IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2018 005052

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)

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

Aboriginal and Torres Strait Islander readers are advised that this content contains the name of a deceased Aboriginal person. Readers are warned that there are words and descriptions that may be culturally distressing.

Inquest into the passing of Baby L

Delivered On:	11 October 2024
Delivered At:	Coroners Court of Victoria, Melbourne
Hearing Dates:	11-20, 25 July 2022 and 7-9 September 2022
Findings of:	Coroner Leveasque Peterson
Representation:	Gordon Chisolm, Counsel Assisting the Coroner
	Joanna Davidson, Counsel for the Department of Families Fairness and Housing
	Naomi Hodgson, Counsel for the Chief Commissioner Victoria Police
	Julie Buxton, Counsel for DCC (Day Care Centre)
	Lucien Richter, Counsel for JHP (LPO's partner)

Amy Brennan, Counsel for LPO (Baby L's father)

Nikolas Barron and Alex Walters, Victorian Aboriginal Legal Service for HPB (Baby L's mother)

Keywords: Aboriginal child; Child Protection; Unascertained causes

A pseudonym order has been made in this matter pursuant to section 55(2)(e) of the Coroners Act 2008. Pseudonyms will be applied in this finding in accordance with this order.

I, Coroner Leveasque Peterson, having investigated the passing of Baby L[1], and having held an inquest in relation to this death over 12 days between 11 July and 9 September 2022 at Wodonga and Melbourne find pursuant to section 67(1) of the *Coroners Act 2008* ('**the Act**)' that;

a. the identity of the deceased was Baby L born on 12 January 2017;
b. the death occurred on 7 October 2018 at The Royal Children's Hospital (**RCH**);
c. from unascertained causes.

I further find, under section 67(1)(c) of the Act that the death occurred in the following circumstances:

INTRODUCTION

1. Baby L, was 20 months old when she tragically passed at the RCH on 7 October 2018 after she collapsed at her place of residence in Wodonga on 6 October 2018.

2. Baby L was born on 12 January 2017 to HPB (**Baby L's mother**) and LPO (**Baby L's father)**. Baby L was an Aboriginal child of the Wiradjuri nation through her mother's family. She was the youngest of three children for HPB, and the first child for LPO.

3. Baby L was a bright, lovely, bubbly child who HPB reported loved swinging and playing in the park with her brothers and sisters and aunt. She also loved music and dancing and singing[2].

4. Some months after Baby L's birth HPB and LPO ended their relationship and HPB assumed full time care of Baby L. When Baby L was 13 months old however, HPB experienced a recurrence of ill health. HPB reluctantly decided it was in Baby L's best interests that LPO take over the care and custody of Baby L for a time.

[1] Pseudonyms of family, friends and associates of the deceased have been created using randomly generated three letter sequences pursuant to section 55(2)(e) of the Coroners Act 2008 (Vic).
[2] Evidence of HPB: Transcript of 14 July 2022 p. 381.

5. Initially LPO was sole parenting with the assistance of his parents and other close friends who would look after Baby L while LPO worked. This arrangement continued until early February 2018.

6. In January 2018, LPO met and commenced a relationship with JHP (**LPO's partner**). The relationship developed to a point where LPO and Baby L moved in with JHP at her home in Wodonga. JHP had eight children, however at the time that LPO and Baby L moved in JHP had the full-time care and responsibility for four of her children and from time to time some of JHP's other children would live at the house.

7. Because LPO maintained a full-time position as a contractor, JHP was frequently responsible for Baby L's care for the periods of time LPO was at work.

THE PURPOSE OF A CORONIAL INVESTIGATION

8. Baby L's passing constituted '*a reportable death'* under the Act, as she ordinarily resided in Victoria and her passing was unexpected.

9. The jurisdiction of the Coroners Court is inquisitorial[3]. The purpose of a coronial investigation is to independently investigate a reportable death to ascertain, if possible, the identity of the person who has passed, the cause and the circumstances of the passing.

10. The cause of death refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

11. The circumstances in which the death occurred refers to the context of background and surrounding circumstances of the death. The 'circumstances of the death' do not refer to the entire narrative culminating in the death, but rather to those circumstances which are sufficiently proximate and causally related to the death. I will return to this aspect of the coroners' role in more detail later in this finding.

3 Section 89(4) Coroners Act 2008 (Vic).

12. The focus of a coronial investigation is to determine what happened, not to ascribe guilt, attribute blame or apportion liability. It is important to note that coroners are specifically prohibited from including a finding, comment or statement that a person is, or may be, guilty of an offence. Whilst it is sometimes necessary to examine whether a person's conduct falls short of acceptable norms or standards, or was in breach of a recognised duty, this is only to ascertain whether it was a causal factor in a passing, or merely a background circumstance.

13. The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through the investigation findings and recommendations that are made by coroners. This is generally referred to as the prevention role.

14. Coroners are empowered to:

    a. Report to the Attorney General on a passing;

    b. Comment on any matter connected with a passing that has been investigated, including matters of public health or safety and the administration of justice; and

    c. Make recommendations to any Minister or public statutory authority, entity or agency on any matter connected with the passing, including public health or safety or the administration of justice.

15. The prevention role of the Court is advanced through the exercise of those powers.

Standard of proof

16. All coronial findings must be made on proof of relevant facts on the balance of probabilities.[4]The strength of the evidence necessary to prove relevant facts varies according to the nature of the facts and circumstances in which they are sought to be proved.[5]

4 *Re State Coroner; ex parte Minister for Health (2009) 261 ALR 152.*
5 *Qantas Airways Limited v Gama (2008) 167 FCR 537.*

17. When assessing the actions of a professional person a coroner must have regard to the prevailing standards of the relevant profession or specialty. An act or omission will not usually be regarded as contributing to a passing unless it involves a departure from reasonable standards of behaviour or a recognised duty.

18. It is also important to recognise the benefit of hindsight and to discount its influence on the determination of whether a person or persons acted appropriately. I am conscious of the need to judge the actions of all involved with Baby L at the time of her passing, having regard to the information known to them at the time.

19. In determining these matters, I am guided by the principles enunciated in *Briganshaw v Briganshaw.*[6]

SOURCES OF EVIDENCE

20. Following Baby L's passing, Victoria Police assigned a coroner's investigator (**CI**) for the coronial investigation. A brief of evidence was compiled which included Medical Examiner and Toxicology Reports from the Victorian Institute of Forensic Medicine (**VIFM**), extracts of medical records, statements obtained by the CI, and statements and documents obtained by the Court from a number of health services and other agencies that interacted with Baby L prior to her passing.

21. This finding draws on the totality of the materials produced to the Court throughout the coronial investigation and inquest into Baby L's passing. That is, the Court records, the brief of evidence, further material obtained by the Court, the evidence adduced during the inquest and submissions provided by Counsel Assisting and Counsel representing the Interested Parties.

22. I have carefully considered all the material. However, in writing this finding, I do not purport to summarise all the evidence. I have referred only to such information and in such detail as is warranted by the forensic significance and for narrative clarity. The

6 *Briganshaw v Briganshaw (1938) 60 CLR 336.*

absence of any reference to any aspect of the evidence does not mean that it has not been considered.

INQUEST

23. In deciding whether to hold an inquest a Coroner should consider factors such as whether there is such uncertainty, or conflict of evidence as to justify the use of the judicial forensic process; whether there is a likelihood that an inquest will reveal systemic defects or risks, and the likelihood that an inquest will assist to maintain public confidence in the administration of justice.

24. Although the circumstances of Baby L's passing did not meet the criteria for a mandatory inquest, I considered that an inquest was in the public interest given that Baby L was an Aboriginal child, who had contact with Child Protection (**CP**) in the months prior to her passing (as a result of her Day Care Centre (**DCC**) observing a number of bruises and injuries on her), and the cause of her death was unascertained.

25. The inquest hearing commenced in Wodonga from 11 July 2022 to 20 July 2022 and continued at Melbourne from 22 until 25 July 2022. A further tranche of evidence was heard at Melbourne from 9 September 2022 to 9 September 2022.

SCOPE OF INQUEST

26. The scope of the inquest was as follows:

    1. The cause of Baby L's passing;

    2. The circumstances in which Baby L passed including;

        i. Her presentation and condition in the days prior to her collapse at home on 6 October 2018;

        ii. Her medical history including assessment, diagnosis, treatment, referrals and access to services;

iii. The involvement of CP in her care from 3 September 2018 until her passing; and

iv. The involvement of the DCC, the Wodonga Maternal Child and Health Service, Southern Rise Early Learning Centre, Daintree Medical Centre (**Daintree**) and Wodonga Sexual Offences and Child Abuse Investigation team (**SOCIT**) of Victoria Police in Baby L's care and welfare in the months prior to her passing.

3. Any remedial measures implemented since Baby L's passing; and

4. The identification of any further measures that might be taken to prevent similar passings in the future.

27. At the inquest the following witness gave evidence:

a. DCD, Director, DCC;

b. DCAD, Assistant Director, DCC;

c. DCW1, Educator, DCC;

d. DCW2, Educator DCC;

e. DCW5, Educator, DCC;

f. Detective Joanne Albert, Victoria Police;

g. CPP11, Child Protection Team Manager, Department of Families, Fairness and Housing (**DFFH**);

h. CPP22, Senior Child Protection Practitioner, DFFH;

i. CPP15, Senior Child Protection Practitioner, DFFH;

j. Dr Siriti Ali Das, General Practitioner (**GP**);

k. Dr Fatima Elnaggar, GP;

l. JHP, partner of LPO (father of Baby L);

m. LPO, father of Baby L;

n. HPB, mother of Baby L;

o. Kirstie Lee Lomas, acting Chief Practitioner and Executive Director of the Office of Professional Practice, DFFH;

p. MCHN, Maternal Child and Health Nurse;

q. Dr Linda Iles, Forensic Pathologist;

r. Dr Melanie Archer, Forensic Pathologist; and

s. Dr Timothy Davis, Sessional Specialist Paediatrician, Victorian Forensic Paediatric Medical Service (**VFPMS**).

28. After the evidence was closed the court received additional information that required further investigation, which carried over to 2023. The parties were provided with the information, however I considered that no further viva voce evidence was required and invited final submissions from the interested parties. Counsel Assisting and Counsel for all the Interested Parties provided written submissions.

Baby L's medical history

29. The scope of inquest included an examination of Baby L's medical history that covered medical assessments, diagnoses, treatments, referrals and access to services. This was relevant to ascertain if there was any aspect of Baby L's medical history that could assist with determining a cause of death.

30. The evidence and medical records were drawn from a number of sources and it is useful to summarise these interactions.

31. Baby L's first childcare centre records[7] referred to Baby L experiencing usual childhood illnesses. There was nothing in these records to indicate any underlying or persistent illness.

32. Baby L attended GPs in both Coolamon and Wodonga. Records showed LPO took Baby L to Coolamon Regional Medical Centre where the GP noted that Baby L's anterior fontanelle had not closed and suggested a review in three months. Overall, the GP noted that all of Baby L's milestones were normal.

33. In July 2018, LPO and JHP took Baby L to the Daintree for review of a persistent cough and speech delay. The records show LPO and JHP had also told the GP about concerns for Baby L's sleeping pattern and feeding. They described instances where Baby L appeared to be "staring for nothing"[8]. Although Baby L was tested for whooping cough, there were no other treatments or referrals. Finally, the Daintree records show that in August 2018, LPO took Baby L there after being called to pick her up from DCC due to fever and runny nose[9].

34. On 17 August 2018, Baby L suffered a fractured arm and went to hospital.[10] No other injuries of note were observed during Baby L's presentation at hospital. Treatment involved placing her in a cast and the injury eventually resolved, with the removal of her cast in September 2018. The expert evidence about this event concluded the injury was not one that is indicative of abuse.

35. On 24 August 2018, Baby L was first examined by Dr Fatima Elnaggar, GP. Dr Elnaggar gave evidence that LPO and JHP were concerned with Baby L's eating habits, her behaviour and her hearing. Following her consultation, Dr Elnaggar provided a referral to a paediatrician for a behavioural assessment and a referral for a hearing test for Baby L.

---

[7] Coolamon Early Childhood Centre records: Coronial Brief p. 1230.
[8] Evidence of Dr Das: Transcript of 19 July 2022: p. 776.
[9] Daintree Medical Centre records: Coronial Brief p. 1235.
[10] Albury Wodonga Health records: Coronial Brief p. 1227.

36. On 17 September 2018, Baby L was examined by MCHN who noted injuries and bruises that are discussed in later in this finding.

37. On 19 September 2018, Baby L was examined by Dr Elnaggar who found no evidence that Baby L suffered from a medical condition that would cause her to bruise easily.

38. The evidence provided to the Court uncovered no new information to suggest Baby L suffered from an underlying illness or other medical condition relevant to her passing.

Overview of agency and entity responses

39. The court heard evidence from numerous witnesses concerning the identification of concerns for Baby L's welfare, the mandatory reporting that followed, and the agency responses to the mandatory reports.
40. As the available evidence does not enable me to determine a connection between Baby L's passing and the injuries that were subject of the mandatory reports, it does not support any adverse comment or finding against the agencies involved in the identification, reporting and investigation of Baby L's injuries. In the circumstances, I do not propose to canvass that body of evidence in detail, rather, I have provided an overview of Baby L's involvement with DCC, CP, and Victoria Police.
41. It was apparent that all the personnel involved in the investigation of Baby L's injuries undertook their duties and responsibilities with diligence.
42. It was also clear that Baby L's passing had a significant impact on those involved and the experience resulted in reflection and improvements designed to strengthen the systemic response to child safety and investigations generally.

Baby L's involvement with DCC

43. In July 2018, LPO enrolled Baby L at DCC, where two of JHP's children were already enrolled. Baby L started attending two days per week, eventually increasing her attendance to four days per week.

44. Staff who interacted with Baby L described her as a" beautiful child[11]", who was "quiet for a two year old", because "she wasn't verbal which is unusual for a toddler"[12]. She largely kept to herself and avoided rough play with other children. Staff also observed that Baby L became more at ease and animated over the course of her time at DCC.

45. Shortly after Baby L commenced at DCC, staff noticed a number of bruises and other marks on her body.

46. Specifically, between 30 July and 14 September 2018, childcare educators at DCC observed, and began to document, bruises and marks they discovered on Baby L. Staff also notified LPO and/or JHP about Baby L's various injuries and generally received an explanation that was also documented.

47. On 3 September 2018, Baby L presented to DCC with a new bruise on her cheek which prompted a report to CP.

48. Following the mandatory report, staff at DCC continued to examine Baby L, and document any new injuries. This information (notes and photographs) was subsequently provided to CP via emails.

49. On 12 September 2018, CP contacted DCC. At that time DCC provided information about new bruising seen on Baby L on 11 September 2018, constituting a second report to CP. CP together with Wodonga SOCIT, attended at the centre following receipt of the new report.

50. On 14 September 2018, staff at DCC found bruising on Baby L's feet which was photographed, but it did not result in a report to CP.[13]

51. On 18 September 2018, DCC received another visit from CP after CP received information about the bruising to Baby L's feet from the MCHN.

[11] Evidence of DCW1: Transcript of 12 July 2022: p. 220.
[12] Evidence of DCAD: Transcript of 12 July 2022: p. 174.
[13] This bruising was reported by MCHN who examined Baby L on 18 September 2018.

52. DCC continued to monitor Baby L, however no more injuries were reported after 14 September 2018. Baby L continued to attend DCC until 5 October 2018, the day before her passing.

53. It was clear from the evidence of the DCC staff that they cared for Baby L and had her best interests in mind at all times. The staff was diligent in identifying concerns for Baby L's wellbeing, documenting them and finally, reporting them in a timely manner. I commend their actions.

Baby L's involvement with CP

54. On 3 September 2018, CP received a report from DCC. Based on the information available at that time the file was assessed as requiring a non- urgent response. An intake document was generated. CP determined it was appropriate to sight Baby L and conduct a home visit.

55. On 12 September 2018, CP contacted DCC to determine whether Baby L was at the centre. During that contact CP received a second report from DCC about injuries to Baby L.

56. Following the contact with DCC, CP and Victoria Police attended at JHP's home to examine Baby L and question LPO and JHP.

57. As a result of the information obtained at that visit, CP considered that further investigative steps were necessary so further information was gathered.

58. On 17 September 2018, LPO and JHP took Baby L to the Maternal Child Health Service in Wodonga. This appointment had been scheduled prior to the involvement of CP and Victoria Police with Baby L.

59. The MCHN examined Baby L and took information from LPO about her behaviour and development. The MCHN also observed a number of bruises on Baby L which concerned her.

60. On 18 September 2018, CP received a report about new bruising from the MCHN who had examined Baby L on 17 September 2018.

61. This information prompted a second CP and Victoria Police attendance to DCC to examine Baby L. Although not all of the bruising was able to be confirmed (due to the passage of time), CP and Victoria Police did observe bruising on Baby L's buttock and bruising on her thigh that appeared consistent with a handprint.

62. CP also attempted visits to JHP's home however these were unsuccessful. In the absence of being able to conduct an in-person visit, CP called LPO and directed him to take Baby L to a GP for an assessment.

63. On 19 September 2018, Baby L was seen by Dr Elnaggar who observed bruising and what appeared to Dr Elnaggar to be bite marks. Dr Elnaggar provided information regarding her observations to CP.

64. CP received and processed the information from Dr Elnaggar noting that there were no new injuries.

65. Dr Elnaggar subsequently spoke to a Paediatrician (Dr Christie) to whom she had referred Baby L. Dr Elnaggar gave evidence that she told the Paediatrician about the bruising she had observed on Baby L and that he had requested that a psychological assessment be conducted first.

66. On 20 September 2018, Dr Elnaggar referred Baby L to the North East Child and Adolescent Mental Health Service (**NECAMHS**) who arranged an appointment for LPO and Baby L. Tragically, Baby L passed before the scheduled appointment.

67. At the time of Baby L's passing the CP investigation file remained open.

68. I cannot exclude the possibility that Baby L suffered injuries at the hand of a third party between July 2018 and 18 September 2018, however in the context of the medical findings I am satisfied that these injuries did not cause or contribute to Baby L's passing and I make no finding.

Baby L's involvement with Victoria Police

69. As detailed earlier, on 12 September 2018, Victoria Police together with CP attended at JHP's home to follow up on a second report from DCC that included a set of photographs of bruising that DCC had sent to CP.

70. Detective Joanne Albert gave evidence that she attended at JHP's home to establish whether a crime had been committed and collect any available evidence to prove the commission of a relevant criminal offence.[14] Upon her examination of Baby L, Detective Albert relevantly observed amongst other bruises and markings, a bruise on Baby L's upper left thigh in the shape of a hand.

71. Detective Albert questioned LPO about this bruising, LPO admitted that he had struck Baby L, causing the bruising. LPO also proffered an explanation that Baby L bruised easily.

72. Given that CP had directed Baby L undergo further medical assessment, Victoria Police took no further action after this visit, pending the outcome of the medical assessment.

73. On 4 October 2018, Detective Albert received information that Baby L had no underlying medical condition that would cause her to bruise easily.

74. Detective Albert then commenced to charge LPO with assault.

75. Baby L passed away before the charge against LPO could proceed and the legal proceedings were discontinued.

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

Identity

76. On 7 October 2018, Baby L was visually identified by her father, LPO.

77. Identity was not in dispute and required no further investigation.

[14] Evidence of Detective Joanne Albert: Transcript of 13 July 2022 pp. 72-97.

CIRCUMSTANCES OF PASSING

78. The Court heard evidence from both LPO and JHP as to the circumstances of the 48-hour period prior to Baby L's passing.

79. After JHP finished giving evidence the court received a statement from one of JHP's former partners, indicating JHP had left her house that morning to drop off her sons to him for an access visit. This account contradicted some of the evidence JHP had provided to the Court.

80. Given the conflict in the evidence, JHP was re-called to clarify aspects of her previous evidence about the events of 6 October 2018. JHP was unable to recall leaving the house as alleged by her former partner. In cross examination JHP told the court that her statement had been very thorough and if events had occurred as indicated by Mr Johansen, they would have been reflected in her statement, however JHP did not deny it was possible that she left the house that morning.

81. LPO was also questioned about the events of 6 October 2018. LPO's evidence was largely consistent with both his statement and JHP's statement and original evidence to the Court concerning the events of 6 October 2018. During his evidence he consistently maintained he could not recollect JHP leaving the house prior to going to the Blazing Stump Hotel.

82. It was disappointing to receive evidence from LPO and JHP about critical events that was vague and at times lacking in cogency. However, consistent with the principles articulated in *Briganshaw* I am not satisfied I have sufficient evidence to make adverse comments concerning LPO and JHP's accounts of the events of 6 October 2018.

83. Based on the available evidence I find the circumstances of Baby L's passing as set out below.

84. On 5 October 2018, LPO and JHP dropped Baby L at DCC where she spent the day.

85. JHP gave evidence that when she collected Baby L that afternoon, she looked pale. After picking up the other children JHP arrived home, the children ate dinner and at

approximately 6.30 pm the youngest three children went to bed. LPO arrived home well after their bedtime.

86. By 7.30 pm JHP heard Baby L coughing and went to check on her. At that point JHP noticed that Baby L was putting her fingers down her throat as if trying to make herself sick. Although Baby L settled, JHP heard her coughing shortly afterwards so went back to check on Baby L. At that time JHP noticed Baby L had vomited so she changed her sheets, offered her water, checked her temperature noting it was normal, and Baby L settled again and went back to sleep[15]. JHP continued to check on Baby L periodically before LPO arrived home.

87. LPO arrived home shortly after 8.00 pm and for the rest of the night he checked in on Baby L. Throughout the night Baby L continued to cough and sometimes vomit. Sometime after 10.30 pm LPO got up to Baby L, and as her discomfort was disruptive, LPO took her into the loungeroom and slept there with her.

88. JHP gave evidence that the next morning Baby L awoke and looked exhausted. LPO checked Baby L's temperature which was normal, however she was quiet, watching as the other children opened birthday presents for one of JHP's sons. During breakfast, Baby L drank water and took a few small bites of toast. She was very clingy.

89. Although Baby L remained unwell, LPO and JHP decided that they would still take her to the Blazing Stump Hotel with the other children for a lunchtime birthday celebration. The available evidence suggests LPO, JHP and the children left for the Blazing Stump for an 11.30 am booking.

90. After arriving at the Blazing Stump Hotel, Baby L wandered into the playground with JHP's children. JHP gave evidence that sometime later one of her daughters approached the adults seated at the table and told them that Baby L was lying on the ground in the kids' room. One of JHP's other daughters then brought Baby L out of the playground

[15] Evidence of JHP: Transcript of 19 July 2022 p. 882.

back to the table where she was put into a highchair and offered food. Baby L refused food however she wanted water, so she was given an ice cube.

91. LPO gave evidence that Baby L began to vomit again, and he took her to the car to change her. He then brought Baby L back into the hotel and she went back into the playground. LPO told the Court that he continued to monitor Baby L throughout the afternoon, however as Baby L did not have a fever and had been taking fluids, he was not particularly worried about her presentation.

92. LPO, JHP and the children left the Blazing Stump at approximately 2.30 pm. LPO had work later that afternoon. When everyone returned to JHP's home LPO began to get ready for work and JHP bathed Baby L and put her to bed at around 3pm. LPO left for work at approximately 3.30 pm.

93. JHP stated that an hour or so later Baby L woke up. She got out of bed, went into the loungeroom and began to eat a small piece of toast in the loungeroom.

94. The Court heard Baby L sat with the food in her mouth, but she was not eating. JHP noticed Baby L's arms and legs became limp and she was staring at the TV. At the time Baby L was sitting in between JHP's legs. JHP then noticed that Baby L's body had stiffened, her back arched and her eyes widened.

95. JHP picked Baby L up and moved her to the bedroom. She noticed that Baby L's breathing had changed and her lips began to turn purple. Baby L made a soft moaning noise, and her body became limp and unresponsive. Emergency services were called at approximately 5.32pm. JHP also called LPO letting him know that she had called an ambulance for Baby L.

96. Paramedics arrived and worked on Baby L before transporting her by ambulance to the Albury Hospital, however given the seriousness of her condition Baby L was subsequently transferred by helicopter to the RCH.

97. Baby L was admitted to the ICU and remained critically unwell. She remained unconscious throughout her admission. Clinicians eventually indicated to LPO that

Baby L had a very poor prognosis and there was little they could do other than make her comfortable.

98. HPB was not notified of Baby L's predicament for some time, however as soon as she learned of the situation she made her way to the hospital to be with her daughter.

99. HPB was able to spend time with her precious daughter before Baby L sadly passed on 7 October 2018.

MEDICAL CAUSE OF DEATH

100. The legislation requires that a coroner, where possible, make a finding about the medical cause of a death.

101. At the conclusion of the evidence relating to the circumstances of Baby L's final weeks, the focus of the hearing moved to the medical experts to determine whether any of the circumstances detailed in the evidence was suggestive of a cause of Baby L's passing or served to exclude possible causes.

102. On 7 October 2018, Dr Timothy Davis, a Sessional Specialist Paediatrician with VFPMS, conducted an examination of Baby L whilst she was at the RCH (**the RCH examination**). The RCH examination noted there was no face or scalp bruising, no retinal haemorrhages, no subconjunctival haemorrhages, and no optical disk swelling was seen on the ophthalmoscopy assessment.

103. Dr Davis gave evidence about the numerous diagnostic test and examinations conducted on Bably L during her admission at the RCH[16]. He noted that whole pattern of bruising was in his opinion, not a result merely of normal toddler activities, and this raised significant concerns about her safety. Dr Davis also gave evidence that the tests performed on Baby L did not demonstrate an inherent susceptibility to bruise easily. However, Dr Davis specifically refrained from drawing a link between these observations and the cause of Baby L's critical illness, and none of these findings narrowed the broad differential in the RCH Medical Deposition as to the cause of Baby L's passing.

[16] Evidence of Dr Timothy Davis: Transcript of 9 September 2022 pp. 312-335.

104. The potential cause of death advanced in the RCH Medical Deposition was described as:

> "*Broad differential including infective aetiology (meningoencephalitis- viral or bacterial), aspiration event and respiratory arrest, primary seizure event or non-accidental injury*."[17]

105. On 9 October 2018, an autopsy was conducted by Dr Melanie Archer of VIFM. Dr Archer found the immediate medical cause of Baby L's passing was an initial collapse that saw a cardiac arrest with brain swelling.

106. In her report, Dr Archer noted:

a. Bruising, which mostly appeared aged and faded, and in a non-specific distribution.

b. No patterned bruising was seen, including no bruises resembling bite marks.

c. The neuropathology examination and ancillary tests showed changes in the corpus collosum indicative of traumatic injury. The injury has two possible explanations, which are both forms of brain trauma. A laceration can occur because of rotational impact of the corpus collosum against the falx membrane, or, as a consequence of brain swelling compressing the upper surface of the corpus collosum against the falx membrane.

d. The neuropathology examination also showed hypoxic ischaemic encephalopathy and myelopathy.

e. There were no lesions found that might cause a seizure, although Dr Archer caveated this observation by noting subtle findings may have been obscured due to time on a ventilator.

f. Dr Archer noted there was no evidence of any significant natural disease that could have caused or contributed to Baby L's passing.

[17] RCH Medical Deposition: Coronial Brief: pp. 55-66.

107. Dr Archer reported that a cerebrospinal fluid culture confirmed the presence of Human Herpes Virus type 6 DNA. Dr Archer observed in the context of this finding, that such an infection only rarely causes severe illness in immune-competent children, and it was not considered a likely explanation for Baby L's passing.

108. Postmortem toxicology showed substances consistent with therapeutic use, and there were no poisons detected.

109. In addition to the autopsy, Dr Linda Isles, Head of Forensic Pathology at VIFM, carried out a neuropathology examination following a referral from Dr Archer. Dr Iles prepared a report dated 6 May 2019.

110. Dr Isles gave evidence that Baby L suffered hypoxic ischemic injury to her brain whereby she suffered a period of poor or absent perfusion of blood to her brain. Baby L also suffered a cardiac arrest.[18]

111. In evidence Dr Archer told the court the question how Baby L came to have a cardiac arrest with brain swelling remains unsettled. Whether the cardiac arrest precipitated the catastrophic brain swelling or whether the catastrophic brain swelling precipitated the cardiac arrest could not be determined.

112. Dr Archer gave evidence that possible causes of Baby L's passing could include an externally delivered head trauma (including non-accidental and accidental injury), or natural disease, however Dr Archer stated it was not possible to favour one over the other as the cause of Baby L's passing.

113. Dr Archer was provided further information about a potential head strike to Baby L. Dr Archer was asked if this head strike could have been the cause of the laceration to the corpus callosum and the subdural bruising observed by Dr Iles, and whether this information would elevate an external head strike as the cause of the brain injury and passing. Dr Archer noted that a strike to a hard surface can lead to death, however there were limitations to what could be concluded from that information.

[18] Evidence of Dr Linda Isles: Transcript of 8 September 2018 pp. 184-223.

114. Dr Isles gave evidence the kind of trauma necessary to cause Baby L's collapse would need to have occurred "quite acutely" and "very proximate" to the time of her collapse on 6 October 2018.

115. In the circumstances, although I acknowledge it is deeply distressing for Baby L's family, I accept the evidence of the medical experts that the cause of Baby L's passing remains unascertained.

CONCLUSIONS AND FINDINGS AS TO THE CAUSE AND CIRCUMSTANCES OF BABY L'S PASSING

116. While it may be proper for a Coroner to receive a range of evidence in inquiring into the potential cause and circumstances of the death, it does not necessarily follow that the coroner has jurisdiction to make findings, comments or recommendations in relation to all matters canvassed in the evidence.

117. The authorities make clear that there is a broad discretion of the Coroner to hear evidence and inquire into matters that are potentially relevant to the cause of death, and a Coroner will not be exceeding their jurisdiction by inquiring into those matters provided:

    a. there is a proper basis for the Coroner to consider that the proposed matter is potentially causally related to the death under investigation;

    b. the matters have a sufficient causal connection with the particular death under investigation; and

    c. the matters are being inquired into for the purpose of making findings as to the cause and circumstances of the death under s 67(1) and not for the sole or dominant purpose of making comments.

118. Ultimately, however, the scope of each investigation must be decided on its facts, and the authorities make it clear that there is no prescriptive standard that is universally applicable, beyond the general principles discussed above.

119. The salient facts of Baby L's case included that at the time of her passing there was:

a. a history of bruising, marks and injuries in a 20 month old, non verbal child;

b. an open CP investigation file;

c. a criminal proceeding commenced by Victoria Police for unlawful assault; and

d. an unascertained cause of death.

120. Given these factors I considered it appropriate to examine Baby L's brief history of her time spent with her father and JHP, including her interactions with medical professionals, CDD, the CP and Victoria Police.

121. Whilst I am satisfied it was appropriate to hear evidence on these matters, based on the evidence I received at inquest, I must now consider the principles of causation and remoteness to ensure that I do not extend my findings to matters that are collateral and too remote from Baby L's passing as to be properly considered causative.

122. The standard, for making a finding that matters are 'connected with' the death for the purposes of making comment under section 67(3) or recommendations under section 72(2) of the Act, is not the same as the standard for making a finding as to the circumstances, which requires proximate connection.

123. In *Thales v Coroners Court*[19], Beach J adopted the interpretation of Muir J in Doomadgee v Clements that 'there was no warrant for reading "connected with" as meaning only "directly connected with", and that the range of matters connected with a death, for the purpose of comments or recommendations, can be 'diverse'.

124. In *Lucas-Smith v Coroners Court of the Australian Capital Territory,*[20] the Court considered the limits to the scope of a coroner's inquiry and the issues that may be

[19] *Thales Australia v Coroners Court (Vic) 2011 VSC 133.*
[20] *Peter Lucas Smith v The Coroners Court of the Australian Capital Territory (2009) ACTSC 40.*

considered. The Court found in the absence of a clear rule that operates to clearly delineate those limits, 'common sense' should be applied. Higgins CJ noted:

> *It may be difficult in some instances to draw a line between relevant evidence and that which is too remote from the proper scope of the inquiry. […] It may also be necessary for a Coroner to receive evidence in order to determine if it is relevant to or falls in or out of the proper scope of the inquiry*.

125. Thus, even when a Coroner has valid reason to cast a wide evidentiary net during an inquest as to matters that are "connected with" a death, it does not follow that findings, comments and recommendations can be made with respect to the breadth of matters canvassed in evidence.

126. The fact that a cause of death is unascertained, as is the case here, does not fetter my ability to make findings and comments. However, I must be satisfied that those matters about which I make comments or recommendations are proximate with the cause or circumstances of Baby L's passing.

127. Dr Archer characterised Baby L's passing as one of the most challenging and puzzling cases she had undertaken.[21] Although the immediate cause of Baby L's passing was cardiac arrest with brain swelling, Dr Archer was not able to determine which of those events precipitated the other. The sequence, which is usually able to be determined, was not obvious in this case.

128. Dr Archer explained to the court that when Dr Isles examined Baby L she observed a laceration to the top surface of the corpus collosum. Dr Archer reported this injury has two explanations which are both forms of brain trauma. Whilst both explanations involve trauma, one cause of that trauma can be natural, the other is due to inflicted trauma. Dr Archer told the court each of these mechanisms produce exactly the same appearance, therefore, in this case, the actual cause is unable to be differentiated.

[21] Evidence of Dr Melanie Archer: Transcript of 9 September 2022 p. 232.

129. Dr Isles was clear that this was not a case of gradual bleeding occurring in the brain, however she could not provide an opinion as to the cause of Baby L's passing. Relevantly however, Dr Isles gave evidence that the mechanism responsible for Baby L's fatal head trauma would likely have occurred in a matter of "minutes rather than hours"[22] before her collapse.

130. After hearing from the medical experts, particularly the evidence of Dr Isles, I was satisfied that I should exclude the cumulative effect of older bruising observed on Baby L, as in any way having caused or contributed to the catastrophic event that occurred on 6 October 2018.

131. Having considered the relevant case law, the available evidence and the written submissions of the parties, I have concluded that the history of Baby L's bruising and injuries sustained while she was living in Wodonga, and her interactions with CP and Victoria Police are not proximate circumstances to her passing. They are invaluable for context, and they form part of the narrative of Baby L's short life, however there is no valid evidentiary basis to characterise these events as sufficiently connected with Baby L's passing.

132. In these circumstances I find that:

    a. The identity of the deceased was Baby L, born 12 January 2017;

    b. The passing occurred at the RCH on 7 October 2018; and

    c. The medical cause of Baby L's passing remains unascertained despite a full post mortem examination and exhaustive ancillary investigations.

COMMENTS

I make the following comments connected with the passing under section 67(3) of the Act:

[22] Evidence of Dr Linda Isles: Transcript of 8 September 2022 p. 189.

a. The unexpected death of a young child is a devastating event. In this case, the pain and tragedy are only compounded by the fact that a cause of death is unable to be determined. The questions that remain unanswered will have an ongoing and significant impact on Baby L's family and those who loved and cared for her.

b. The absence of a specific cause for Baby L's passing means I am not able to identify any preventative measures that would prevent the occurrence of similar deaths.

I order that this finding be published on the court website subject to the usual conditions and the application of pseudonyms in accordance with my order dated 19 July 2022.

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

HPB

LPO

JHP

DFFH

CCP

CCD

Signature:

CORONER LEVEASQUE PETERSON

Date: 11 October 2024

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an inquest. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.