling smoke or touching surfaces or accidental ingestion could explain the low concentration of drugs detected in Baby A's blood and urine. Ingestion could also occur through a mother's breast milk. Dr Gerostamoulos clarified that the drug does not have to have been metabolised through blood to be present in a hair sample.

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[29] CB 82, 84.
[30] T 71.
[31] T 72.

64. Dr Gerostamoulos was of the opinion that the level of methylamphetamine concentration in the urine at .16 which is less that the limit of reporting being .2, could have been transferred through oral fluids by an adult performing CPR on a child within 24 to 48 hours. He noted the levels may persist in a child longer than for an adult as the child is not able to metabolise the drugs as an adult can.[32] In his experience at the Victorian Institute of Forensic Medicine, Dr Gerostamoulos stated typically its drugs in the hair that is detected, and that rarely are drugs found in the blood or urine of a child.

65. With respect to whether these drug levels could have contributed to death, Dr Gerostamoulos stated:

> *They may have. They're an adverse finding. They shouldn't be in the child and we know that these drugs can cause toxic effects and that's irrespective of really the concentration that has been measured here. The fact is you have … quite a strong stimulant that is associated with changes to the cardiac function that can lead to death and it's difficult [for] determine what that dose or how much of that drug has been consumed, but they're clearly a risk factor in the well being of the child.*[33]

66. Dr Gerostamoulos agreed that methylamphetamine produces an adrenaline like effect and the risk from ingestion can include cardiac arrhythmias and sudden death from excessive stimulation of the heart.

67. Some of the symptoms of methylamphetamine ingestion, such as vomiting and a fever were symptoms Baby A exhibited in the 24 hours prior to his final presentation to hospital. Dr Gerostamoulos described other symptoms could be crying, vomiting, diarrhoea, a high temperature, and a high heart rate.

68. Dr Gerostamoulos was asked whether the cause of death be amended to include '*In the setting of detected methylamphetamine*.' He stated he could not comment directly on the cause of death, but noted that the presence of methylamphetamine is a risk – a significant risk factor to be considered in the death of this child and that methylamphetamine is a really strong stimulant that triggers all sorts of adverse responses, particularly around the heart and the function of the heart:

> *… we've had a number of instances here we've found it as an adverse finding in a number of deaths that are otherwise determined unascertained, and it's often difficult*

[32] T 74.
[33] T 77.

to pinpoint exactly what the contribution of these stimulants are to the deaths, but that's certainly … there's no doubt that these drugs are a risk factor and can produce toxic effects and adverse effects in children leading to death.[34]

Consideration of findings identified post death

Mesentery injury

69. With respect to the mesenteric injuries, in evidence Dr Baber stated:

> *But essentially the fibrosis of the mesentery, so all the scarring, it's at least weeks old, but it is still healing, in fact I can see fat necrosis which is dying fat cells and those haven't been tidied up by the body's healing processes, means that its months old.*[35]

70. She estimated as to when the injury occurred to be in the ballpark of three weeks to three months.[36]

71. Dr Baber described the mesenteric injuries as caused by *'significant trauma'.* She likened the injury to being caused by a high-speed traffic collision with seat belt restraint as:

> … a *common cause of this type of injury ... not something that a three year old would've inflicted in the normal sort of rough and tumble of siblings, no*.[37]

Rib fractures and wrist fracture

72. Dr Cain concluded:

> *In my opinion, it is highly likely the injuries identified post mortem were non accidental inflicted injuries. I form this view because Baby A had fractures to his ribs which is an uncommon site of fractures in young children and which would have required significant force, fractures to his right wrist which are unlikely to have occurred in the same incident, and mesenteric fibrosis which implies direct trauma to the abdomen.*
>
> *Had the other bony injuries demonstrated in the post mortem imaging been identified ante-mortem, they would have raised a very high index of suspicion for inflicted injury.*[38]

[34] T 82.
[35] T 50.
[36] T 50.
[37] T 52.

73. With respect to Baby A's wrist fractures, Dr Lobo stated: *This could have been caused by a fall on an outstretched arm either from an accident or from being pushed.* [39]

Injury to testicles

74. With respect to Baby A's right testicle, Dr Baber described:

> *… quite a lot of dark purple haemorrhage or bruising of several points around the testicle ... and to a slightly extent in the left ... so again, probably more that one episode of trauma for there to be those specific areas*.[40]

When asked about the time frame of this injury, Dr Baber stated she did not see any yellowing or healing of the bruise:

> *It really did look quite purple, so ... more recent ... the fact that there's red blood cells and some chronic inflammatory cells means that there's been some blunt force trauma to the tissue.*[41]

Dr Baber was not of the opinion this was caused by the normal rough and tumble of daily activity.[42]

75. Dr Baber noted that when Baby A presented to the RCH on 18 January 2015 with a bruised scrotum and this was diagnosed as *'idiopathic scrotal oedema'.* An ultrasound scan was not conducted, meaning the diagnosis was made by clinical observation only. Dr Baber's findings at autopsy were that the bruising to the testicles was caused by trauma.

Methylamphetamine in hair toxicology

76. I asked Dr Baber whether in light of finding of methylamphetamine in the hair toxicology results this should be referenced in the formulation of the cause of death. In her opinion it could be included as a factor, although there was no evidence of an acute contribution.

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[38] CB 1014-1015.
[39] Report by Dr Maryanne Lobo, CB pp 53-4.
[40] T 53.
[41] T 53.
[42] T 54.

Bruising to right thumb

77. In his second statement, Dr Cain also considered the x-rays taken of Baby A's left hand at the RCH on 16 February 2015 conducted by Radiology Fellow, Dr Cyril Ong, in association with Radiologist Associate Professor Lee Coleman. Dr Ong's report found:

> *The opacity projected adjacent to the base of the left thumb is of uncertain significance. If there is a clinical suspicion of fracture, a follow-up radiograph of the left thumb is warranted.*[43]

78. After reviewing the x-rays considered by Dr Ong, Dr Cain was not of the opinion there was evidence of '*any bony injury to the left thumb*.'[44]

Evidence of choking on vomit

79. In the 000 call made on 19 February 2015, Mr Christoforou described Baby A as having 'choked on vomit.'

80. Dr Baber stated in her 10 years looking at paediatric deaths '*in the context of a normal healthy child I have never seen a child die as a result of choking on his own vomit*.'[45] Choking on vomit was not corroborated in her histology findings as there *'was very, very sparse stomach contents in the lung samples*,' and she would expect there to be '*a florid amount in the airways*.'[46] Dr Baber stated:

> *If someone had choked on vomit it takes – it would take a lot and there would be, you know, a florid amount in the airways. And plus the,..., paramedics,..., commented in their report as well, in the ambulance report, that there was no evidence of choking when they arrived and they were trying to resuscitate him, ..., because often as they go through the airway, breathing, circulation commentary in their report, ..., if there's a lot of vomit in the airways and they have to suction it out, you know, they will document that. And they've specifically documented that there was none of that*.[47]

81. The fire brigade record notes the incident type as *'Medical unknown, possible choking'* and ambulance officers' statements on the coronial brief do not refer to vomit in the airways that

[43] CB 52.
[44] CB 1013.
[45] T 56.
[46] T 57; CB 167-173.
[47] T 57.

required suctioning.[48] The ambulance record refers to (page 1) '*vomiting – pts father states pt had vomited whilst in bed*' and (page 3) '*airway clearance – via yankauer, successful, triple airway manoeuvre, >> small amount of saliva/vomitus – nil evidence of choking*.[49]

82. When asked about the causes of Baby A's cardiac arrest, Dr Baber went through a number of possibilities in her report such as cardiac arrhythmia, neurological condition, congenital or metabolic conditions, but could find no evidence supporting the presence of these conditions. She did not identify evidence of active gastroenteritis, despite extensive bowel sampling, '*it was all completely normal*.'[50] She considered asphyxiation, such as choking with an airway obstruction that is subsequently removed. There was no evidence of that, or of a pulmonary embolism or HHV-6 infection.

83. Dr Maryanne Lobo, forensic paediatrician from the Victorian Forensic Paediatric Medical Service at the RCH examined Baby A whilst he was in the Intensive Care Unit on 20 February 2015. She noted the precise cause for Baby A's cardio-respiratory arrest is as yet undetermined:

> *Baby A was developing normally; hence it is most unlikely that he would choke on vomitus and suffer a cardi-respiratory arrest. He should have been able to guard his airways from vomitus. It would also be extremely rare for a normally developing child to have a generalised seizure and choke on vomitus or become hypoxic and suffer a cardiorespiratory arrest within 10 minutes of last being observed to be normal though asleep by an adult.*
>
> *Acute cardiac arrest in young children is rare and may occur for a structural and or a functional problem of the heart. Baby A's echocardiogram and subsequent cardiac monitoring was normal suggesting a cardiac cause is most unlikely*.[51]

84. In the context of the injuries identified by the radiology findings, Dr Lobo stated:

> *The presence of these multiple healing fractures raises the concern that Baby A's presentation with cardiorespiratory arrest might be from a non-accidental mechanism possibly smothering/suffocation.*[52]

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[48] T 57; CB 202.
[49] Inadvertently, the ambulance records were not included in the coronial brief. For completeness and as they were referenced by Dr Baber in her evidence, they were located and distributed to interested parties on 17 November 2021 and given an opportunity to comment.
[50] T 59.
[51] Report by Dr Maryanne Lobo, CB pp 53-4.

85. Dr Lobo went on to discount other possible causes of the cardiac arrest, such as human herpes virus 6, and excluded bacterial infection as a cause for cardiorespiratory arrest.

Conclusions regarding cause of death

86. The medical evidence supports a finding that at the time of his death Baby A had a significant injury to his right wrist which radiology revealed as a healing fracture. This injury was traumatic in origin and there was no explanation as to how this injury occurred although it could have been caused by falling onto the outstretched hand.

87. At the time of his death Baby A had healing rib fractures to his sixth, seventh, and eight ribs. I accept the evidence these injuries were likely between three and five weeks old and given the position of the injury, they are unlikely to be accidental.

88. At the time of Baby A's death there was evidence of a healing injury to his mesentery, namely the membrane that attaches the intestine to the abdominal wall and holds it in place. The evidence of fibrosis indicates this was a healing injury of an age of between three weeks and three months. I accept Dr Baber's evidence significant force, akin to the force of a car accident, would be required to cause this injury.

89. At the time of Baby A's death, he had recent bruising to his testicles, particularly his right one, I accept Dr Baber's opinion the bruising to his testicles was caused by trauma.

90. I accept the evidence of Dr Baber and Dr Cain these injuries (aside from possibly the wrist injury) were likely non accidental and of traumatic origin. Given the medical opinion regarding the time frame of the occurrence of these injuries, they are likely to have occurred during the time JK was in a relationship with Mr Christoforou. Whilst these injuries individually were not causal to Baby A's death, they are relevant to the circumstances of his death and the evidence is strongly indicative they were inflicted injuries.

91. I accept Dr Baber's opinion, and her evidence of her findings at autopsy, and the report of Dr Lobo's forensic examination on 20 February 2015, that it was highly unlikely Baby A choked on his own vomit.

92. Baby A had a reported choking incident with a wet wipe on 23 November 2014 and a reported choking on vomit incident on 15 February 2015. Both incidents have occurred whilst

[52] Report by Dr Maryanne Lobo, CB pp 54.

he was in the care of Mr Christoforou when his mother was asleep. Both were reported as choking incidents by Mr Christoforou.

93. In the absence of any medical cause for Baby A's cardiac arrest, Dr Baber raised asphyxiation as a possible cause and Dr Lobo raised the possibility of smothering or suffocation. Dr Baber referred to:

> *… putting something in the child's mouth such that they can't breathe, and then removing it afterwards. So there's no compression actually on the mouth and nose but actually … effectively gagging the child*.[53]

94. Whilst there is the coincidence of Mr Christoforou being the sole adult carer of Baby A at both the first incident of choking and the second reported incident of choking, and an absence of medical evidence in support of Baby A choking on vomit, there is no direct evidence in support of asphyxiation, smothering or suffocation by way of either forensic evidence or admission.

95. The presence of methylamphetamine and amphetamine in Baby A's hair is likely to have been in his system for at least seven to 10 days prior to his death. Although there is no direct evidence the presence of methylamphetamine in Baby A's toxicology results was causal to his death, I am satisfied from Dr Gerostamoulos' evidence its presence was adverse to his health and constituted *'a risk factor.'* It is unknown what caused Baby A's cardiac arrest, but the evidence supports methylamphetamine is a strong stimulant that triggers adverse responses, particularly around the function of the heart, and children are not able to metabolise the drug the same way as adults.

96. In Mr Christoforou's evidence he admitted smoking ice in JK's car. I am of the view Baby A has been exposed environmentally to ice when he has been in the car. Further, given his urine and blood results it is highly likely Baby A was exposed to and somehow ingested methylamphetamine through his close contact with Mr Christoforou.

97. I intend to amend the cause of death as follows: '*1(a) Global cerebral ischaemic injury following cardiorespiratory arrest of unknown cause in the setting of detected methylamphetamine.'*

98. Unfortunately, the coronial investigation has not been able to identify to the requisite standard of proof the cause of Baby A's cardiac arrest.

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[53] T 61.

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED PURSUANT TO SECTION 67(1)(c) OF THE ACT

JK and Mr Christoforou's relationship

99. Mr Christoforou stated he met JK on an internet dating site in August 2014 when she had just returned from England, and they started seeing each other a month later. He helped her move into her unit in Pascoe Vale and by February 2015 he was staying overnight two to five nights a week. [54]

100. He stated:

> *Jen has two little kids Baby A & Child B. I treat them as if they're my own. Baby A is 22 months old and Child B is 3. Child B and I get on like a house on fire. I look after the boys on my own occasionally*.[55]

101. During their relationship with JK, JK started weaning Baby A from breast feeding to a bottle, she ceased co-sleeping with him by putting him in a cot next to her bed, and then later moved the cot into a room with his brother, Child B. Mr Christoforou described Baby A as quite *'clingy'* with JK. He gave an example of her having to comfort him from crying by stroking his leg whilst he was in the backseat of the car whilst she was driving.

102. Of her relationship with Mr Christoforou, JK stated she had *'positive memories of that time.'*[56] She described Child B as following James around quite a bit and '*Baby A still preferred to be with me which was nothing unusual*.'[57] In describing the dynamics between herself and the boys and Mr Christoforou she stated, '*I didn't see any red flags in regards to jealousy or where my attention was given at any point.*'[58] Looking back, she noted Mr Christoforou '*tried to make me not mother him [Baby A] too much ... get him not to be so clingy to me ... in my mind it was to help me so I could do things without having a baby attached to me*.'[59] She agreed Mr Christoforou was helpful in the family role of the house and that he would *occasionally* supervise the boys on his own, '*it wouldn't have been more than*

[54] CB 123.
[55] CB 124.
[56] T 145.
[57] T 145.
[58] T 145.
[59] T 146.

maybe once or twice a month.'[60] She never saw him discipline or be even a little bit rough with the children.

103. In September 2014 KI became aware JK was in a relationship with Mr Christoforou. He stated:

> *… she would come to me if things went bad, if they'd had a fight. At one stage she told me he was on her roof and had stolen money off her and it was all really weird. Another time she came over and said they'd broken up*.[61]

104. KI described one day she turned up *'covered in bruises on her wrist and leg because he'd gone through her phone and seen that she'd been messaging me.*'[62] In her evidence JK described this as an '*over exaggeration'* and that Mr Christoforou had refused to return her mobile phone and the bruise probably occurred when she '*tripped and fell on a pedestal fan that was at the bottom of my bed*.'[63]

105. JK did not recall the contents of her brother Graeme Kington's statement which referred to Mr Christoforou shoving her to the ground. [64] She could not recall whether it was her tripping, or *'him pushing and then me tripping.'*[65]

106. KI described blocking Mr Christoforou's number because he was receiving threats, harassment and *'lots of psycho stuff.'* Police suggested he obtain an intervention order, but he did not feel the need after blocking his number.

107. JK stated in evidence she had been working hard to suppress a lot of what happened in that period and six years on she was extremely traumatised but trying to be as honest as she could from what she could recall.[66]

108. JK made two statements to the coronial investigation in which she provided some details about her relationship with Mr Christoforou. She described the relationship '*started deteriorating in December 2014*,'[67] referencing a day in December 2014 (which presumably was 12 December 2014) when Mr Christoforou broke into her house and stole $200 cash. She reported this to Fawkner Police and when he returned later that night, she called police again.

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[60] T 147.
[61] CB 117.
[62] CB 117.
[63] CB 182-3.
[64] T 183 & 184, CB 153.
[65] T 184.
[66] T 184.
[67] CB 110.

An intervention was applied for and granted following this incident that still allowed for contact, and the relationship continued. In evidence JK stated the 12 December 2014 incident was the only occasion during her relationship with Mr Christoforou when he was threatening to her.[68] Other occasions occurred after Baby A's death.[69]

109. On 24 March 2015 JK went to Mr Christoforou's mother's house in Tullamarine to get her (bank) card back from him. He was upset and did not want her to leave. She described him going into the garden and pouring petrol over his head and threatening to set himself alight.[70]

110. Further, on 27 March 2015 she arranged to meet him, and ended up telling him the relationship was over as Child Protection had applied for a court order preventing him from seeing Child B. She stated:

> *I also told him there was no point in continuing the relationship if the court order was put into place. He was begging me to stay with him and not leave him alone.*[71]

JK returned his ATM card and was in her car with the doors locked. She described him throwing himself on the bonnet of her car and hanging onto the bonnet. He then lay on the middle of the road, causing three cars to brake hard. He then pursued her in his car and cut her car off in the middle of an intersection. When she evaded him, he again cut her off at a Caltex petrol station, begging her to get out of her car. When she pressed her horn to attract attention, he reversed his car into her car, and drove off. JK called 000, '*I was too scared to drive home because I kept thinking that he could have been around the corner*.'[72]

Health issues and Baby A

23 November 2014 – Choking on wet wipe

111. JK described that she and Mr Christoforou would take it in turns to get up with the boys, and on this particular Sunday morning, '*I was sleeping and he got up with them*.'[73]

112. On 23 November 2014, JK was asleep when Baby A choked on a wet wipe. In his statement, made on 20 February 2015, Mr Christoforou described he was giving the boys breakfast. Child B was in the kitchen eating toast and Mr Christoforou took Baby A outside to change

[68] T 186.
[69] T 185.
[70] CB 110.
[71] CB 111.
[72] CB 111-113.
[73] CB 88.

his nappy. He gave him a wet wipe after he changed him and went back inside to check on Child B:

> *Wouldn't have been five minutes … I walked outside with Child B and Baby A was by this stage, had this wipe in his mouth, he puts a lot of things in his mouth. He was lying on the ground and leaning back trying to support himself with his arm and was gasping for air.*[74]

113. Mr Christoforou described what happened:

> *I saw something in his mouth and straight away rested his head on the ground and put my finger in his mouth … I had a feel of what it was and thought it was a baby wipe and it looked like a white ball and had been sitting at the back of his throat … I put his head back and levered open his mouth and it was slippery to grab. I put my finger behind it and flicked it out. He let out a gasp of air. I picked him up and Jen was getting out of bed, he was between gasps. He'd lost a bit of colour.*[75]

114. When JK woke and walked into the kitchen, she saw Baby A over Mr Christoforou's shoulder, that Baby A's face was grey, and '*I thought he was dead*.' She described in her statement calling 000 and being told to put Baby A on the kitchen table on his back:

> *He wasn't responding to begin with and his eyes were a little rolled back into his head. I was relaying messages from the operator to James. It was such a blur. They were obviously giving us instructions on how to treat him I suppose. Cause he was breathing and slowly coming around.*[76]

115. Mr Christoforou stated, '*When Jen called the ambulance, I sat him on the table. Within minutes he was sitting again. No CPR or nothing*.'[77]

116. KI stated he was not informed about Baby A's choking incident with the wet wipe on 23 November 2014 until after he was discharged from hospital.

117. Both JK and her brother, Graeme Kington, stated that Baby A was '*always putting things in his mouth*.' JK said he tried to put a tissue in his mouth at the hospital after the wet wipe

[74] CB 125.
[75] CB 125.
[76] CB 89.
[77] CB 126.

incident, and Mr Kington detailed another occasion at his place when '*Baby A got a wet wipe and tried to put it in his mouth …*'.[78]

118. At the RCH Baby A was assessed by emergency department (**ED**) consultant Dr Joanna Grindlay. Although it was regarded as an 'odd' incident, Baby A was seen to be placing similar items, such as tissues and gloves in his mouth in ED. The ED social worker and Dr Grindlay concluded this was a 'plausible' accident. Baby A's mother and boyfriend responded appropriately in promptly seeking medical attention, were concerned and responded well to a discussion about age appropriate supervision of Baby A. [79]

18 January 2015 – Bruised scrotum

119. KI detailed '*reoccurring bruising on Baby A's scrotum*' and attendances at the Unit Street Medical Clinic. On 18 January 2015 KI took Baby A to Melton Health where he was referred to the RCH. He met JK there and was told they thought the bruising to Baby A's scrotum was '*an allergic reaction or infection down there*.'[80] JK stated, '*It was like an unexplained thing like an odema. I thought they said it was a bacterial infection and to get some antihistamine*.'[81]

120. JK stated around the same time Baby A had a case of hand, foot, and mouth, and she thought he may have infected the area. She stated:

> *My boys are rough and tumble boys, they don't sit still for 5 minutes. They are always play fighting and having fun. I always take them around the block on their bikes. They got bikes for Christmas. I push Baby A on his little trike*.[82]

121. KI made a second statement to the coronial investigation and included some photos taken of bruising to Baby A's face,[83] (left) hand,[84] and scrotum.[85] He stated:

> *Each time I saw bruising on Baby A, I asked my ex-wife about it but did not receive a satisfactory explanation; I was told that Child B must have caused the bruising to*

[78] CB 153.
[79] Confidential Medical Report by Dr Nirishini Kennedy dated 18 February 2015, CB 40.
[80] CB 119.
[81] CB 90.
[82] CB 90.
[83] Photo taken 4 November 2014 (T 101).
[84] Photo taken 2 February 2015 (T 101) In evidence JK stated she took this photo on Monday 2 February 2015 and sent it to KI to see if he had noted the injury to Baby A's hand as he had him for contact over the weekend (T 155-6).
[85] Photo taken 17 January 2015 (T 102).

Baby A's face, and that he must have sat on something that caused the bruising to his scrotum. I took Baby A to the doctor and hospital to have him checked.[86]

122. At RCH on 18 January 2015, Baby A presented with scrotal swelling and was diagnosed with idiopathic scrotal oedema. Whilst an ultrasound was not performed, the description of both doctors who assessed him appears consistent with this clinical diagnosis.[87]

17 February 2015 – Bruised scrotum

123. After the boys had spent the weekend with KI, JK described finding a small bruise of Baby A's right testicle. KI had also mentioned it, and she noticed the bruising had got worse. On Monday 17 February 2105 she took Baby A to the Moonee Ponds Medical Centre and Dr Wong referred Baby A to the RCH. Mr Christoforou stated he drove JK and Baby A to RCH that evening at 6.00 to 7.00pm and she arrived home at midnight and had to go back the next day. On 18 February 2015 they returned to the RCH together for an 11.30am appointment.

124. On 17 February 2015, Baby A was assessed by Dr Nirishini Kennedy at RCH. She stated:

During his assessment with me on 17 February 2015, the definitive cause of Baby A's symptoms was not clear. One of the differential diagnoses that was considered was idiopathic scrotal oedema.

She further stated:

While Baby A's mother told me there was a possibility of an accidental injury, I considered the possibility of an inflicted injury, and discussed this directly with his mother, including the possibility of involving Child Protection. However, in the setting of this single possible injury, for which medical causes had not been excluded, given he had no other external injuries, he presented as a happy and well-cared for child, and his mother seemed to be appropriately seeking and responding to medical advice for him, I did not form the view that he was a child in need of immediate protection. I planned to review his investigation results prior to any further action.[88]

[86] CB 121 The three photos are at pp 1008-110.
[87] Confidential Medical Report by Dr Nirishini Kennedy dated 18 February 2015, CB 40.
[88] Supplementary report by Dr Nirishini Kennedy dated 11 July 2016 CB 67.

18 and 19 February 2015

125. That night both boys vomited. Mr Christoforou described JK picking up Baby A in the early hours of the next morning: '… *he was in agony, He was crying his tummy was in pain, he had the runs. I gave him Panadol. Jen changed his nappy*.'[89]

126. The next morning, 19 February 2015, Baby A vomited again. By lunchtime JK was becoming ill as well. She went to bed at approximately 6.00 to 6.30pm leaving the boys in Mr Christoforou's care. Baby A vomited his dinner. Mr Christoforou put the boys to bed at about 7.30pm. He describes Baby A nodding off sleeping on his stomach and Child B was still awake. He returned to the room 10 to 15 minutes later and could smell vomit. Baby A was on his back, Mr Christoforou put the blinds up. He described what happened:

> *He was blue, he wasn't breathing. He had vomit around him on the pillow. I could tell he wasn't breathing because of the colour of his face. I put my ear near his mouth and I couldn't hear anything. I had my phone in my hand, I started CPR with the phone up to my ear holding it with my shoulder, I held his nose and started compressions. Vomit came up after the first few compressions. I had his head to the side. I put my phone on loud speaker, I got him down off the bed onto the floor.*[90]

Mr Christoforou followed the operator's instructions and started CPR and ran to the kitchen and then the bedroom to tell JK. Ambulance officers arrived and Baby A was moved into the lounge room where they took over CPR. Baby A was then transported to hospital by ambulance.

127. JK first became aware of Baby A being unresponsive when Mr Christoforou told her to get up. She described him as pretty panicked and:

> *Baby A was on the floor and James was over him doing chest compressions I believe. And he had the 000 operator on loudspeaker … I took Child B and remember racing to the front door to open it … when the ambulance did … come in.*[91]

[89] CB 128.
[90] CB 130.
[91] T 168.

Possible explanation for Baby A's injuries

128. JK was asked in evidence if she could recall an incident between three and five weeks or possibly up to three months prior to Baby A's death, when the rib fractures may have been incurred and whether she noticed him having soreness to the rib area. She stated:

> *No and that's really confusing to me … I don't recall any indication that he was in pain from me picking him up or holding him. I would just pick him up from under the arm pits and get him up on my hip … and certainly if I had any worries I would have taken him … doctor.*[92]

129. JK described Baby A was advanced physically, climbing, and then walking early, and that the boys play together would sometimes end up with one of the crying, normal sibling quarrels, '*nothing too alarming*.'[93] When asked if she saw any injuries on the boys as a result of their fighting she stated, '*they were normally on the floor playing so there was probably a little bit of kicking between the two of them. Nothing really springs to mind significantly*.'[94]

130. When asked whether she was aware of what could have caused the healing injury to Baby A's mesentery, and that the evidence from Dr Baber was it could not have been caused by a kick from a sibling she stated: '*No, absolutely – none comes to mind … and there wasn't anything that would indicate any soreness in that area with him*.'[95]

131. JK was asked about the healing fracture identified to Baby A's right wrist, but she was unable to recall him hurting it.

132. Following the evidence at Inquest, JK, via an email dated 22 April 2021 from her brother Graeme Kington, sent the court five short videos depicting Baby A alone and Baby A and Child B playing, dating from October 2014 to January 2015. These have been provided to Dr Baber, and her response and the videos have been provided to the interested parties. Dr Baber stated:

'*However, in my opinion having dealt with children in the ED (although many years ago), and having watched the video dated 18th Dec 2014 which shows a few kicks to Baby A's genital area I do not think the scrotal bruising resulted from that episode.*

[92] T 171-2.
[93] T 148.
[94] T 148.
[95] T 173.

Baby A was wearing a nappy and shorts which would have protected his scrotum, and showed NO signs of distress.' [96]

133. JK gave evidence she was not a drug user and she was not aware that Mr Christoforou was using methylamphetamine or amphetamines.[97] She indicated she did become aware of this after Baby A's death.

134. Mr Christoforou [98] was asked if he had any knowledge of how Baby A may have received the injury to his mesentery, which would have required substantial force, similar to a seat belt injury or how Baby A sustained the rib injuries and right wrist fracture. Mr Christoforou detailed a particular time, he could not pinpoint the time, but estimated it to be midway through the relationship with JK that they installed a 'nanny cam' in the loungeroom.

135. He stated:

> *One day I've walked in … Baby A had a blanket on top of him, lying on his back … Child B was standing on the side on the … pretty much using the couch to keep his balance, and jumping up and down on Baby A's chest. Now, … I remember that was a particular reason why we ended up getting this nanny cam*.[99]

And:

> *It was simply because of situations like this, because I actually walked in and the way it was with Child B bouncing up and down, laughing – like, having fun … there was nothing coming out of Baby A, because he couldn't even get his breath, there was that much weight on his actual chest and on his stomach … he couldn't even cry, couldn't even, you know, scream if he wanted to*.[100]

136. Although he could not recall bringing this incident up with JK, he stated '*It probably would have been discussed*.'[101] He also stated as the incident was out of the ordinary, it did get mentioned and JK was aware of it.[102] Mr Christoforou confirmed that when they were at the RCH about Baby A's swollen scrotum, he did not mention this incident.[103] He denied

[96] Email from Dr Baber to Coroners court dated 26 November 2021
[97] T 174.
[98] Mr Christoforou was granted a certificate pursuant to section 57 of the Coroners Act 2008 with respect to his evidence at inquest.
[99] T 247.
[100] T 248.
[101] T 252-3.
[102] T 253.
[103] T 267.

inventing it.[104] I note JK made no reference to this incident in her evidence or when she was directly asked about possible causes of Baby A's injuries.

137. In his evidence at Inquest Mr Christoforou was asked about his drug use from September 2014 to February 2015 during the time of his relationship with JK. He admitted using methylamphetamine,[105] he denied he used daily, and described it as an occasional habit, once a fortnight. Although he admitted using methylamphetamines in BW's house and also his mother's house where his 14-year-old sister resided, he stated did not use drugs in JK's presence or at her house.[106] He stated JK was not aware of his drug use. He did admit to smoking ice in JK's car, and that, '… *it would've happened on a few occasions, yes*.'[107]

138. Although he admitted that the methylamphetamine in Baby A's toxicology results came from himself, being an ice user involved with Baby A's care, he denied using ice on 19 February 2015 shortly prior to performing CPR on Baby A.[108]

139. Mr Christoforou denied using any violence towards Baby A.[109]

140. Mr Christoforou also denied ever using violence against women and denied material in the coronial brief which suggested this. He denied he slapped his sister. He also denied a report on 4 April 2012 by Carla Fabris, a former partner, who alleged he flicked a cigarette into her car, threw a remote control at her, and slapped her on the face.[110] However he did agree with a report on 8 July 2011 by Rachel Dobson, a former partner, that during an attempt by her to end the relationship, he followed her in his car, pursued her, then attempted to cut her off with his car and caused a minor collision. He also agreed in the same month, he was a passenger in Ms Dodson's car and put the handbrake on whilst the car was in motion. He denied there a subsequent physical and verbal argument between the two. He reiterated his position: '*I've never hit a woman and I've never hit a child. Simple. I've never been charged with hitting a woman, and I've never been charged with hitting a child*.'[111]

[104] T 267-8.
[105] T 235.
[106] T 277-8.
[107] T 278.
[108] T 283.
[109] T 261.
[110] T286-7.
[111] T 290.

141. Mr Christoforou admitted the criminal history in the coronial brief. He also indicated whilst he had mentioned his prior drug use to JK during their relationship, he did not tell her about his criminal offending history.[112]

142. KI described a period when he had not been allowed to see the boys for a month and so he contacted Relationships Australia to mediate access. He described a four-week access cycle and as being two weeks into the first cycle when Baby A died. KI denied any illicit drug use and stated whenever he had contact with his sons, he was with them at all times.

143. KI was aware of Baby A's scrotal bruising from when he changed his nappies, and noting his discomfort, attended the doctors twice. He had no knowledge of an incident or event that may have caused the injuries to Baby A's mesentery or being aware of Baby A being in pain.[113] He was not aware of any signs to suggest Baby A had fractured ribs but did note '*he would want to be carried a lot, and follow me around quite a lot*.'[114] He did not notice Baby A as having an injury to his right wrist.

144. KI described Baby A as an otherwise healthy child.

145. KI gave evidence he was unaware of the extent of time Mr Christoforou was spending with his sons and that he was:

> *… parenting the children on his own unsupervised by JK, so I was unaware how much time James was spending with the children, but it just was not disclosed to me at all.*[115]

Was Child Protection engagement with Baby A and his family in the lead up to his death reasonable?

12 December 2104 – Response to family violence incident

146. On 12 December 2014 JK ended her relationship with Mr Christoforou. He contacted her asking for his wallet, and she was in her car and was not at home to check. When she arrived home, she found him on her bed, and he left taking $200 cash with him. She called police and advised them he had broken in. At 10.00 pm the same night, she heard someone on the garage roof and Mr Christoforou called her and she said she would call the police. She later noticed the flyscreen from the bathroom window was removed and there were fresh marks on the

[112] T 293.
[113] T 117.
[114] T 118.
[115] T 126.

wall. Police attended at 11.00 pm but he had left the premises. Police applied for an intervention order protecting JK and her children.

147. Early the next morning, Mr Christoforou again returned to JK's house and she found him asleep in the garage. She again called the police, but he left prior to police arrival, then sent JK texts to the effect that as police were now involved, things could get '*messy*' and threatening to kill himself. The information regarding Mr Christoforou's third attendance at JK's house was not provided from Victoria Police by an L 17 to Child Protection.

148. Mr Christoforou was asked about this incident and the text about things getting 'messy'. He could not recall sending the text but said it '*was something that could have got sent in the heat of the moment*.'[116] He then stated he did send it, '*it was something I couldn't keep a lid on … its the equivalent of game on …*'.[117]

149. Following the report of family violence to police, police generate a L 17[118] document to Child Protection.

150. The relevant Child Protection policies were Receiving and Processing Report – Advice 1154 (17 April 2014) [119] and High Risk Infants Practice Requirement – Advice 1012 (17 April 2014). [120] The policies indicate that additional information should be sought, for example from the reporter, and in cases where a child is under two years old.

151. The L17 case narrative included, '*The AFM and the RESP are in a de facto relationship for approximately 12 months.*' JK stated this information was incorrect, she would never have described the relationship on those terms and she and Mr Christoforou had not known each other for 12 months.[121] She was unable to recall many other details in the case narrative but denied other information in that Mr Christoforou never had a key to her house.

152. On 13 December 2014 at 12.16 pm, the L 17 was sent to Child Protection Intake by Victoria Police.

153. Tracy Beaton, Chief Practitioner Human Services, Director, Officer of Professional Practice, Community Services Operations at the DHHS,[122] indicated the first report to Child Protection

[116] T 257.
[117] T 258.
[118] CB 986.
[119] CB 304-316
[120] CB 443-450
[121] T 188.
[122] CB 289.

was made on 9 January 2015 in response to the Victoria Police L 17 in response to the family violence incident on 12 December 2014. Ms Beaton stated:

> *I am aware that Child Protection has been unable to explain the delay in the registration of the L 17 report. I have been advised that following Baby A's death Child Protection staff in the Department's North Division were reminded to record these reports on the same day they are received.*[123]

154. Ms Beaton went on to state:

> *The decision of Child Protection to close the report was based on information available to Child Protection at that point in time, including consideration that the original family violence incident had occurred approximately one month previously and there had been no further L 17 reports or other concerns for Baby A communicated to Child Protection since that incident.*[124]

155. After assessing risk and protective factors, Child Protection closed the report, without taking further action, on the following grounds: the children were not present during the incident, the relationship had ended, it was the first reported incident of family violence and appropriate action had been taken to call the police.

156. Child Protection was asked to provide further information to the coronial investigation regarding the apparent delay between receipt of the L 17 report on 13 December 2014 and the decision which appears to have been generated on 9 January 2105. Standard Child Protection practice requires consideration of an L 17 report within three days. The further statement from Tracy Beaton stated:

> *In summary, there is nothing to suggest that there were discrepancies in practice or that Baby A's L 17 Intake Report was not assessed within the prescribed three-day window. It is certainly apparent that after it was assessed and designated to be a 'take no further action' matter, it was not uploaded into the Child Protection computer system, CRIS, (Client Relationship Information System) system for three weeks. However, for matters allocated as 'take no action' this delay – whilst not ideal – would not have changed the Child Protection response.*[125]

[123] CB 290.
[124] CB 291.
[125] Statement, Tracy Beaton Department of Families, Fairness and Housing dated 21 May 2021, paragraph 17.

157. This response is at odds with the reason for closure provided previously which included reference to the family violence incident having occurred one month previously. The apparent delay in consideration of the L 17 notification by Child Protection has not been adequately explained. The DFFH submissions state it is *believed* to be an administrative delay,[126] but Ms Beaton's first statement was that the report was closed in part because the family violence incident had occurred approximately one month previously.

158. It is well known that family violence is dynamic and not static. The suggestion that action was not taken in response to the L17 due to the historical nature of the incident fails to consider whether police involvement may have escalated the victim's risk of violence. Child Protection did not make any investigations of its own which potentially compromised the ability of staff to accurately assess risk to the children. The L 17 was incomplete, and Victoria Police has conceded it omitted information in the L 17 which was not available to Child Protection.

159. Since this incident Child Protection now has access to the L 17 Portal that can be checked to see whether people have been recorded in family violence incidents and if they have been charged. This was implemented on 6 December 2016 in partnership with Victoria Police.[127]

160. If this had been in place at the time, 12 December 2014, it would have revealed Mr Christoforou as involved in other family violence incidents with a previous partner, his sister and both parents. JK was not aware of these other family violence incidents or Mr Christoforou's criminal history or that he was on a community corrections order during their relationship.

161. The intervention order was made on 18 December 2014. JK recalled, '*I believe James had talked me into continuing the relationship and convinced me it was no longer necessary*.'[128] She stated:

> *Well in reflection obviously I can see now that that was a mistake but at the time I wasn't aware of how my mental health was at that stage … I had been diagnosed with post-natal depression*.[129]

[126] DFFH submissions p 11.
[127] Victoria Police letter from L Callaway, April 2021, paragraphs 43-45.
[128] T 192-3.
[129] T 193.

Police response regarding L 17

162. Victoria Police noted a:

> *… new L 17 should have been submitted for the incident at 1.20 am on 13 December 2014 as it was a separate incident with a new set of circumstances to those that had occurred on 12 December 2014.*[130]

163. Victoria Police conceded the L 17 for the incident on 12 December 2014 at 10.20 pm was deficient as it did not include Mr Christoforou's prior criminal history or history of family violence. Victoria Police conceded is should have submitted a separate L 17 for the further incident on 13 December 2014 at 1.30 am.[131]

164. Further, Victoria Police stated, '*these omissions are regrettable and were not consistent with relevant policy and guidance in place at the time*.'[132]

165. Changes introduced as a result of the recommendations from the Royal Commission into Family Violence have strengthened the Victoria Police response to family violence and the L 17 was replaced in 2019 with the FLR L 17. This includes additional fields automatically populated from the LEAP database, addressing a respondents' family violence history, including whether the respondent has a history of any contravention charges, breach court order charges or charges for a violent offence.

JK and RCH 'social services'

166. JK made the point that on 23 November 2014 when she attended the RCH with Baby A for the 'wet wipe incident' she spoke with '*social services*.' It was clarified the social worker at RCH is not connected with Child Protection. JK confirmed she did not raise any concerns regarding Mr Christoforou's conduct with the RCH social worker in November 2014 and that the clinical notes from that presentation note that she spoke to the social worker 'one on one' without Mr Christoforou being present. However, she did state in evidence:

> *Maybe every single social services … input should be reported … you don't know how vulnerable mothers are, especially when their partners are present. I mean I was extremely vulnerable at that point.*[133]

[130] Victoria Police letter from L Callaway, April 2021 paragraph 22.
[131] Victoria Police letter from L Callaway, April 2021 paragraph 24.
[132] Victoria Police letter from L Callaway, April 2021 paragraph 25.
[133] T 199.

167. JK went on to explain that since Baby A's death, because of what she subsequently had learnt about Mr Christoforou's involvement with BW, she now had suspicions about the incident with Baby A and the wet wipes.

168. JK acknowledged that when she attended RCH in November 2014 and three subsequent occasions on 18 January and 16 and 17 February 2015, she had significant discussions with RCH clinicians without Mr Christoforou being present. JK stated '… *I was still in the thick of that relationship with James. I was still in an emotionally vulnerable state. I was still being very much manipulated by him*.'[134]

169. JK accepted (although she did not recall much of the conversations) she was asked in discussions with RCH clinicians about possible causes for Baby A's scrotal swelling and bruising. An RCH clinician raised with her the possibility that Baby A's injuries may have been inflicted by a carer. She did not raise any concerns about Mr Christoforou's care of Baby A. JK stated it never entered her mind '*how anyone could do that to a child,*'[135] and there were no occasions which indicated to her that Mr Christoforou may have behaved in that way.[136]

170. I am satisfied on 23 November 2014 the RCH social worker spoke to JK 'one on one' in Mr Christoforou's absence, and clinicians spoke with her on 18 January and 16 and 17 February 2015, again in Mr Christoforou's absence. She was asked by clinicians if the scrotal injury could have been inflicted by a carer. I am of the view RCH acted appropriately.

171. I accept the submission made by RCH regarding their access to Child Protection information and have made a recommendation regarding this.

Was there a connection between the recent hospital attendances in the lead up to Baby A's death?

172. The question considered at inquest was whether RCH missed anything given Baby A's hospital presentations on 23 November 2014, 18 January, and 16 and 17 February 2015.

173. Dr Niroshini Kennedy, paediatrician at the Victorian Forensic Paediatric Medical Service of the RCH who assessed Baby A on 17 February 2015 following his referral from Dr Katherine Franklin RCH ED, prepared two reports dated 18 February 2015 and a supplementary report dated 11 July 2016. Dr Maryanne Lobo, sessional forensic paediatrician at the Victorian

[134] T 203.
[135] T 205.
[136] T 204-6.

Forensic Paediatric Medical Service of the RCH, examined Baby A whilst he was in the Intensive Care Unit on 20 February 2015 and prepared a report dated 10 March 2015.[137] Dr Lobo made the forensic assessment because of Baby A's recent assessment by Victorian Forensic Paediatric Medical Service (**VFPMS**) and subsequent presentation to RCH on 19 February 2015 with a cardio-respiratory arrest of uncertain cause.

RCH – Review following Baby A's death

174. Professor Matthew Sabin, Executive Director of Clinical Services at the RCH, gave evidence to the Inquest.

175. In his statement (complied from RCH records) he noted with respect to the incident on 23 November 2014 involving the wet wipes:

> *Ms Serratore [social worker] documented that she spoke with JK on her own following the meeting with James. It appears she ensured that JK had the opportunity to discuss her individual concerns regarding James' capacity to care for the children and she noted no concerns were reported by JK regarding James having any aggressive behaviours.*[138]

176. The social work department was not involved on 18 January 2015 for Baby A's presentation at RCH for scrotal swelling and bruising.

177. On 16 February 2016 Baby A presented to RCH with testicular pain and scrotal bruising and bruising to his left hand. He was referred for an x-ray and blood tests and referred to VFPMS for further assessment. He returned the following day for review.

178. On 17 February 2016, Baby A was assessed by Dr Niroshini Kennedy. The results of his left-hand x-ray were not available. General Surgical Registrar Dr Vavilov assessed Baby A as having probably traumatic scrotal haematoma, with nil testicular pathology. Dr Kennedy determined it was appropriate for Baby A to return home with JK. Dr Kennedy was to review investigation results before determining any necessary further action.

179. Dr Lobo reached the following opinions regarding Baby A's injuries:

> *… The location of a bruise on the left loin and the scrotal bruise are uncommon sites for trauma from accidental mechanisms. However the bruises are non-specific in*

[137] Report by Dr Maryanne Lobo dated 10 March 2015 CB pp 43-55.
[138] CB 1018.

shape and it is not possible to determine the nature of the trauma that caused them on the basis of their appearance …

… Post mortem whole body CT and radiographs have identified bilateral anterior 6th-8th rib fractures and fracture of the distal right radius and possibly distal right ulna. These fractures are all reported to be consistent with healing fractures and likely to be several weeks old.

… these fractures are very concerning for blunt force trauma such as from a blow to his chest either from a heavy object contacting his chest with force or from a punch or kick to his chest.

Baby A also has a fracture in his distal right radius and ulna. This could have been caused by a fall on an outstretched arm either from an accident or from being pushed. These fractures would have caused him pain, discomfort and he would have been reluctant to use his right forearm at least for a few days. However there is no such history provided; this is concerning for neglect of his health and/or supervision.[139]

180. On 19 February 2016 Dr Kennedy received the left-hand radiology report and planned to repeat the x-ray to determine if there was a fracture. If a fracture was confirmed a skeletal survey would have been ordered.[140] Baby A re-presented on 19 February 2016 at 11.17 pm before further investigations occurred.

181. Following Baby A's death, the RCH conducted a Critical Incident Review, and a case review panel examined his presentations from 23 November 2014 to 19 February 2015.

182. The panel identified:

(a) On 23 November 2014 the nurse was not present for the risk assessment between social worker and ED consultant and after Baby A's death, the nurse expressed concern about his discharge to the ED consultant;

(b) An informal system was in place requiring the on-call social worker to discuss with senior on-call social worker children at risk or where protection issues are raised;

[139] Report by Dr Maryanne Lobo, CB pp 53-4. Dr Lobo examined Baby A in the ICU at RCH and other materials, including medical records, the interim report of Dr Kennedy, as well as the radiology findings.
[140] Following Baby A's death Dr Cain reviewed the radiology report and subsequently confirmed the absence of a fracture. It is unlikely a skeletal survey would have proceeded. The requirement to proceed with a skeletal survey is also balanced by the risk posed to child by radiation exposure.

(c) Social work personnel to do not cover ED 24/7; and

(d) The standard practice for the VFPMS consultant to phone radiology for results before finalising a care plan did not occur for Baby A's hand x-ray results on 17 February 2017.

183. Recommendations to address the above were adopted and actioned by RCH between August 2015 and February 2016.

184. In their submission following the inquest, RCH noted they were unaware at the time of Baby A's presentations on 23 November 2014 or 16 and 17 February 2015 of Mr Christoforou's forensic or family violence history. They noted there was no suggestion of family violence raised by Baby A's carers who they submitted presented as responsive and appropriate in their care. They note that had the index of suspicion been raised on either occasion or Mr Christoforou's history revealed, the outcome may have been different. To that end they submit a coronial recommendation with a view to improving information access within tertiary paediatric health services should be considered.[141]

185. The RCH submissions note that greater communication of and access to information held by Child Protection and Victoria Police is relevant to the care of children in tertiary health care settings. This would be beneficial to paediatric health care service providers as a means of early identification and intervention in circumstances where there may be a wellbeing or safety concern.[142]

186. In order to facilitate information sharing, the RCH submissions also suggest a coronial recommendation that the RCH and public hospitals be included as agencies authorised to use the Child Link database. Child Link database is a web-based Victorian Government initiative to draw information together from existing government information management systems to display information about a child to authorised key professionals who have responsibility for child wellbeing and safety.[143]

Dr Sabin's evidence about how children cope with pain

187. Dr Sabin stated a child's experience of pain is similar to an adult, save a child's response is expressed differently, given a child of Baby A's age inability to articulate. He described

[141] RCH submissions p 9.
[142] RCH submissions p 9.
[143] RCH submissions pp 10-11.

'*generally the child would be miserable, they would be attention seeking and they would be, you know, sort of seeking affection in terms of being cuddled and held and the like.*'[144]

188. With respect to a child with broken ribs, he stated, '*it would be very unusual for a child with current fractures to be able to be handled in such a way that there is movement across that fracture without there being some visible sign of distress*.'[145] With respect to a fractured wrist, he was of the view if the area was handled the child would show distress and pain, and probably not use that hand as much.

189. When asked how it was neither Baby A's parents nor clinicians at RCH noticed Baby A to be in pain from fractured ribs or his right wrist, Dr Sabin stated the pain would be acute in the first 24 to 48 hours and '*probably to a declining rate out to a week depending on whether they're given pain killers, how they're handled and what the treatment is*.'[146]

190. Dr Sabin's opinion was given Baby A's fractured ribs, fractured wrist, and injured mesentery he would have been in a significant degree of pain. Baby A was given Panadol syrup for his hand, foot and mouth condition and for the scrotal swelling, and Dr Sabin agreed this could have impacted on his symptoms of pain for fracture injuries. Baby A was also recommended Nurofen and Panadol for his hand, foot and mouth, and an anti- inflammatory such as Nurofen can reduce inflammation and pain.

Conclusions regarding the circumstances of death

Assessment of the evidence

191. Both KI and JK gave evidence at inquest and their credit was not impugned. I note JK was supportive in her evidence of Mr Christoforou's role with the boys, and there was a discrepancy in the evidence between how much time each of them said Mr Christoforou spent staying at her home and supervising the boys on his own. I note her evidence was that she remains deeply traumatised by Baby A's death and has sought to suppress her memories from that time, and this impacted on some of her recollection.

192. I found Mr Christoforou to be a less credible witness. At times he was evasive in his answers as well as dissembling, which was apparent when he asked about asked questions about his family violence history, for example, denying he had been violent to women but admitting

[144] T 213.
[145] T 214.
[146] T 215.

behaviour such as aggressive driving, pursuing a woman in his car and cutting her off causing a minor collision.

Baby A's injuries

193. The cause of Baby A's significant injuries identified at the time of his death by the radiology report to his ribs and right wrist and by autopsy to his mesentery have not been identified. The evidence is that they are traumatic injuries, and the medical opinion supports a finding the injury to his mesentery and ribs were non-accidental.

194. JK and KI were unable to explain how the injuries may have occurred or noticing or being aware that Baby A was in pain.

195. The injuries occurred in a time frame when Mr Christoforou was in a relationship with JK. Although they were not living together, and JK reported to Dr Kennedy on 17 February 2015 that Mr Christoforou '*is not actively involved in her children's care*',[147] the evidence from KI and Mr Christoforou suggests that he was more frequently looking after the boys on his own.

196. Mr Christoforou described witnessing Child B jumping up and down on Baby A. Mr Christoforou did not refer to this incident in his statement, and this event was not referred to by JK in her evidence, which lessens the weight I give to the report. JK was asked about possible causes of Baby A's injuries and she referred to the rough and tumble of the boys' play. Given the medical evidence I find it highly unlikely that Baby A's rib, wrist, or mesentery injuries were caused by sibling activity. JK provided to the court five videos of her boys playing together following the inquest.[148] One of these videos dated 18 December 2014 shows Baby A and Child B kicking each other in play fight. Some of Child B's kicks land on Baby A's groin region. Dr Baber's advice is that this type of play is unlikely to explain the injury to Baby A's testicle identified at autopsy.

197. Baby A's parents, JK and KI, acted protectively towards Baby A by taking him to the doctor for his bruised scrotum and for hand foot and mouth disease, and to the hospital when recommended by the doctor and calling 000 for ambulance attendance.

[147] CB 32.

[148] These were sent to the court by email dated 26 April 2015 by JK's brother Graeme Kington following the conclusion of evidence at the inquest. He stated they were sent in response to the questioning of JK at inquest as to why she did not notice Baby A's injuries and range in dates from 23 October, 26 November, 2 & 18 December 2014 and 26 January 2015. They are short videos (up to 30 seconds duration) and have been distributed to the interested parties.

198. I find the cause of Baby A's significant injuries to his ribs and mesentery is from non-accidental trauma. There is a possibility the injury to his right wrist could have been caused by accident.

Baby A being in pain

199. Dr Sabin's evidence was that Baby A's injuries identified post-mortem would have caused him pain at the time they occurred sometime during December 2014 to January 2015 period. The impact of the pain would have lessened over time and the administration of Panadol and Nurofen (for his hand foot and mouth, as well as his bruised scrotum) would have also lessened the pain.

200. Neither JK, KI nor Mr Christoforou gave evidence of ever observing Baby A to be in pain, save for Mr Christoforou describing Baby A as in '*agony*' from apparent gastro on 19 February 2015. Neither JK nor KI could recall any accident or incident when Baby A sustained a blow or injury. JK's videos from October, November, December 2014, and January 2015 depict Baby A playing as a normal toddler. Baby A had a number of general practitioner and RCH attendances and there is no record reflecting evidence of him presenting in pain, save for discomfort around his groin area. In her report of 17 February 2015 for Baby A's attendance at RCH for scrotal bruising Dr Kennedy noted:

> *... he had no other external injuries, he presented as a happy and well-cared for child, and his mother seemed to be appropriately seeking and responding to medical advice for him ...*[149]

201. It is difficult to reconcile the evidence of Baby A's injuries identified post-mortem with the absence of evidence of Baby A manifesting pain. This is the evidence not only of the three adults mainly involved with his care, but also the health care professionals who saw him over the three-month period prior to his death.

202. Baby A's absence of pain indicators is inconsistent with his injuries and the evidence of Dr Sabin. A partial explanation may be the masking combination of medications, the effluxion of time and his behaviour, interpreted as 'clingy' and wanting to be held, which was most likely comfort seeking. This however does not explain the adults in Baby A's life not being aware of when the casual incidents for the injuries occurred or the accompanying pain reaction.

[149] CB 67.

203. Unfortunately, the coronial investigation has not been able to identify how any of the injuries were caused or reconcile Baby A's injuries identified at death with the evidence of his health, wellbeing, and behaviour whilst alive.

Wet wipe incident

204. Mr Christoforou left Baby A alone and unsupervised on 23 November 2014 for five minutes when the wet wipe choking incident occurred. He reported removing the wet wipe from Baby A's mouth.

205. JK acted protectively by calling 000 and taking Baby A to hospital following the wet wipes incident on 23 November 2014.

Exposure to methylamphetamines

206. Mr Christoforou smoked ice in JK's car during their relationship, unbeknownst to her, thereby exposing the family to methylamphetamine.

207. Mr Christoforou's direct contact caring of the boys exposed them to methylamphetamines from his person. In the context of having just commenced a truck driving job Mr Christoforou denied having consumed Ice on the evening of 19 February 2015.

208. Mr Christoforou was not candid with JK during the course of their relationship regarding his past and present drug use, his forensic history, or his family violence history.

Child Protection

209. The delay between the L 17 report on 12 December 2014 and closure on 9 January 2015 has not been adequately explained. Child Protection did not make any independent enquiries regarding the family violence incident and relied solely on what was an incomplete L 17. The action taken at In-take by Child Protection to *take no further action* was based on the incomplete information provided by Victoria Police in the L 17.

210. Victoria Police conceded the L 17 report provided to Child Protection regarding the family violence incident on 12 December 2014 was incomplete.

211. Victoria Police conceded a further L 17 report should have been provided to Child Protection with respect to the further family violence incident in the early hours of 13 December 2014.

Attendances at Royal Children's Hospital

212. During Baby A's presentations to the RCH on 23 November 2014, 18 January, and 16 and 17 February 2015 I find he was appropriately reviewed and examined, and care was reasonable. The medical examinations for each presentation revealed nothing to suggest Baby A was at risk, that he had the injuries subsequently identified by the radiology report, or that he would present having suffered a cardiac arrest from an unknown cause on 19 February 2015 and subsequently die on 21 February 2015.

213. On 23 November 2014 and 16 and 17 February 2015 the RCH was not aware of Mr Christoforou's forensic history and there was no suggestion of intentional injury or family violence by Baby A's carers to raise suspicion. The decision by RCH not to notify Child Protection appears to have been based on a reasonable assessment of the available evidence.

FINDINGS AND CONCLUSION

214. Having investigated the death, and having held an inquest, I find pursuant to section 67(1) of the *Coroners Act 2008* that Baby A, born 12 April 2013, died on 20 February 2015 at The Royal Children's Hospital, 50 Flemington Road, Parkville, Victoria, from global cerebral ischaemic injury following cardiorespiratory arrest of unknown cause in the setting of detected methylamphetamine in the circumstances described above.

COMMENTS PURSUANT TO SECTION 67(3) OF THE ACT

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

215. I adopt the recommendations proposed by the RCH with respect to strengthening the relationship between health services and access to information from the DFFH. RCH noted that the lack of inter-agency information sharing and collaborative risk management contributes to child deaths.

216. I note the concerns raised by KI that he was not advised about Baby A's attendance at the RCH on 23 November 2014 following the choking incident with the wet wipe. I note his request:

> *... that non-custodial parents are contacted upon any injury of their child, contacted upon any involvement with DHHS, contacted upon any amendments to active Police intervention orders that relate to their children and also allow the non-custodial*

parent to have information on the living conditions and essential information relating to any non-parental persons providing care of their child/children and to go through the appropriate processes if they believe their child/children is in danger.[150]

217. I note there was no active Child Protection involvement and no applications to amend an intervention order in this case. Information about the living conditions of children and any non-parental persons providing care for children, in the absence of intervention by the state or relevant court orders, is a matter for communication between the parents.

218. The submissions from the RCH indicate that given the high numbers of children attending with life threatening injuries it would not be feasible administratively for a requirement to be imposed that the hospital contact the non-custodial parent. I accept that position.

RECOMMENDATIONS PURSUANT TO SECTION 72(2) OF THE ACT

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

1. To the **Secretary, Department of Health**[151] I recommend that consideration be given to establishing positions similar to the initiative at the Child Protection Divisional Office at Footscray of a Royal Children's Hospital Clinical Nurse Coordinator, in each Divisional Child Protection Office linked to the local hospital or major health service.

2. To the **Secretary, Department of Families, Fairness and Housing** I recommend that consideration be given to the placement of a senior state-wide child protection officer at the Royal Children's Hospital to enhance information sharing and collaborative risk assessment and management.

3. To the **Secretary, Department of Education and Training**[152] I recommend in the interests of enhancing information sharing and collaborative risk assessment and management, that consideration be given to including public hospitals in the group of agencies authorised to use the Child Link database when it becomes operational December 2021.

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

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[150] CB 884.
[151] 'Secretary, Department of Families, Fairness and Housing' amended to 'Secretary, Department of Health' pursuant to section 76 of the *Coroners Act 2008* (Vic).
[152] 'Secretary, Department of Families, Fairness and Housing' amended to 'Secretary, Department of Education and Training' pursuant to section 76 of the *Coroners Act 2008* (Vic).

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

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

JK, senior next of kin
KI, senior next of kin
Mr Graham Kington
Royal Children's Hospital (care of HWL Ebsworth)
Department of Families, Fairness and Housing (care of Minter Ellison)
Commissioner for Children and Young People
Ms Sandy Pitcher, Secretary, Department of Families, Fairness and Housing
Professor Euan Wallace, Secretary, Department of Health[153]
Ms Jenny Atta, Secretary, Department of Education and Training[154]
Ms Eleri Butler, CEO, Family Safety Victoria
Sergeant Tracy Weir, Victoria Police, Police Coronial Support Unit
Detective Senior Constable Kim Cuccia, Victoria Police, Coroner's Investigator.

Signature:

CAITLIN ENGLISH

DEPUTY STATE CORONER

Date: 13 December 2021

[153] Added pursuant to section 76 of the *Coroners Act 2008* (Vic).
[154] Added pursuant to section 76 of the *Coroners Act 2008* (Vic).