IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2015 004327
Related matters: COR 2016 002914
COR 2017 001028
COR 2017 002630

**Amended pursuant to section 76 of the Coroners Act 2008 (Vic) on 14 February 2025 by order of the State Coroner, Judge Cain.*

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)

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

Inquest into the Deaths of:

CHILD 1

CHILD 2

CHILD 3

CHILD 4

JUDGE JOHN CAIN, STATE CORONER

28 November 2024

A proceeding suppression order was made pursuant to section 18(2) of the *Open Courts Act 2013*, pseudonyms replace the names of all the deceased children, their family members, names of frontline workers and child protection practitioners.

** The name of the Maternal and Child Health Nurse has been removed from paragraph 2.169 and replaced with MCHN.*

Findings of:	Judge Cain, State Coroner
Delivered On:	28 November 2024 (Amended Finding 14 February 2025)
Delivered At:	Coroners Court of Victoria 65 Kavanagh Street, Southbank, Victoria, 3006
Hearing Dates:	14-25 February 2022, 1-11 August 2022, 15 December 2022, 15-17 February 2023, 20 April 2023 and 5 October 2023
Counsel Assisting the Coroner:	Ms Teresa Porritt and Ms Bonnie Renou of counsel, instructed by Mr Nicholas Ngai of the Coroners Court of Victoria
Representation:	Ms Erin Gardner and Mr Michael Allen of counsel representing the Secretary of the Department of Families, Fairness and Housing, instructed by Mr John Tuck and Ms Jade Saunders of Corrs Chambers Westgarth Mr Matthew Hooper of counsel representing Mallee Family Care, instructed by Mr David Guthrie and Ms Evie Xanthos of HWL Ebsworth Lawyers Ms Rachel Ellyard of counsel representing Uniting (Victoria & Tasmania) Limited, instructed by Mr Philip Battye and Mr Thomas Klepper of HWL Ebsworth Lawyers Ms Arna Delle-Vergini of counsel representing Victorian Aboriginal Child Care Agency (VACCA) instructed by France Prasad of VACCA internal legal service Ms Carmen Currie of counsel representing Darebin City Council, instructed by Ms Amber Davis and Ms Kirsten Sullivan of Maddocks Ms Deborah Foy of counsel representing Melbourne Health - North Western Mental Health, instructed by Ms Jan Moffatt of DTCH Lawyers
Keywords	Filicide; Family violence; Child Protection, Victoria Police, Corrections; Cluster Inquest

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ACKNOWLEDGEMENT & CULTURAL WARNING

Aboriginal and Torres Strait Islander readers are advised that this Finding contains the name of a deceased Aboriginal person.

Readers are warned that there may be words and descriptions that may be culturally distressing.

I acknowledge the Traditional Owners of the land where the Coroners Court of Victoria sat in this matter, the Wurundjeri and Dja Dja Wurrung peoples of the Kulin nations. I acknowledge their longstanding connection to Country, and I pay my respects to their Elders past and present.

Much of what this inquest has revealed is confronting and traumatic. I would like to acknowledge all the First Nations people who gave their time, evidence, and insights to my investigation. This process has benefited profoundly from their participation, and I acknowledge the emotional toll of their engagement in the coronial process.

PART ONE - CORONIAL INVESTIGATION

INTRODUCTION

1.1 Between 2016-2017, the Court received reports regarding the deaths of four children including Child 1, Child 2, Child 3, and Child 4. A review of the evidence collected by various coroner's investigators and the Victorian Systemic Review of Family Violence Deaths (**VSRFVD**)[1] culminated in a decision to group these deaths together and hold a public inquest into these deaths and key services that were involved with the deceased children and their immediate families.

1.2 I decided to hold a clustered inquest in these four children's deaths to understand the family violence risk factors that each child and their immediate families experienced in the lead up to the fatal incidents and explore any potential prevention opportunities.

1.3 Part of my duty is to give a voice to the four children who lost their lives in tragic circumstances. By understanding and learning from the circumstances surrounding their deaths, we are better able to make recommendations to develop processes, procedures and practices that enhance safety and work to prevent similar deaths from occurring in the future.

JURISDICTION AND PURPOSE OF THE CORONIAL JURISDICTION

1.4 The deaths of Child 1, Child 2, Child 3, and Child 4 constituted 'reportable deaths' pursuant to section 4 of the *Coroners Act 2008* (**the Act**), because their deaths occurred in Victoria, were unexpected, violent and resulted directly from injury.

1.5 The Coroners Court of Victoria is a specialist inquisitorial court.[2] The purpose of a coronial investigation is to independently investigate a reportable death to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which the death occurred.

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[1] The VSRFVD provides assistance to Victorian Coroners to examine the circumstances in which family violence deaths occur. In addition, the VSRFVD collects and analyses information on family violence-related deaths. Together this information assists with the identification of systemic prevention-focused recommendations aimed at reducing the incidence of family violence in the Victorian Community.

[2] Subsections 1(d) and 89(4) of the Act.

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

1.7 The circumstances in which the death occurred refers to the context or background and surrounding circumstances of the death. It is confined to those circumstances that are sufficiently proximate and causally related to the death.

1.8 The broader purpose of a coronial investigation 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. This is generally referred to as the prevention role.

1.9 Coroners are empowered to:

a) report to the Attorney-General on a death;[3]

b) comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice;[4]

c) make recommendations to any Minister or public statutory authority or entity on any matter connected with the death, including public health and safety or the administration of justice;[5]

These powers are the means by which the prevention role may be advanced.

1.10 Coroners are not empowered to determine any civil or criminal liability arising from the investigation of a reportable death and are specifically prohibited from including a finding or comment or any statement that a person is, or may be, guilty of an offence.[6] It is not the role of the coroner to lay or apportion blame but to establish the facts.[7]

[3] Section 72(1) of the Act.
[4] Section 67(3) of the Act.
[5] Section 72(2) of the Act.
[6] Section 69(1) of the Act. However, a coroner may include a statement relating to a notification to the Director of Public Prosecutions if they believe an indictable offence may have been committed in connection with the death. See ss. 69(2) and 49(1) of the Coroners Act.
[7] *Keown v Khan* (1999) 1 VR 69.

1.11 The coronial system should operate in a fair and efficient manner.[8] When exercising a function under the Act, a person should have regard to those factors set out in section 8, which includes the desirability of promoting public health and safety and the administration of justice.[9]

CORONIAL INQUEST

1.12 A coroner must hold an inquest if the coroner suspects a death was the result of homicide.[10] A coroner is not required to hold an inquest if a person has been charged with an indictable offence in respect of the death being investigated by the coroner.[11]

1.13 This inquest was not a mandatory inquest as it involved the deaths of four children and in each case, there was an individual charged with an indictable offence relating to the homicide of the deceased child.

1.14 Section 52(1) of the Act provides that a coroner may hold an inquest into any death that the coroner is investigating. I chose to exercise this discretion in a manner that is consistent with the preamble and purposes of the Act.

1.15 In deciding whether to conduct an inquest, I considered the following factors:

a) Where there is such uncertainty or conflict of evidence as to justify the use of the judicial forensic process;

b) Whether there is a likelihood that an inquest will uncover important systemic defects or risks not already known about;

c) Whether an inquest is likely to assist in maintaining public confidence in the administration of justice or other public agencies;

d) Whether the family or another person has requested an inquest; and

[8] Section 9 of the Act.
[9] Section 8(e) of the Act.
[10] Section 52 (2)(a) of the Act.
[11] Section 52(3)(b) of the Act.

e) To draw attention to the existence of circumstances which, if unremedied, might lead to further deaths.

1.16 It was apparent, upon reading all four coronial briefs of evidence initially prepared by the Coroner's Investigator, and after careful review of further evidence collected at my direction by the VSRFVD that the circumstances of each death raised concerns about services that had proximate contact with the deceased children and their immediate family with regard to the administration of justice and issues of public health and safety. Consequently, I determined that these issues warranted further investigation to:

a) Ascertain how each offender charged with an indictable offence in connection with the deaths of the four children came into contact with the child and their immediate families;

b) Understand the environment that allowed the offender to operate and navigate his way around the child protection and criminal justice system; and

c) Learn from the deaths of the four children to potentially reduce the risk of such events occurring again and to ensure that services that have a mandate to protect children are better able to anticipate and respond when confronted with similar circumstances.

1.17 I held an initial directions hearing on 12 November 2021 to consider the scope of the inquest, proposed witness schedule and preparing of the inquest brief.

INTERESTED PARTIES

1.18 The following parties were granted interested party status:[12]

a) Families of the four deceased children (**Families**)

b) Department of Families, Fairness and Housing (**Child Protection**)

c) Mallee Family Care (**MFC**)

[12] Section 56 of the Act.

d) Uniting (Victoria & Tasmania) Limited (**Uniting**)

e) Victorian Aboriginal Child Care Agency (**VACCA**)

f) Darebin City Council

g) Melbourne Health - North West Mental Health (**NWMH**)

h) Chief Commissioner of Police (**CCP**) (not involved in the inquest)

i) Department of Justice and Community Safety (**DJCS**) (not involved in the inquest)

SCOPE OF THE INQUEST AND WITNESSES

1.19 The purpose of the inquest was to investigate the following specific issues:

Child 1

Child Protection

1. What engagement did Child Protection have with Child 1 and her family in the lead up to the fatal incident?

2. At the time of the fatal incident, what were the applicable best practice guidelines in place for when Child Protection decided to close engagement with a child and their family? What did Child Protection consider when they decided to close engagement in July 2015 and were the best practice guidelines followed?

3. In 2015, what factors should have been considered by Child Protection workers when deciding whether statutory intervention was required with a family? Were these factors considered in relation to Child 1 and was the decision not to undertake statutory intervention reasonable in the circumstances?

4. When did Child Protection become aware that Child 1's mother had a new partner, Mr AI and what frequency and type of contact were they aware that Mr AI had with Child 1 and her siblings?

5. What steps were taken by Child Protection to gather information about any risks that Mr AI might have posed to Child 1 when he had contact with her; what assessments were made about his level of risk to Child 1; and what responses were put in place to mitigate any risk he posed?

6. What factors do Child Protection consider when determining whether a parent's partner meets the definition of a stepparent under the *Children Youth and Families Act 2005*? If Mr AI had been considered to meet the definition of a stepparent, would this have altered Child Protection's approach in assessing his risk to Child 1?

7. What is cumulative harm and what applicable policies were in place to determine how this was assessed in the context of Child Protection engagement with vulnerable children and their families in 2015?

8. Was cumulative harm assessed appropriately in the circumstances of Child 1's case according to the policies in place at the time, what are the requirements if this case occurred in present times?

9. To what extent was the allocated child protection practitioner supervised and/or provided an opportunity to consult with senior practitioners in respect of their management of the family and decision-making?

Mallee Family Care

1. What was Stronger Families' understanding of the protective concerns when they commenced engagement with the family? Was there sufficient opportunity to consult with Child Protection in relation to discussing the protective concerns for the family prior to and at the time their involvement ceased?

2. What information was provided to Stronger Families by Child Protection in relation to the wellbeing of Child 1 on the day before Child 1's death? What reporting obligations did Stronger Families have to Child Protection with respect to such information, and reporting to Child Protection in general about protective concerns for a family they were involved with? What mechanisms were in place for such reporting? What, if any, changes

have been made in respect of reporting requirements and mechanisms since Child 1's death?

Child 2

Child Protection

1. From 1 October 2015, what engagement and support did Child Protection provide to Child 2 and his family in the lead up to the fatal incident? What are the different statutory and policy requirements for engaging with Aboriginal and/or Torres Strait Islander children and how were these met in the circumstances of this case? Applicable statutory and policy requirements are to be set out as at the time of Child 2's passing and currently.

2. What were, and now are, the statutory and policy requirements for Child Protection to intervene in relation to unborn vulnerable children? What policies were and are now in place to guide practitioners in deciding whether to work voluntarily with a family or commence court proceedings? Why was the decision made to engage voluntarily with the family and not file a Protection Application at the time of Child 2's birth? Was this decision made in line with applicable policies at the time?

3. Prior to Child 2's birth on 21 December 2015, should Child Protection have undertaken a 'pre-birth' case conference?

4. From 1 October 2015, what are the policy requirements for Child Protection to conduct home visits to assess and evaluate the risks and appropriateness of a child's accommodation and living environment? Do these requirements differ depending on whether the family is involved with Child Protection on a voluntary basis or if there is a court order in place? Were these requirements met in the circumstances of Child 2's case?

5. What steps did Child Protection take to support Child 2's mother to safely retain care of Child 2 after their decision not to initiate court proceedings? During the period Child Protection were involved voluntarily with the family, what ongoing risk assessments took place to consider whether circumstances had changed such that a Protection Application

ought to have been filed? What policies were in place at the time about ongoing risk assessment and the need to consider court proceedings being commenced?

6. From 1 October 2015, what supervision was provided to the Child Protection practitioners involved with Child 2 and his family in the lead up to the fatal incident?

7. Were Child Protection aware that Child 2's mother had a new partner, Mr DL, and the contact that Mr DL was having with Child 2?

8. From 1 October 2015, what information was used by the Child Protection practitioners engaged with Child 2 and his family to assess Child 2's welfare and safety and to inform decision making by the practitioners? Was there any other information available that might have assisted Child Protection support Child 2 and his family?

VACCA – Cradle to Kinder

1. What were the relevant policies and legislative requirements to monitor and undertake risk assessments of families Cradle to Kinder (**C2K**) were assigned and were these complied with in the case of Child 2?

2. Were there any legislative or policy requirements to share relevant risk information about a C2K child client to agencies like Child Protection at the time of Child 2's death? What if any changes have been made to information sharing protocols/policies since Child 2's death?

3. At the time of Child 2's death, was education and training in place for C2K workers in relation to conducting risk assessments for families they had been assigned? What is the situation now?

Child 3

Child Protection

1. What engagement and support did Child Protection provide to Child 3 and her family in the lead up to the fatal incident? What risks were known and how were they mitigated?

2. Were Child Protection aware that Child 3's mother had reunited with her previous partner, Mr CQ, and if so the nature and extent of any contact he had with Child 3? Did Child Protection assess any risks that Mr CQ might have posed to Child 3 when he had contact with her and if so, what was put in place to mitigate that risk? What policies and procedures were in place at the time for Child Protection to assess the partners of parents and their contact with children subject to court orders, particularly orders where the Secretary held parental responsibilities?

3. Did Child Protection engage in safety planning with other agencies in relation to Child 3 spending weekends away from her foster care placement in the lead up to the fatal incident? What were the safety planning procedures and were these met in the circumstances of Child 3's case? Was Child Protection's oversight of the contact and safety plans completed by Bridges (now Uniting Wyndham) adequate?

4. Did Child Protection take steps to link Child 3's mother with housing or other supports to assist her to accommodate Child 3 more safely on weekends?

5. How did Child Protection ensure Child 3 received culturally appropriate services?

Uniting Care - Wyndham

1. What policies and procedures were in place at the time of Child 3's death in relation to the ongoing assessment of risk for children in their care, including those required by the service agreement with Child Protection? Were these complied with?

2. Who developed the safety plan for Child 3 in relation to contact with her mother? What information was relied upon? To what extent was Child Protection consulted? Where Child Protection have delegated case management to a contracted agency, who takes the lead on ensuring a client's risk assessment is up to date?

3. To what extent did Uniting have knowledge of and assess any risks to Child 3, including from Mr CQ and/or Child 3's illicit substance use? If there were risks identified, were any strategies put in place to mitigate the risks? To what extent did Uniting consult with Child Protection about risk assessment and mitigation?

4. Did Uniting take adequate steps to ensure Child 3 received culturally appropriate services? Did they meet their obligations under policy/legislative requirements at the time?

5. Did Uniting Care have adequate resourcing for frontline staff at the time of Child 3's passing, and what is the current state of resourcing?

VACCA

1. To what extent did VACCA support Child 3 and her immediate family in the lead up to her passing? Was Child 3's case appropriately recorded and followed up?

2. Did VACCA meet their obligations to Child 3 under the *Protocol between the Department of Human Services Child Protection Services and the Victorian Aboriginal Child Care Agency* (**the Protocol**)? Are there any challenges faced by Lakidjeka Aboriginal Child Specialist Advice and Support Service (**ACSASS**) in working with Child Protection to meet the intentions outlined within the Protocol, and are VACCA adequately resourced to do so?

Child 4

Child Protection

1. What engagement and support did Child Protection provide to Child 4 and her family in the lead up to the fatal incident? Were there any specific cultural issues or policies for Child Protection to consider when engaging children and their families from CALD backgrounds? Is this different to any requirements today?

2. What steps were taken to gather information pertaining to the welfare and risk posed to Child 4 following the notification made to Child Protection on 16 May 2017? What was the rationale behind classifying this notification as a 'wellbeing report' and making a referral to Child First? Was this decision and referral appropriate in the circumstances of Child 4's case?

Maternal Child Health Services

1. At the time of Child 4's death, what policies and legislative requirements were in place concerning the provision of information to Child Protection where a Maternal Child Health Nurse (**MCHN**) held concerns for the safety of a child? To what extent were these complied with in Child 4's case? In particular, should the MCHN have relayed their concerns for the family to Child Protection in addition to NWMH?

2. What policies, training and/or documentation and supervision was available to MCHNs at the time of Child 4's passing to provide guidance about monitoring and assessing any risk to children they saw? Were the cultural sensitivities applicable to this family adequately considered, and if so, how? Is the situation the same now?

3. To what extent are there measures in place to audit workforce compliance with policies, record keeping and supervision?

4. What were the qualifications, training and experience required of MCHNs at the time of Child 4's passing, and are they the same now?

North West Mental Health

1. What legislative requirements and policies were in place in 2017 to monitor, assess, record and report risk of harm to children who had either directly presented to the hospital, or who hospital staff knew were in the care of a parent who was a patient with mental health concerns? What changes, if any, have been made since Child 4's passing?

2. What education/training was in place for clinicians at the time, and has this changed since Child 4's passing? What were the options available for clinicians to discuss any concerns with a supervisor, either on a regular basis or a case-by-case basis? Has this changed today?

3. In Child 4's case, did NWMH discuss with Child Protection the further information provided to them by the MCHN, particularly as they were aware that Child Protection had closed their involvement on the same day? If not, should this follow up with Child Protection have occurred? What were the relevant information sharing protocols in place

at the time, and were they complied with? Have there been any relevant changes made since Child 4's passing?

4. Were there cultural sensitivities applicable to this family adequately considered, and if so, how? Has this changed today?

Child Protection (Common to all cases)

1. How do Child Protection's current policies and practices prevent similar deaths occurring again today?

2. What progress and updates can Child Protection provide to the Court about the work done following the recommendation to review and audit Child Protection policies and procedures in the case of Baby S (COR 2013 2108)?

3. What are the qualifications, experience and training required of child protection practitioners at the commencement of their employment and how does it differ for the various roles within Child Protection? To what extent is further training provided or mandated for practitioners (about new policies and legislative requirements and refresher education)? Is compliance monitored or audited? Does this vary across the regions?

4. What would Child Protection recommend as the ideal workload for a Child Protection practitioner? Is there a resourcing issue which impacts on the workload of child protection practitioners and their supervisors? Does this recommendation change depending on the team that the practitioner is in e.g. intake, investigations, case management, and if specified for contracted case management? To what extent is there monitoring and/or auditing of Child Protection workloads?

5. What progress has been made in relation to implementation of the *Child protection workforce strategy 2017-2020*, including any evaluations of improvements? And in the implementation of the *Child Protection workforce strategy 2021-2024*?

6. What is the rationale for the policy that approval is required to hold an investigation open beyond specific time periods without statutory intervention? How has this policy

impacted on the management of cases by front line workers?

7. Should there be a process whereby compliance with policy is regularly audited and reported on? What form should this audit take? Should this form of accountability be integrated with, or separate from professional supervision mechanisms?

1.20 The inquest was held over the course of 19 days from 14 to 25 February 2022, 1 to 11 August 2022, 15 December 2022, 15 to 17 February 2023, 20 April 2023, and 5 October 2023.

1.21 The inquest received oral evidence from 28 individuals, this included senior policy and operational leaders, former and current child protection practitioners, specialist child services workers, mental health clinicians, maternal child health nurses and lay witnesses.

1.22 A significant number of the witnesses and family members were visibly affected by the trauma of reliving the events of and the lead up to each fatal incident. The hearings were regularly punctuated by moments of trauma, pain and loss that intruded upon the memories and composure of those witnesses. I acknowledge their bravery, courage, and service to the Victorian public in giving evidence at the inquest.

1.23 The following witnesses gave evidence at the inquest:

Mallee Family Care

- Ms AF, Senior Case Worker, Stronger Families, Mallee Family Care
- Mr AG, Manager, Victorian Family Services, Mallee Family Care

Child Protection and /or DFFH

- Ms AH, Practice Leader, Child Protection, North Division, DFFH
- Ms BF, Senior Child Protection Practitioner, North Division, DFFH
- Tracy Beaton, Chief Practitioner for DFFH & Director of the Office of Professional Practice

- Ms BE, Team Manager, Child Protection, North Division, DFFH
- Kirsty Lomas, Statewide Principal Practitioner, Child Protection
- DI, Advanced Child Protection Practitioner, North Division,
- Ms DJ, Acting Team Manager, Child Protection, North West Areas Intake team

VACCA

- Ms BD, Senior Program Manager, VACCA and Manager of Cradle to Kinder program

Darebin City Council

- Ms DF, Maternal and Child Health Nurse, Darebin City Council
- Donna Karmis, Coordinator Family & Community Programs, Darebin City Council

Northern Area Mental Health Services and North West Mental Health Service

- DG, Psychiatric Nurse working as Key Clinician, Northern Area Mental Health Service
- Dr DL, Consultant Psychiatrist, Northen Area Mental Health Service
- Dr DM, Psychiatric Hospital Medical Officer, Northen Area Mental Health Service
- A/Prof (**A/Prof**) Vinay Lakra, Psychiatrist, North West Mental Health

Various

- Ms CN, Case Manager, Bridges Foster Care Program
- Ms DK, currently Team Leader of Child Youth and Family Services, Wyndham (was Coordinator/Program Manager, Bridges Foster Care, Uniting Care in 2017)

- Philip Yew, Senior Manager, Child, Youth, Family and Residential, Uniting Care

Expert

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

SOURCE OF EVIDENCE AND STANDARD OF PROOF

1.24 This finding draws on the totality of the coronial investigation into the deaths of Child 1, Child 2, Child 3, and Child 4. That is, the Court records maintained during the coronial investigation, the inquest brief, tendered exhibits, evidence adduced during the inquest and all oral and written submissions provided by Counsel Assisting and counsel representing the interested parties.

1.25 In writing this Finding, I do not purport to detail all the vast body of evidence before me. I have referred to relevant parts of it and only in such detail as appears warranted by the scope of the inquest, its forensic significance, and the interests of narrative clarity. The absence of reference to any particular aspect of the evidence should not lead to the inference that it has not been considered.

1.26 All coronial findings must be based on proof of relevant facts on the balance of probabilities.[13] The strength of evidence necessary to prove relevant facts varies according to the nature of the facts and the circumstances in which they are sought to be proved.[14]

1.27 In determining these matters, I am guided by the principles enunciated in *Briginshaw v Briginshaw*.[15] The effect of this and similar authorities is that coroners should exercise caution when considering adverse findings against, or comments about, individuals or entities.

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[13] *Re State Coroner; ex parte Minister for Health* (2009) 261 ALR 152.
[14] *Qantas Airways Limited v Gama* (2008) 167 FCR 537, [139] per Branson J, noting that his Honour was referring to the correct approach to the standard of proof in a civil proceeding in the Federal Court with reference to s. 140 of the *Evidence Act 1995* (Cth). *Neat Holdings Pty Ltd v Karajan Holdings Pty Ltd* (1992) 67 ALJR 170, 170-171 per Mason CJ, Brennan, Deane and Gaudron JJ.
[15] (1938) 60 CLR 336.

1.28 Proof of facts underpinning a finding that would, or may, have an extremely deleterious effect on a party's character, reputation or employment prospects demands a weight of evidence commensurate with the gravity of the facts sought to be proved.[16] Facts should not be considered to have been proven on the balance of probabilities by inexact proofs, indefinite testimony or indirect inferences. Rather, such proof should be the result of clear, cogent or strict proof in the context of a presumption of innocence.[17]

CHARTER OF HUMAN RIGHTS AND RESPONSIBILITIES

1.29 In making my finding, I have been mindful of the rights enshrined in the *Charter of Human Rights and Responsibilities Act 2006* (Vic) (**Charter**), as they are relevant to the coronial jurisdiction, particularly the right to recognition and equality before the law,[18] the right to life,[19] the right to liberty and security of the person[20] and the right to a fair hearing.[21]

AVOIDANCE OF HINDSIGHT BIAS

1.30 By its very nature, a coronial inquiry is wholly retrospective. This carries with it an implicit danger for the court in prospectively evaluating events through '*the potentially distorting prism of hindsight'*.[22] That is, it can be easy or seductive to conclude that what did occur was always going to occur and, from that conclusion, to view the actions or inactions of those involved more critically and as if the outcome was obvious and should have been foreseen. In writing this finding, I have remained cognisant of the potential intrusion of hindsight bias.

1.31 This was a matter addressed in detail in the written and oral submissions of some of the interested parties, and I was referred to various authorities on this point throughout the

[16] *Anderson v Blashki* [1993] 2 VR 89, following *Briginshaw v Briginshaw* (1938) 60 CLR 336.
[17] *Briginshaw v Briginshaw* (1938) 60 CLR 336, pp. 362-3 per Dixon J.
[18] Section 8 of the *Charter of Human Rights and Responsibilities Act 2006* (Vic).
[19] Section 9 of the *Charter of Human Rights and Responsibilities Act 2006* (Vic).
[20] Section 21 of the *Charter of Human Rights and Responsibilities Act 2006* (Vic).
[21] Section 24 of the *Charter of Human Rights and Responsibilities Act 2006* (Vic).
[22] *Adamczak v Alsco Pty Ltd* (No 4) [2019] FCCA 7, [80].

coronial investigation and inquest process.[23] It was submitted that the temptation to use hindsight is particularly pronounced in the context of considering issues of causation and whether, if other action had been taken, or if opportunities for apprehension were missed, that another and better outcome would or might have ensued.[24]

1.32 Further, in the context of understanding the decisions and services provided by frontline service workers, it was submitted this must be judged by reference to the pressure of events and the agony of the moment, not by reference to hindsight.[25]

1.33 I acknowledge that throughout the available evidence, decisions were made quickly and in dynamic circumstances beset by competing considerations and this readily attracts the '*agony of the moment'* principle. However, that is not to say that the mere fact that a person decided to act or not act means that the moment involved '*agony'*. Much depends upon the circumstances, and there can be questions of degree involved. I have carefully considered the various submissions made on this topic and borne the phenomenon steadily in mind when making the findings required of me in performing my statutory function.

PROCEDURAL FAIRNESS

1.34 Coronial investigations must be conducted in a fair and efficient manner, complying with the rules of natural justice and procedural fairness.[26] The principle of natural justice requires that any person or entity that may potentially be the subject of an adverse criticism or finding, must be afforded the opportunity to be heard on that matter.[27]

1.35 I acknowledge and naturally have considered the requirements of procedural fairness, including the 'rule' in *Browne v Dunn*.[28] However, to some extent, the written

[23] See *Brodie v Singleton Shire Council* (2001) 206 CLR 512, [320]; *Hawthorne v Hillcoat* [2008] NSWCA 340, [47]; *Vairy v Wyong Shire Council*(2005) 223 CLR 422, [443]; *Neindorf v Junkovic* (2005) 222 ALR 631, [93] per Hayne J; *Roads and Traffic Authority (NSW) v Dederer* (2007) 24 CLR 330, [65]-[66] per Gummow J; *DPP v Hicks* (No 1) (2014) 240 A Crim R 171, [74]-[75].
[24] Written submissions submitted on behalf of Secretary to the Department of Families, Fairness and Housing dated 28 February 2024, 5.
[25] *Woodley v Boyd* [2001] NSWCA 35, [37].
[26] *Coroners Act 2008* (Vic), s. 9; *Annetts v McCann* (1990) 170 CLR 596; *Harmsworth v State Coroner* [1989] VR 989, 994.
[27] *Annetts v McCann* (1990) 170 CLR 596, p. 601.
[28] (1893) 6 R 67.

submissions tended to advance the underlying proposition a little too baldly, as if no finding can ever be made unless a specific piece of '*puttage'* appears in which that particular proposition was asked and answered. That is not the law,[29] certainly not in respect to witnesses whose evidence was to a significant extent under general challenge.

1.36 Further, the limits of such a requirement must be borne in mind in the present; in which there is a written scope of inquiry, all witnesses called have made written statements and many other witnesses have also made written statements that, together, are compiled in a Coronial Brief available to all interested parties. In those circumstances, it is and was evident in the hearing that, where particular matters were in issue, the witnesses and their counsel were quite aware of the competing propositions.

1.37 For these reasons, I take account of the various submissions (including those of parties who have had limited involvement with the inquest including the Chief Commissioner of Police in relation to Child 3 and the Department of Justice and Community Safety in relation to Child 2) made concerning procedural fairness and the '*rule'* in *Browne v Dunn*,[30] but certainly do not accept that in the present circumstances the operation of that '*rule'* prevents me from making findings, including adverse findings, unless the transcript contains some precise point at which the finding, in the terms that I would find it, appears and is '*put'*. That would not be warranted and is also not the law.

PART TWO - THE FOUR DECEASED CHILDREN

2.1 With the benefit of the substantial material in the Coronial Brief, and to avoid unnecessary duplication, a statement of facts and circumstances was agreed among the interested parties and forms the basis for the factual findings in the inquest. These agreed facts and circumstances are set out in full in the finding. I am grateful to all parties for their work in reaching agreement as it has saved significant Court time in the running of the inquest and narrowed the scope of the inquest. The agreed facts and circumstances tell me what happened, and the focus was then able to shift to focus on why.

[29] *Casey v Transport Accident Commission* [2015] VSCA 38, [39]-[40].
[30] (1893) 6 R 67.

CHILD 1

BACKGROUND

2.2 Child 1 was two and a half years old when she was discovered deceased on 25 August 2015. Child 1 was the youngest of four siblings born to Ms AA and Mr AB. Child 1's three older siblings, AC, AD and AE were aged seven, six and five, respectively at the time of Child 1's passing.[31]

2.3 Child Protection received three reports concerning Child 1's siblings prior to Child 1's birth, and two reports during Child 1's lifetime.[32] The protective concerns noted prior to Child 1's birth included her siblings' exposure to verbal family violence between her parents; insufficient supervision of the children; and underdeveloped parenting skills.[33] All three reports were closed at intake. The family engaged with Mallee Family Care (**MFC**) from May 2010 to June 2011.[34]

2.4 The first report to Child Protection in March 2013 following Child 1's birth was the fourth in relation to the family, with a consistent theme of the children being exposed to family violence.[35] Child Protection made unsuccessful attempts to contact the parents during that time, and proceeded to closure on the basis that it was understood they had separated.[36] It was believed this would reduce the risk of the children being exposed to further family violence.[37] Child Protection Deputy Area Manager, Ms AH, gave evidence that there were a range of things Child Protection could have explored with the family after this report, prior to closure.[38]

2.5 The second report in relation to Child 1 (and fifth in relation to the sibling group) was received on 17 February 2015 after AC showed a teacher a bruise on her upper thigh

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31 Child Protection CRIS records, Intake Document, Inquest Brief Part 1, v2.2 at [865].
32 See AH statement, CB1-5268, [13]-[14], [34]].
33 See intake report commencing in Inquest Brief Part 1, v2.2 at [865].
34 See intake report commencing in Inquest Brief Part 1, v2.2 at [865].
35 See intake record CRIS, Inquest Brief Part 1, v2.2 commencing at [865].
36 Statement of AH, 17 July 2017, paragraph 9, Inquest Brief Part 1, v2.2 at [882]; Oral evidence of Tracey Beaton, Inquest transcript of evidence for 24 February 2022, pages 574-575.
37 Statement of AH, 17 July 2017, paragraph 10, Inquest Brief Part 1, v2.2 at [882].
38 Oral evidence of AH, Inquest transcript of evidence for 16 February 2022, 184-185.

which looked like a hand mark, which she said was caused by Mr AB.[39] During the Child Protection investigation, [40] Mr AB admitted he had used physical discipline, and during the intervention Ms AA was assisted to enter refuge accommodation.[41] Referrals were made for Mr AB to undertake a men's behaviour change program and drug and alcohol counselling,[42] and for Ms AA to engage with MFC's Family Preservation Program (**FPP**)[43] for parenting supports.[44]

2.6 MFC is a provider of human services in the fields of family, youth and children, disability, mental health, housing and settlement, legal, financial, research and education in the Mallee area on both sides of the Victorian and New South Wales border.[45] MFC ran various programs for families and children including the FPP and the Stronger Families Program funded by DFFH,[46] both of which the family was referred to by Child Protection.

2.7 The work of MFC is guided by a '*family action plan'* developed with the parents following referral from Child Protection. Child Protection are not required to endorse this plan.[47] The referral to the FPP was made by Child Protection on 26 February 2015, and Child Protection provided MFC with a summary of Child Protection's intake reports from 28 April 2010.[48] From the time of referral, 12 hours of support were provided to the family by the FPP until their referral to the Stronger Families program on 1 May 2015.[49]

2.8 The FPP ran for up to 12 weeks while Child Protection's case remained open. That program was aimed at facilitating contact between Mr AB and the children, as well as strengthening consistent parenting skills between the households.[50] The program noted Ms AA was sleeping during the day and that environmental concerns continued during

[39] Statement of AH, 17 July 2017, paragraph 11, Inquest Brief Part 1, v2.2 at [882].
[40] Statement of AH, 17 July 2017, paragraphs 11 to 15, Inquest Brief Part 1, v2.2 at [882].
[41] Statement of AH, 17 July 2017, paragraph 16 to 18, Inquest Brief Part 1, v2.2 at [883].
[42] Statement of AH, 17 July 2017, paragraph 21, Inquest Brief Part 1, v2.2 at [883].
[43] The Family Preservation Program was an intensive placement prevention program designed to work with families at imminent risk of having children removed from their care. The 12-week program worked toward addressing protective concerns with targeted and intensive supports, guided by intervention goals identified by the family.
[44] Statement of AH, 17 July 2017, paragraph 22, Inquest Brief Part 1, v2.2 at [883].
[45] Statement of AG, undated, paragraph 4, Inquest Brief Part 1, v2.2 at [5841].
[46] Then DHHS, Statement of AG, undated, paragraph 6, Inquest Brief Part 1, v2.2 at [5842].
[47] Oral evidence of AH, Inquest transcript of evidence for 16 February 2022, pages 227-228.
[48] Statement of AF, undated, paragraph 10, Inquest Brief Part 1, v2.2 at [5689].
[49] Statement of AF, undated, paragraph 12 & 14, Inquest Brief Part 1, v2.2 at [5690].
[50] Statement of AH, 17 July 2017, paragraph 25, Inquest Brief Part 1, v2.2 at [884].

the intervention.[51] The children were engaged with the Mallee Sexual Assault Unit (**MSAU**).[52] At a home visit on 1 April 2015, Ms AA was warned that if she was unable to address the significant environmental concerns in the home within three weeks, then Child Protection would pursue legal intervention.[53]

2.9 On 2 April 2015, a further report was received by Child Protection that the children had been associating with a male neighbour who had previously been investigated for stalking underage girls. Ms AA informed a neighbour that AD and AE had returned home from his house without all their clothes as the neighbour had told them to take a shower, and also that he had kissed the children.[54] Victoria Police's Sexual Offences and Child Abuse Investigation Team (**SOCIT**) investigated, and the children said they had gone to the neighbour's house while Ms AA had been sleeping. During SOCIT's investigation, Ms AA said she subsequently stopped allowing the children to go to the neighbour's house.[55]

2.10 On 8 April 2015, during a joint home visit between Child Protection and MFC, it was noted that Ms AA had made minimal changes during the period of intervention.[56] She was again warned that a protection application may be pursued if she was not able to demonstrate appropriate boundaries for the children or improvement with respect to the environmental concerns.[57]

2.11 On 1 May 2015, the MSAU worker advised Child Protection that the children had reported Ms AA had a new boyfriend.[58] On the same day at a home visit, Ms AA told Child Protection her new partner's name was '*A'* who resided at 8 Oram Court.[59] She told Child Protection she was aware he was on bail and had to report daily, and that he had

[51] Statement of AH, 17 July 2017, paragraph 27, Inquest Brief Part 1, v2.2 at [884].
[52] Statement of AH, 17 July 2017, paragraph 28-29, Inquest Brief Part 1, v2.2 at [884].
[53] Statement of AH, 17 July 2017, paragraph 32, Inquest Brief Part 1, v2.2 at [884].
[54] Statement of AH, 17 July 2017, paragraph 33-34, Inquest Brief Part 1, v2.2 at [884]-[885].
[55] Statement of AH, 17 July 2017, paragraph 34 & 40, Inquest Brief Part 1, v2.2 at [884]-[885].
[56] CRIS notes, Inquest Brief Part 1, v2.2 at [645]-[646].
[57] CRIS notes, Inquest Brief Part 1, v2.2 at [645]-[646].
[58] CRIS notes, Inquest Brief Part 1, v2.2 at [607].
[59] Statement of AH, 17 July 2017, paragraph 41-42, Inquest Brief Part 1, v2.2 at [885].

offences for assault. Ms AA was advised by Child Protection that they would return on Monday to assess the home.[60]

2.12 Child Protection had determined on 1 May 2015 that a protection application would not be pursued, rather Ms AA would be referred to MFC's Stronger Families program.[61] The FPP ceased at eight weeks, as it was identified there had been little progress toward the family's goals, and Stronger Families would be able to continue to support the family for 12 months.[62]

2.13 On 5 May 2015, at the next home visit, Child Protection had found Ms AA at Mr AI's home, who appeared to be hiding from the Child Protection workers, and told them over the phone she was down the street shopping. [63] She subsequently allowed the home visit and Child Protection were able to view her house, as had been foreshadowed on 1 May, and it was observed that the home environment had not improved.[64]

2.14 At a subsequent joint home visit on 13 May 2015 Ms AF from Stronger Families attended and discussed the program with Ms AA.[65] At this visit, Ms AA provided the full name of her new partner, Mr AI, but could not provide his date of birth.[66]

2.15 Stronger Families was seen as appropriate for the family given their flexible approach to service delivery, as well as a coordinated approach between agencies.[67] There was consistent communication between Child Protection and Stronger Families including joint home visits.

2.16 A professionals meeting was convened by MFC on 27 May 2015.[68] Among the issues discussed was that '*A'* had previously been incarcerated for physical assault, and it was

[60] Statement of AH, 17 July 2017, paragraph 44, Inquest Brief Part 1, v2.2 at [885].
[61] CRIS notes, Inquest Brief Part 1, v2.2 at [608].
[62] See MFC Family Preservation Program Final Report, Inquest Brief Part 1, v2.2 commencing [591].
[63] CRIS notes, Inquest Brief Part 1, v2.2 at [587].
[64] CRIS notes, Inquest Brief Part 1, v2.2 at [587].
[65] Inquest Brief Part 1, v2.2 at [565].
[66] Statement of AH, 17 July 2017, paragraph 51, Inquest Brief Part 1, v2.2 at [887]; Inquest Brief Part 1, v2.2 at [565].
[67] Statement of AF, undated, paragraph 29, Inquest Brief Part 1, v2.2 at [5693]; Oral evidence of AH, Inquest transcript of evidence for 17 February 2022, pages 340-341.
[68] As confirmed in the statement of AF, undated, paragraph 35, Inquest Brief Part 1, v2.2 at [5694].

noted the '*Children are not to sleep over at A's home*.'[69] MFC Senior Case Worker, Ms AF, indicated it was her view that Child Protection would communicate that decision to Ms AA.[70] Ms AF could not recall (and there was no record of her) discussing this with Ms AA herself at the next home visit, or follow up why that recommendation had been made at the professionals meeting.[71] Ms AF further said in oral evidence that she had assumed Child Protection had that discussion with Ms AA.[72]

2.17 The determination that the children were not to spend overnight at Mr AI's residence was recorded at this professionals meeting, as set out above. Child Protection relevant policy guidance indicated that, '*where there is evidence that a parent's capacity to make sound decisions regarding their child's exposure to others is compromised, a criminal history check on persons having contact with the child may be appropriate*'.[73]

2.18 Child Protection were then informed by Ms AF on 9 June 2015 the family (including Mr AI) intended on travelling to Shepparton in the school holidays.[74] The trip ultimately did not occur as Ms AA was told Child Protection would need to approve it.[75]

2.19 In her evidence at inquest, Principal Practitioner Tracy Beaton confirmed that to obtain a criminal history check, Child Protection needed a full name and date of birth. The first date on which Child Protection was provided with Mr AI's date of birth was 2 June 2015.[76] On that occasion, Mr AI's name was falsely given as '*Johnny Gimm*'. His name was later corrected by Victoria Police. Child Protection were also made aware during the 2 June 2015 home visit that Mr AI no longer had contact with his children.[77] It does not appear that CRIS was checked following this information to identify if Mr AI had been noted as a person responsible for harm.

[69] CRIS notes, Inquest Brief Part 1, v2.2 at [553]-[555]; Statement of AF, undated, paragraph 35, Inquest Brief Part 1, v2.2 at [5694].
[70] Oral evidence of AF, Inquest transcript of evidence for 14 February 2022, page 41.
[71] Oral evidence of AF, Inquest transcript of evidence for 14 February 2022, pages 41-43.
[72] Oral evidence of AF, Inquest transcript of evidence for 14 February 2022, pages 42.
[73] 'Criminal history checks' Advice 1524, 23 May 2013, Inquest Brief Part 1, v2.2 commencing at [4436].
[74] CRIS notes, Inquest Brief Part 1, v2.2 at [536].
[75] Oral evidence of AF, Inquest transcript of evidence for 14 February 2022, page 50.
[76] Oral evidence of Tracey Beaton, Inquest transcript of evidence for 25 February 2022, page 711.
[77] See CRIS note, Inquest Brief Part 1, v2.2 at [549]-[550].

2.20 Child Protection conducted a criminal records check on Mr AI and received a history from Victoria Police on 4 June 2015 (including that there were intervention orders in each of Victoria, NSW, and Queensland in which he was named as the respondent).[78] On 4 June 2015, Child Protection advised Ms AF of Mr AI's history of perpetration of family violence (noted in email correspondence as '*A is a DV perp!)*[79] Ms AF intended on following up this issue with the children's counsellor,[80] and did so on 5 June 2015.[81]

2.21 Ms AF identified that risk assessment in relation to Mr AI was Child Protection's responsibility[82] and she had not herself pursued more information.[83] Ms AF gave evidence that she had never been made aware of the extent of his history of family violence offending, and was only apprised of this in the witness box at this inquest.[84] She said it would have assisted her intervention with the family if she had have been provided with the information.[85]

2.22 Further records were obtained on 5 June 2015, with that CRIS note titled '*CRIMINAL RECORDS CHECK AI – NOT SATISFACTORY'*.[86] Child Protection received an interstate history on 19 June 2015, the corresponding CRIS note again titled '*UNSATISFACTORY.*'[87] The Victorian and interstate records each demonstrated a history of violent and other offending over the previous ten years by Mr AI.[88]

2.23 On 6 June 2015, the Stronger Families worker reported to Child Protection that Ms AA's home was very clean, but that the worker was concerned about Mr AI as he had arrived at the home and smelled strongly of cannabis.[89]

2.24 Ms AF relayed to Child Protection the improvements that had been made with respect to the environmental concerns following a home visit on 9 June 2015, with Child Protection

[78] CRIS notes, Inquest Brief Part 1, v2.2 at at [547].
[79] Statement of AF, undated, paragraph 37, Inquest Brief Part 1, v2.2 at [5694].
[80] Statement of AF, undated, paragraph 37, Inquest Brief Part 1, v2.2 at [5694].
[81] Statement of AF, undated, paragraph 74, Inquest Brief Part 1, v2.2 at [5701].
[82] Oral evidence of AF, Inquest transcript of evidence for 14 February 2022, page 45.
[83] Oral evidence of AF, Inquest transcript of evidence for 14 February 2022, page 48.
[84] See oral evidence of AF, Inquest transcript of evidence for 14 February 2022, pages 54-58.
[85] Oral evidence of AF, Inquest transcript of evidence for 14 February 2022, page 58.
[86] CRIS note, Inquest Brief Part 1, v2.2 at [545].
[87] CRIS note, Inquest Brief Part 1, v2.2 at [531].
[88] Statement of AH, 17 July 2017, paragraph 56, 57, Inquest Brief Part 1, v2.2 at [888].
[89] Statement of AH, 17 July 2017, paragraph 58, Inquest Brief Part 1, v2.2 at [888].

Team Manager, Ms AJ responding that Mr AI seems to have been contributing to this '*despite the concerns I have about his history*.'[90] At this same home visit, Mr AI disclosed inappropriate discipline methods in the form of making the children stand with their arms horizontal until their arms fell down, and making them apologise, which Ms AF relayed to Child Protection.[91]

2.25 At a home visit on 10 June 2015 with the father Mr AB, Ms AF noted that Mr AB admitted to telling the children that '*[Mr AI] probably does needles*" in order to make the children stop speaking positively about him.[92]

2.26 On 26 June 2015 it was communicated by Ms AJ to Ms AF that Child Protection were considering closure and that '*I know [Mr AI] is a concern, however given he hasn't done anything to date, we can't hold the case open on the chance that he does start committing family violence*.'[93] It was noted in CRIS that at the point of closure, Mr AI was classified as a stepfather.[94]

2.27 At Child Protection's final joint home visit with MFC on 10 July 2015, where closure of the Child Protection investigation was discussed, it was documented that should the family '*cease to engage with services and the home environment deteriorate, a further report will be raised with CP and the likelihood of the Court action is high*.'[95] The closure correspondence from Child Protection to MFC, Ms AA and Mr AB also provided a local contact number for Child Protection should they seek further discussion or information.[96] Ms AF indicated that this was not in fact the process at the time, and that they could not consult formally or informally[97] with Child Protection post-closure (only re-report).[98] Stronger Families' Family Services Manager, Mr AG, concurred with this position, and that because of policy constraints, section 38 consultations[99] were not available to the

[90] Statement of AF, undated, paragraph 38, Inquest Brief Part 1, v2.2 at [5695].
[91] Statement of AF, undated, paragraph 40, Inquest Brief Part 1, v2.2 at [5695]; see also contemporaneous record at [5771].
[92] Statement of AF, undated, paragraph 40, Inquest Brief Part 1, v2.2 at [5695].
[93] Inquest Brief Part 1, v2.2 at [526].
[94] See CRIS records, Inquest Brief Part 1, v2.2 at at [483].
[95] CRIS note, Inquest Brief Part 1, v2.2 at [497]-[498].
[96] See CRIS notes, Inquest Brief Part 1, v2.2 at [476], [478] & [479].
[97] Oral evidence of AF, Inquest transcript of evidence for 14 February 2022, pages 59-60; 92-93; 96-97.
[98] Child and Family Information Referral and Support Teams (Child FIRST), services in The Orange Door, and registered family services, are able to consult with child protection at any time under section 38 of the *Child, Youth and families Act 2005* (Vic).
[99] Oral evidence of AG, Inquest transcript of evidence for 15 February 2022, pages 137-138.

Stronger Families practitioners. It was put to Mr AG that there did not appear to be any impediment in the legislation or service agreement to such a consultation for his workers, however Mr AG maintained it was the agreed practice – and he believed contained in the extant program guidelines (not produced) – that such a consultation was not available to Stronger Families practitioners.[100]

2.28 Stronger Families were also not able to consult with the community-based Child Protection practitioners on Ms AF's evidence.[101] Ms AH's evidence was that she believed Stronger Families would have been able to as would all community programs permitted under section 38, or via direct contact to the previous worker.[102]

2.29 Child Protection closed on 13 July 2015.[103] The case closure decision had been made in the context of the children engaging in counselling,[104] having improved their school and childcare attendance, the environmental concerns having been addressed, and the ongoing engagement with MFC.[105] MFC and other services were to monitor any ongoing risks. At the time of Child Protection's proposed closure of the file, Ms AF's view was that given Child Protection were privy to more information than MFC, their determination to close its case would be on the basis of the entirety of that constellation of factors.[106] At the time of giving her evidence in this inquest, it was her view that if she had knowledge of Mr Ai's history of family violence she would not have supported closure.[107]

2.30 In the lead up to the fatal incident, Child 1 ceased attending childcare. Ms AA stated she was concerned about injuries on Child 1 and what childcare might conclude as she did not want to be blamed for accidental injuries.[108] The childcare service did not advise MFC of Child 1's absenteeism, but MFC would not necessarily expect them to unless they had specific concerns about a child.[109]

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[100] Oral evidence of AG, Inquest transcript of evidence for 15 February 2022, 150-152, 154, though he could not produce any document evidencing this, see page 154.
[101] Oral evidence of AF, Inquest transcript of evidence for 14 February 2022, pages 96-97.
[102] Oral evidence of AH, Inquest transcript of evidence for 17 February 2022, pages 296-298, 300.
[103] Statement of AH, 17 July 2017, paragraph 71, Inquest Brief Part 1, v2.2 at [890].
[104] See CRIS record, Inquest Brief Part 1, v2.2 at [482].
[105] Ibid.
[106] Oral evidence of AH, Inquest transcript of evidence for 14 February 2022, pages 53-54.
[107] Oral evidence of AF, Inquest transcript of evidence for 14 February 2022, pages 54, 58-59.
[108] Statement of AA, 25 August 2015, Inquest Brief Part 1, v2.2 at [129].
[109] Oral evidence of AF, Inquest transcript of evidence for 14 February 2022, page 60-61.

2.31 Ms AF was informed by Ms AA in August about the children being defiant in putting their toys away, and her response being confiscating their toys for a period of three months, and Mr AI sending the children to their rooms for extended periods of time.[110] MFC discussed with Ms AA and Mr AI '*why that was an inappropriate consequence for unwanted behaviour and offered an alternative strategy*'[111] but they were not referred to any specific or additional support.[112]

2.32 Ms AF also received information from Mr AB on 14 August 2015 that Mr AI was denying his access with the children.[113] Mr AB further alleged a mutual friend had told him that Mr AI has asked him to obtain methylamphetamine ('ice'), and that Mr AB believed he needed to get the children out of the house '*and fast*' before it was too late.[114] Ms AF made contact with the parents to follow up on these issues. Mr AB repeated the allegation regarding illicit substances and Mr AI at a home visit on 18 August 2015, however Ms AF responded she had '*no evidence*' she could use to make a report to Child Protection.[115]

2.33 When Ms AF reached Ms AA by phone on 18 August 2015 to follow up on Mr AB's allegations, she did not raise the allegation about Mr AI and ice directly with Ms AA.[116] When pressed about why, Ms AF thought it might have been because Mr AB had previously conceded making similar allegations falsely, but also because of the conflict between the parents, and because Mr AI was within earshot of Ms AA.[117] Ms AF did not have any collateral evidence such as her having seen Mr AI acting ice-affected or erratic.[118] No other service had reported Mr AI presenting as drug affected, and Mr AB's information had been third-hand.[119] Ms AF provided Mr AB with the Child Protection intake number on 24 August 2015 for him to contact if he had any significant concerns for the children's safety and wellbeing.[120]

[110] Statement of AF, undated, paragraph 61, Inquest Brief Part 1, v2.2 at [5699].
[111] Oral evidence of AF, Inquest transcript of evidence for 14 February 2022, page 53.
[112] Oral evidence of AF, Inquest transcript of evidence for 14 February 2022, page 52.
[113] Statement of AF, undated, paragraph 58, Inquest Brief Part 1, v2.2 at [5698-9].
[114] Statement of AF, undated, paragraph 59, Inquest Brief Part 1, v2.2 at [5699].
[115] Statement of AF, undated, paragraph 62, Inquest Brief Part 1, v2.2 at [5699].
[116] Oral evidence of AF, Inquest transcript of evidence for 14 February 2022, page 65.
[117] Oral evidence of AF, Inquest transcript of evidence for 14 February 2022, page 65.
[118] Oral evidence of AF, Inquest transcript of evidence for 14 February 2022, page 100.
[119] Oral evidence of AF, Inquest transcript of evidence for 14 February 2022, page 66.
[120] Statement of AF, undated, paragraph 66, Inquest Brief Part 1, v2.2 at [5700].

2.34 Ms AF had a home visit planned with Ms AF on 27 August 2015 but this did not proceed. There was no further contact between MFC and the family prior to Child 1's passing.

CIRCUMSTANCES LEADING TO THE FATAL INCIDENT

2.35 On 25 August 2015, Child 1 was reported missing to the Mildura Police by Ms AA after she was put to sleep at 11.00am, and then not found in her room when Ms AA woke after a nap at 2.40pm.[121] Ms AA said Mr AI encouraged her to collect the other children from school, which she did at 2.50pm.[122] Child 1's body was eventually discovered by police later in the afternoon in the roof cavity of the family home.

2.36 Mr AI was tried for murder and manslaughter before the Victorian Supreme Court sitting in Mildura, and on 23 April 2018 he was acquitted of both charges by a jury. Mr AI had given evidence that he had helped to conceal the body, but that Ms AA was responsible for Child 1's death

IDENTITY OF THE DECEASED

2.37 Child 1 was visually identified by her father on 28 August 2015. Identity is not in dispute and requires no further investigation.

MEDICAL CAUSE OF DEATH

2.38 On 26 August 2015, Dr Yeliena Baber, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, performed an autopsy on the body of Child 1.

2.39 Upon review of all the evidence from autopsy and post-mortem CT scans, Dr Baber provided a written report dated 5 January 2016. She concluded that Child 1's death was due to blunt force trauma to the chest and abdomen and that Child 1 had evidence of experiencing repeated blows to these areas resulting in severe trauma to the liver with haemorrhage into the peritoneal cavity, large bowel mesentery and around the right kidney as well as haemorrhage into the diaphragm, both lungs and the soft tissue anterior to the heart. I accept Dr Baber's opinion.

[121] Statement of AA, dated 25 August 2015, Inquest Brief Part 1, v2.2 at [124].
[122] Statement of AA, dated 25 August 2015, Inquest Brief Part 1, v2.2 at [124].

CHILD 2

BACKGROUND

2.40 Child 2 was six months old when he passed on 26 June 2016. Child 2 was identified as being of Aboriginal descent by his mother, Ms BA. Ms BA separated from Child 2's father, Mr BB, before he was born. Child 2 died after being assaulted by Ms BA's then-partner, Mr BJ.

2.41 Prior to Child 2's death, Mr BJ had been charged and sentenced in relation to several offences. Between 2013 and 2015, Mr BJ was sentenced to three terms of imprisonment for armed robbery, reckless conduct endangering life, unlawful assault, committing an indictable offence whilst on bail, retention of stolen goods and unlicensed driving.[123] On 17 September 2015, Mr BJ was also sentenced to a 12-month Community Corrections Order (**CCO**) after being found in possession of methylamphetamine. Mr BJ was simultaneously sentenced to a 12-month Commonwealth Corrections Order for the possession of counterfeit money.[124]

2.42 Mr BJ continued to have contact with police,[125] accrued further charges,[126] was excluded from his residential address by virtue of a family violence intervention order,[127] and served a further custodial sentence (from 6 November 2015 to 16 December 2015) for unlawful assault and possession of amphetamine.[128] On 6 January 2016, Corrections issued an *'Authority to Commence Breach Action'*[129] however, Mr BJ was not formally breached or detained again until after Child 2 passed away.

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[123] Corrections Victoria, Offender Management File 2 of Mr BJ, 45-65. [this document is not in evidence].

[124] Ibid, 45; Ibid, 67-68; Ibid, 169-170. Mr BJ's overall risk level was assessed as 'high' (at 442), as he was found to have a high risk of general re-offending, and a history of significantly harmful behaviour (at 439). The assessor commented that Mr BJ had a history of non-compliance with respect to previous community based and parole orders. It was considered he would benefit from treatment intervention to address his long-standing illicit substance abuse issues. Mr BJ reported strong pro social family supports, as he resided with his mother and had familial support and was engaged with his children and wanted to make the appropriate changes to be a positive influence for them (at 548).

[125] CCS received notifications that Mr BJ had been in police attendance at a police station on 10 October 2015, 11 March 2016 and 16 March 2016. On all three occasions, CCS wrote to the police station either on the same day or within two days to seek further information from the police stations to assist in the case management of Mr BJ. However, it does not appear that any further information was provided or obtained in respect of these attendances. (Ibid respectively at 403; 355; 353)

[126] On 5 November 2015 he advised the CCS officer he had been 'charged with possession of prescription medication' (Ibid at 391).

[127] Ibid 391.

[128] Ibid 378-9.

[129] Ibid 365-366.

2.43 Child Protection received an unborn child report (for Child 2) on 1 October 2015, citing concerns around Ms BA's ice use, transience, lack of antenatal care and previous removal of her older child.[130] A second unborn report was received on 4 November 2015 citing similar concerns.[131]

2.44 During the '*unborn'* phase, Child Protection do not hold statutory or coercive powers and thus must engage a family voluntarily. As noted by Tracy Beaton during her evidence in the inquest, even where a mother cannot be compelled to engage, Child Protection recognise the benefits of professional coordination in the unborn phase.[132]

2.45 Child Protection determined in the unborn phase that they would not hold a pre-birth meeting on the basis that intervention was likely following the birth.[133] Ms Beaton conceded that even if Ms BA was not engaged with the professional supports, that pre-birth meeting should have been held to coordinate a response[134] and could have provided an opportunity to engage during the voluntary, pre-birth phase.[135]

2.46 In the unborn phase, Child Protection undertook consultations internally and the matter was transferred to the community-based team, while information continued to be shared with Mercy Hospital where she was receiving her antenatal care.[136] Northern Hospital were also put on notice that Child Protection needed to be advised if Ms BA presented to give birth.[137]

2.47 From the first unborn report on 1 October 2015, Child 2 was classified as a '*high risk infant.*'[138] Ms BA had presented as heightened at the Mercy Hospital, and Child Protection noted her history of substance abuse, transience, and little engagement with professional supports.[139] Classification as a '*high risk infant*' requires, by the policy

[130] Child Protection CRIS records, Inquest Brief Part 1, v2.2 at [2979].
[131] Child Protection CRIS records, Inquest Brief Part 1, v2.2 at [2965].
[132] Statement of Tracey Beaton, 29 September 2020, paragraph 24, Inquest Brief Part 1, v2.2 at [3763].
[133] Statement of Tracey Beaton, 29 September 2020, paragraph 16, Inquest Brief Part 1, v2.2 at [3761].
[134] Statement of Tracey Beaton, 29 September 2020, paragraph 18-19, Inquest Brief Part 1, v2.2 at [3761]; Statement of Tracey Beaton, 28 January 2022, paragraph 100, 105 & 106, Inquest Brief Part 1, v2.2 at [5322]-[5323]; Oral evidence of Tracey Beaton, Inquest transcript of evidence for 24 February 2022, pages 553-554.
[135] Oral evidence of Tracey Beaton, Inquest transcript of evidence for 24 February 2022, page 554.
[136] Statement of BE, 28 January 2022, paragraph 23, Inquest Brief Part 1, v2.2 at [4217]-[4218].
[137] CRIS records, Inquest Brief Part 1, v2.2 at [2961].
[138] Statement of Tracey Beaton, 29 September 2020, paragraph 15, Inquest Brief Part 1, v2.2 at [3760].
[139] Statement of Tracey Beaton, 29 September 2020, paragraph 15, Inquest Brief Part 1, v2.2 at [3761].

introduced on 1 December 2015 (and updated on 1 March 2016), the practitioner to consider:

a) consulting a practice leader or principal practitioner about the assessment and plan;

b) referral for placement on the high-risk infant schedule and referrals for parental assessment and supports; and

c) prior to closure, convening a case conference to confirm arrangements for ongoing protection and support.[140]

2.48 Child 2 was born on 21 December 2015 at the Mercy Hospital, and the following day Child Protection conducted their first visit at the hospital, with the Mercy's Aboriginal liaison worker and Lakidjeka in attendance.[141] During this visit, Ms BA disclosed she used ice during pregnancy, as recently as September 2015, but denied use since. She stated she was in a relationship with Mr BC and intended on residing with him and his mother upon discharge.[142] It is case noted Ms BA did not have access to Centrelink benefits.[143]

2.49 Child Protection advised the home would need to be visited, which occurred on 24 December 2015. At this home visit, it was noted that the hallway in the home was cluttered, a couple of persons present were smoking, and there was a strong odour in the home.[144] Mr BC's mother was observed to be proactive in supporting Ms BA.[145] Ms Beaton conceded that the first home visit on 24 December 2015 should ideally have involved a more thorough assessments of the home environment and the other persons in the home (including criminal records checks).[146]

[140] Statement of Tracey Beaton, 29 September 2020, paragraph 26, Inquest Brief Part 1, v2.2 at [3763]-[3764].
[141] Child Protection CRIS records, First Visit Case Note, Inquest Brief Part 1, v2.2 commencing page [2941].
[142] Statement of BE, 28 January 2022, paragraph 29, Inquest Brief Part 1, v2.2 at [4218].
[143] Inquest Brief Part 1, v2.2 at [2944].
[144] Statement of BE 28 January 2022, paragraph 31, Inquest Brief Part 1, v2.2 at [4218]-[4219]; Inquest Brief Part 1, v2.2 at [2928].
[145] Statement of BE 28 January 2022, paragraph 31, Inquest Brief Part 1, v2.2 at [4218]-[4219].
[146] Statement of Tracey Beaton, 28 January 2022, paragraph 117, Inquest Brief Part 1, v2.2 at [5325]-[5326].

2.50 Child Protection allocated the report on 11 January 2016 to Advanced Child Protection Practitioner, Ms BG, and she first spoke with Ms BA on 13 January to set up a home visit on 19 January 2016.[147]

2.51 Child Protection are required to consult with ACSASS and did attempt to do so in this case during the unborn phase[148] but three calls went unanswered.[149] Once allocated the family, Ms BG attempted to contact ACSASS between 13 January and 10 February 2016 by phone and email, but it appears they were on leave during this period.[150]

2.52 On 18 January 2016, Child Protection asked Lakidjeka to attend the first home visit as well, but they were unable to do so.[151] Child Protection noted at the home visit on 19 January[152] that the house was run down and cluttered, however there were no SIDS risks identified with the bassinette. Ms BA reported she was exhausted, but Mr BC's family were assisting her. Mr BC was noted to be supporting her financially and Child Protection observed that Ms BA was not yet registered to receive Centrelink benefits. Child Protection reported no issues with Ms BA tending to Child 2, and no safety concerns were identified.[153]

2.53 On 22 January 2016, Child Protection consulted with VACCA[154] about an appropriate referral and VACCA's C2K program was recommended, in place of Stronger Families.[155] There was a referral made in January 2016 to the culturally appropriate intensive postnatal support service C2K provided by VACCA. While C2K is available in the unborn phase, in this case a referral was only made after Child 2 was born.[156] The information provided with the referral noted Ms BA's transience and the possibility of parenting capacity as protective concerns, but did not refer to family violence or illicit substance use – VACCA

147 Statement of BE 28 January 2022, paragraph 34, Inquest Brief Part 1, v2.2 at [4219].
148 Statement of BE, 28 January 2022, paragraph 23(a), Inquest Brief Part 1, v2.2 at [4217].
149 CRIS records, Inquest Brief Part 1, v2.2 at [2976].
150 Statement of BE 28 January 2022, paragraph 35, Inquest Brief Part 1, v2.2 at [4219].
151 CRIS records, Inquest Brief Part 1, v2.2 at [2913].
152 Inquest Brief Part 1, v2.2, record commences at [2909].
153 CRIS notes, Inquest Brief Part 1, v2.2 at [2909]- [2912].
154 VACCA are the lead Aboriginal child and family service provider in Victoria. VACCA also operate Lakidjeka, the Aboriginal Child Specialist Advice and Support Service, providing expert consultation to CP when they are responding to notifications, investigating allegations of abuse or neglect, and when CP make significant decisions in relation to Aboriginal children.
155 CRIS record, Inquest Brief Part 1, v2.2 at [2907]; Ms BD believed this may be because it is a longer-term intervention, oral evidence of BD, Inquest transcript of evidence for 21 February 2022, page 364.
156 Oral evidence of BD, Inquest transcript of evidence for 21 February 2022, pages 365-367.

Senior Program Manager, Ms BD, confirmed VACCA would expect Child Protection to have relayed all information they had at the point of referral.[157] Initially, Ms BA identified goals around her parenting for VACCA,[158] and VACCA staff sought further information from Child Protection about their protective concerns.[159] Ms BA agreed to the support from C2K, however due to staff shortages, C2K was not able to engage with Ms BA until 2 March 2016.[160]

2.54 On 3 February 2016, Ms BA and Mr BC attended the Child Protection office without appointment in order for Mr BC to be assessed. He disclosed previous ice abuse but said he had been clean for 12 months.[161] Mr BC and Ms BA described Ms BA's previous ice use as '*on and off*' for seven years. Mr BC also disclosed previous mental health issues, criminal charges, a previous corrections order, and previous intervention orders.[162] No protective concerns were noted by the Child Protection practitioner.[163]

2.55 At C2K's first home visit on 2 March 2016, C2K Team Leader Ms BH attended Ms BA's home to discuss the goals of the program. Ms BA said she and Mr BC had been fighting and she wanted to explore those issues, which formed part of the goals of service engagement.[164] On 4 March 2016, Child Protection conducted a home visit, and it was noted Ms BA and Child 2 were progressing well, were willing to engage with C2K, and Child Protection were working towards closure. No concerns were noted.[165]

2.56 C2K attempted to contact Ms BA on 8 and 15 March 2016 unsuccessfully and so sent her a letter on 16 March saying they would attempt a home visit on 22 March.[166] Ms BH advised Child Protection that they had been unable to engage with Ms BA.[167] Ms BA told Child Protection she had been asleep during the attempted home visit and was still

[157] VACCA records, Inquest Brief Part 1, v2.2 at [3595-3596], Oral evidence of BD, Inquest transcript of evidence for 21 February 2022, page 365.
[158] VACCA records, Inquest Brief Part 1, v2.2 at [3589]-[3590].
[159] CRIS records, Inquest Brief Part 1, v2.2 at [2883].
[160] CRIS record, Inquest Brief Part 1, v2.2 at [2901].
[161] Inquest Brief Part 1, v2.2, record commences at [2895].
[162] Statement of BE 28 January 2022, paragraph 39, Inquest Brief Part 1, v2.2 at [4218]; CRIS records, Inquest Brief Part 1, v2.2 at [2895] – [2897].
[163] Statement of BE 28 January 2022, paragraph 39, Inquest Brief Part 1, v2.2 at [4220].
[164] Statement of BD, 30 November 2021 at paragraph 8b, Inquest Brief Part 1, v2.2 at [3884].
[165] CRIS record, Inquest Brief Part 1, v2.2 at [2880].
[166] Statement of BD, 30 November 2021 at paragraph 8c, Inquest Brief Part 1, v2.2 at [3884].
[167] CRIS record, Inquest Brief Part 1, v2.2 at s [2878].

wanting to engage.[168] Child Protection advised Ms BA they would close if C2K's planned visit the next week went well.[169]

2.57 Consultation with ACSASS did not occur until 23 March 2016, at which point closure was endorsed by ACSASS.[170]

2.58 C2K Case Worker, Ms BI, attempted the second home visit on 5 April 2016, but Ms BA was not home, having gone to her grandfather's house after a fight with Mr BC.[171]

2.59 Child Protection and C2K workers attended Ms BA's home on 8 April 2016[172] for a joint home visit. During this visit Ms BA said that during an argument, Mr BC '*was in her face'* and she was concerned that she was going to get hit.[173] Child Protection spoke with Ms BA about Child 2's exposure to this verbal argument and the impact this could have on children, to which the mother responded she understood. Ms BA did not identify feeling unsafe or feeling like her and Child 2 were in danger. Child Protection told Ms BA they would proceed to closure so long as she engaged with C2K. Child Protection also noted they would check in with the MCHN before closing the case.[174]

2.60 On 14 April 2016, C2K conducted a home visit[175] during which Ms BA disclosed a further argument with her partner. The observations of Ms BA and Child 2 did not raise any other concerns.[176] Child Protection closed their investigation on this date with the protective concerns unsubstantiated.[177]

2.61 Four days later, on 18 April 2016, Child Protection received a report that alleged Ms BA had tried to obtain ice and gamma hydroxybutyrate (**GHB**) and her friend had been bashed as the deal had gone wrong. It was also reported Ms BA had resumed drug use after Child

[168] CRIS records, Inquest Brief Part 1, v2.2 at [2868].
[169] CRIS records, Inquest Brief Part 1, v2.2 at [2866].
[170] Statement of BE 28 January 2022, paragraph 35, Inquest Brief Part 1, v2.2 at [4219].
[171] Statement of BD, 30 November 2021 at paragraph 8e, Inquest Brief Part 1, v2.2 at [3884].
[172] C2K record, Inquest Brief Part 1, v2.2 commences [3552].
[173] Statement of BD, 30 November 2021 at paragraph 8f, Inquest Brief Part 1, v2.2 at [3884].
[174] CRIS records, Inquest Brief Part 1, v2.2 at [2855].
[175] Inquest Brief Part 1, v2.2, record commences [3547].
[176] Statement of BD, 30 November 2021 at paragraph 8g, Inquest Brief Part 1, v2.2 at [3884].
[177] CRIS records contain the closure summary, Inquest Brief Part 1, v2.2 commencing [2842].

Protection closed. It was further alleged Ms BA and Mr BC had separated two days prior because of Ms BA resuming drug use, and she was now homeless.[178]

2.62 Child Protection commenced an investigation and made phone contact with Ms BA on 19 April 2016. Child Protection asked Ms BA to disclose where she was staying and save for indicating she was at a house in Craigieburn, Ms BA would not provide the address to Child Protection. Child Protection informed Ms BA that they needed to sight her and Child 2 that day or soon. Ms BA replied that she would attend the Child Protection office in Preston when she wanted. When asked about a time to do this, Ms BA hung up on Child Protection. Child Protection called again, and Ms BA said she was going to the Epping MCHN the next day at 4.00pm and Child Protection could meet her there. She again hung up on Child Protection.[179] Child Protection conducted a '*responsible for harm assessment*' and substantiated the allegations with respect to the risk posed to Child 2 by Ms BA of significant physical and emotional harm.[180]

2.63 Child Protection was subsequently advised that the MCHN appointment the following day was at 10.00am and not 4.00pm.[181] Child Protection were unsuccessful in arranging an alternative time to meet with the mother and so applied for a search warrant.[182] Child Protection also continued to attempt to negotiate with the mother so that a welfare check could be conducted.[183] Ms BA agreed to meet with Child Protection at a local shopping centre on 20 April, and Child Protection later negotiated to attend the address where Ms BA was staying with a friend that same day.[184] A plan was outlined and agreed upon by Child Protection and Ms BA, whereby she would stay two nights at this home, she would meet with Child Protection to undertake a drug screen the following day, and she would meet with Ms BI in two days so that she could assist her in finding other accommodation.[185] Child 2 had been co-sleeping with Ms BA, so Child Protection ensured the sleeping area was appropriately set up. The cot available at the house had a

[178] CRIS records, intake report, Inquest Brief Part 1, v2.2 commencing on [2822].
[179] CRIS records, Inquest Brief Part 1, v2.2 at [2809].
[180] CRIS records, Inquest Brief Part 1, v2.2 at [2801], [2802].
[181] Inquest Brief Part 1, v2.2 at [2788].
[182] CRIS records, Inquest Brief Part 1, v2.2 commencing [2797].
[183] CRIS records, Inquest Brief Part 1, v2.2 at [2795] & [2772].
[184] CRIS record, first visit case note, Inquest Brief Part 1, v2.2 commencing [2756].
[185] CRIS record, first visit case note, Inquest Brief Part 1, v2.2 [2758].

number of cockroaches in it and needed to be cleaned out. Ms BA did not appear substance affected and was cooperative with Child Protection during the home visit.

2.64 On 21 April 2016, Child Protection delivered two slips for completion of drug screens to Ms BA, and she confirmed she would complete one that day.[186] The screen was not completed and was not followed up by Child Protection. Ms BI was not able to attend her home visit with Ms BA as she was unwell, and so it was rescheduled to 29 April, but this visit also did not proceed.[187]

2.65 On 26 April 2016, Child Protection Practitioner Ms BF was allocated to Child 2's file.[188] Following allocation, attempts were made to contact Ms BA, Ms BI, as well as Lakidjeka/ACSASS.[189] Ms BF confirmed with Ms BI by email that she was the allocated worker and Child Protection were concerned about Ms BA's transience, non-engagement, and possible drug use.[190]

2.66 Ms BF sent Ms BA a letter proposing a home visit on 5 May 2016.[191] Ms BF was able to reach her by phone on 5 May. Ms BA said she was not able to attend and asked to reschedule to 11 May 2016.[192]

2.67 It was noted that Ms BF discussed the absence of a case plan for the family at her first supervision session post allocation, 29 days after substantiation – where the policy required it to be completed within 21 days. Ms BF suggested this may be because they wanted to develop that case plan through the Aboriginal Family-Led Decision Making (**AFLDM**) process.[193]

2.68 Ms BI was able to meet with Ms BA on 2 May 2016, after she had attended on the MCHN. Ms BI accompanied Ms BA to Centrelink to attempt to lodge a claim for payments, however Ms BA did not have identification, and so a further appointment on 16 May was

[186] CRIS record, Inquest Brief Part 1, v2.2 at [2751].
[187] Statement of BD, 30 November 2021 at paragraph 8k, Inquest Brief Part 1, v2.2 at [3885].
[188] Statement of BF, dated 24 January 2022, paragraph 2, Inquest Brief Part 1, v2.2 at [4196].
[189] Statement of BF, dated 24 January 2022, paragraph 20, Inquest Brief Part 1, v2.2 at [4199].
[190] CRIS record, Inquest Brief Part 1, v2.2 at [2737]- [2738].
[191] Statement of BF, dated 24 January 2022, paragraph 23, Inquest Brief Part 1, v2.2 at [4196].
[192] Statement of BF, dated 24 January 2022, paragraph 27, Inquest Brief Part 1, v2.2 at [4196].
[193] Oral evidence, BF, Inquest transcript of evidence for 23 February 2022, 465 & 480-481.

booked.[194] Ms BI made attempts to obtain identification for Ms BA, including through Child Protection and Ms BF confirmed she could provide a statutory declaration confirming identity, but Ms BI had difficulty contacting Ms BA to follow this up.[195]

2.69 On 11 May 2016, Ms BF phoned Ms BA regarding the home visit and Ms BA stated she was no longer living at the address Child Protection had previously visited. Ms BA would not tell Ms BF the new address. Ms BF said she '*really did need to just see the baby*', Ms BA responded that Ms BF would not be taking her baby and terminated the call.[196] Ms BF called Ms BA again and said it was necessary for Child Protection to see Child 2 or Child Protection may be required to take legal action. Ms BA then agreed to attend the office the following day.[197]

2.70 Ms BA attended the Child Protection office on 12 May 2016 and provided an address where she was residing, and a home visit was scheduled for 16 May.[198] Ms BF was able to sight Child 2, who presented well, and she also provided Ms BA with an application for his birth certificate,[199] that Ms BA completed and returned to Child Protection.[200] Ms BF offered to assist Ms BA to complete the form, which she declined.[201] Ms BF did not recall looking at the form – which listed Mr BJ as Child 2's father – prior to Child 2's passing.[202] The available evidence indicates that no further information regarding who Ms BA and Child 2 were residing with, the stability of this accommodation other than noting that stability was important for both her and Child 2, his development, Ms BA's drug use or the family's other needs appear to have been discussed. Ms BF recorded that she advised Ms BA that she would need to provide Child Protection with supervised urine screens, and she said she would do so,[203] however ultimately no screens were undertaken.

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194 Statement of BD, 30 November 2021 at paragraph 8m, Inquest Brief Part 1, v2.2 at [3885].
195 Statement of BD, 30 November 2021 at paragraph 8n, Inquest Brief Part 1, v2.2 at [3885].
196 Statement of BF, dated 24 January 2022, paragraph 28, Inquest Brief Part 1, v2.2 at [4199]; CRIS record, Inquest Brief Part 1, v2.2 at [2729].
197 Statement of BF, dated 24 January 2022, paragraph 28, Inquest Brief Part 1, v2.2 at [4199]; CRIS record, Inquest Brief Part 1, v2.2 at [2728].
198 Statement of BF, dated 24 January 2022, paragraph 31, Inquest Brief Part 1, v2.2 at [4199]-[4200]; CRIS record, Inquest Brief Part 1, v2.2 at [2726].
199 Statement of BF, dated 24 January 2022, paragraph 31, Inquest Brief Part 1, v2.2 at [4199]-[4200].
200 CRIS record Inquest Brief Part 1, v2.2 at [2725].
201 Statement of BF, dated 24 January 2022, paragraph 31, Inquest Brief Part 1, v2.2 at [4199]-[4200].
202 Statement of BF, dated 24 January 2022, paragraph 32, Inquest Brief Part 1, v2.2 at [4200]; VACCA records, Inquest Brief Part 1, v2.2 at [3727].
203 CRIS record, Inquest Brief Part 1, v2.2 at [2725].

2.71 On 16 May 2016, Ms BA told Ms BF she was not available for the home visit that day, and instead negotiated to attend the Child Protection office on 18 May with Ms BI.[204] Ms BF noted at the office visit on 18 May that Ms BA still did not have identification, which was preventing her from obtaining housing and undertaking drug screens.[205] Ms BA's Centrelink appointment on 16 May could not proceed because this documentation had not been obtained.[206] Though a confirmation of identity form had been lodged, Ms BA was required to contact Centrelink's Indigenous Call Centre to pursue that application.[207]

2.72 On 20 May 2016, Ms BI attended where Ms BA was staying, and though other adults were sighted, details of those people were not obtained.[208] Ms BI contacted Ms BF to see how her planned home visit had gone and whether she had followed up with obtaining Child 2's birth certificate.[209] Ms BF advised Ms BI on 25 May that Ms BA had completed the application for a birth certificate for herself and not Child 2. A joint home visit was scheduled for 26 May. Ms BI did attend this visit,[210] however Ms BF was unavailable due to an emergency situation with a young person on another Child Protection file.[211] Ms BF rescheduled to 30 May[212] but Ms BA was not able to attend, saying she would do so on 31 May.[213]

2.73 On 31 May 2016, Ms BA sent Ms BI a text seeking assistance for accommodation in a family violence refuge. Ms BI was unable to then speak with Ms BA and so sent her the information via text message and, on 1 June 2016, relayed this to Ms BF.[214] VACCA offered assistance with obtaining accommodation on 31 May and 2 June 2016, however Ms BA did not ultimately follow up with this.[215] Brokerage and a flexible support fund

[204] Statement of BF, dated 24 January 2022, paragraph 33, Inquest Brief Part 1, v2.2 at [4200].
[205] Statement of BF, dated 24 January 2022, paragraph 34, Inquest Brief Part 1, v2.2 at [4200].
[206] Statement of BD, 30 November 2021 at paragraph 8q, Inquest Brief Part 1, v2.2 at [3886].
[207] Statement of BD, 30 November 2021 at paragraph 8r, Inquest Brief Part 1, v2.2 at [3886].
[208] Statement of BD, 30 November 2021 at paragraph 8s, Inquest Brief Part 1, v2.2 at [3886].
[209] Statement of BD, 30 November 2021 at paragraph 8t, Inquest Brief Part 1, v2.2 at [3887], CRIS records, Inquest Brief Part 1, v2.2 at [2720].
[210] CRIS record, Inquest Brief Part 1, v2.2 at [2716].
[211] Statement of BD, 30 November 2021 at paragraph 8v, Inquest Brief Part 1, v2.2 at [3887]; CRIS records Inquest Brief Part 1, v2.2 at [2719]-[2718]; Statement of BF, dated 24 January 2022, paragraph 36, Inquest Brief Part 1, v2.2 at [4200].
[212] Statement of BD, 30 November 2021 at paragraph 8v, Inquest Brief Part 1, v2.2 at [3887].
[213] Statement of BD, 30 November 2021 at paragraph 8w, Inquest Brief Part 1, v2.2 at [3887].
[214] Statement of BD, 30 November 2021 at paragraph 8x, Inquest Brief Part 1, v2.2 at [3887]; Statement of BF, dated 24 January 2022, paragraph 37, Inquest Brief Part 1, v2.2 at [4200].
[215] Statement of BD, 30 November 2021 at paragraph 11, Inquest Brief Part 1, v2.2 at [3889].

had been available but Ms BD confirmed VACCA did not utilise this to fund anything for Ms BA.[216]

2.74 Ms BI remained in touch with Ms BA regarding where she was residing and on 3 June 2016, Ms BI attended a residence in South Morang where she was staying. Ms BA reported she was '*not ok where she was*' due to arguments between the couple there.[217] Ms BI advised Ms BF of the conflict, who spoke with Ms BA advising her if she was having issues with her accommodation that she needed to contact C2K or Child Protection for assistance, and to reinforce that it was not good for Child 2 to be exposed to conflict.[218] Ms BA agreed to attend the Child Protection office on 8 June 2016,[219] and did so with Ms BI.[220] Ms BF discussed with Ms BA that Child Protection would close their involvement once she obtained stable housing. She also advised Ms BA that she needed her to complete a supervised urine drug screen. Ms BI offered to transport her, however as Ms BA did not have photo identification, it could not be completed.[221] Ms BI coordinated with Ms BF to obtain a statutory declaration in place of identification,[222] which was collected on 15 June 2016.[223]

2.75 Also on 8 June 2016, Ms BF discussed convening an AFLDM with Ms BA, and a consultation was subsequently scheduled for 14 June.[224] Unfortunately due to workload issues, Ms BF was unavailable at the time that consultation was booked, and it was agreed it would be rebooked, however it does not appear this occurred before the date of Child 2's death.[225]

2.76 Between 14 and 17 June 2016, Ms BF had contact with Ms BI about arranging a statutory declaration concerning Ms BA's identification and obtaining birth certificates.[226]

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[216] Oral evidence of BD, Inquest transcript of evidence for 21 February 2022, pages 405-406 & 412.
[217] Statement of BD, 30 November 2021 at paragraphs 8y, z, aa, Inquest Brief Part 1, v2.2 at [3887]-[3888].
[218] CRIS records, Inquest Brief Part 1, v2.2 at [2714].
[219] CRIS records, Inquest Brief Part 1, v2.2 at [2714].
[220] Statement of BF, dated 24 January 2022, paragraph 39, Inquest Brief Part 1, v2.2 at [4200]-[4201].
[221] CRIS records, Inquest Brief Part 1, v2.2 at [2712].
[222] CRIS records, Inquest Brief Part 1, v2.2 at [2705]-[2708].
[223] CRIS records, Inquest Brief Part 1, v2.2 at [2704].
[224] CRIS records, Inquest Brief Part 1, v2.2 at [2712].
[225] Statement of BE 28 January 2022, paragraph 59, Inquest Brief Part 1, v2.2 at [4222].
[226] Statement of BF, dated 24 January 2022, paragraph 41, Inquest Brief Part 1, v2.2 at [4201].

2.77 On 16 June 2016, Ms BI accompanied Ms BA to lodge her application for a birth certificate, however the form provided by Child Protection was not correct. She was also advised it can take up to 60 days to process.[227]

2.78 On 20 June 2016, Ms BF attempted to contact Ms BA and left a message requesting that her call be returned.[228]

2.79 There was no further service contact prior to Child 2's death.

CIRCUMSTANCES LEADING TO THE FATAL INCIDENT

2.80 Ms BA stated there were two significant family violence incidents perpetrated by Mr BJ in the lead up to Child 2's death. On 20 June 2016 during a disagreement, Mr BJ was trying to prevent Ms BA leaving where they were staying, resulting in him throwing Ms BA on the floor and pinning her down and choking her. Child 2 was present, and during the incident Mr BJ said, '*I don't care if I kill you*.'[229] On 21 June 2016, there was another incident during which Mr BJ assaulted Ms BA in front of Child 2, who started screaming.[230]

2.81 On 24 June 2016, Ms BA, Mr BJ and Child 2 moved into a unit rented by their friend Ms BK – a short-term arrangement while they secured their own accommodation. On Saturday 25 June, Mr BJ left the premises shortly after midday. Ms BA and Child 2 remained at the unit during the day and evening, and Ms BK was with them for most of that time, apart from a couple of hours when she went to her mother's house in Craigieburn. At about 11:00 pm, Ms BK returned to the unit in the company of a friend, Ms BL. The three women, Ms BA, Ms BK and Ms BL, then remained at the premises talking, and smoking methylamphetamine. Mr BJ returned to the unit shortly after 1:15am on 25 June 2016, and over the next three hours also smoked methylamphetamine.[231]

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[227] Statement of BD, 30 November 2021 at paragraph 8dd, Inquest Brief Part 1, v2.2 at [3888].
[228] Statement of BF, dated 24 January 2022, paragraph 42, Inquest Brief Part 1, v2.2 at [4201].
[229] Statement of BA, dated 26 June 2016, paragraph 11, Inquest Brief Part 1, v2.2 at [2395].
[230] Statement of BA, dated 26 June 2016, paragraph 12-15, Inquest Brief Part 1, v2.2 at [2396].
[231] Factual circumstances of death a set out in *DPP v Lindsey (Sentence) [2018] VSC 239* (22 May 2018).

2.82 Child 2 awoke at about 4:00am on 25 June 2016 and he was fed. At about 4:30am, Ms BA, Ms BK and Ms BL left the unit to go shopping. Mr BJ was feeding Child 2 with a bottle while seated on a porta cot mattress on the floor next to the wall heater in the lounge room. The occupant of the adjoining unit, Mr BM, heard Child 2 crying between about 1:00am and about 3:00am, but he did not hear any other noise from the unit until about 8:00am, when he heard noises that were consistent with Mr BJ trying to rouse Child 2. Mr BM heard him repeatedly call out '*Hey you'*, swearing and stamping his foot a couple of times. At 8:20am, Mr BJ telephoned Ms BA, and told her '*there is something wrong with the baby, he's not breathing*'. Emergency Services were contacted, and Child 2 was found to be unconscious and not breathing.

2.83 Mr BJ was observed to be highly anxious and agitated when emergency services arrived at the flat. Ms BA, Ms BK and Ms BL returned to the unit, and shortly after that, Mr BJ fled the scene and remained in hiding until his arrest in Sunshine North four days later, on 30 June 2016. While in Mr BJ's care, Child 2 suffered catastrophic head injuries which resulted in his death, together with a number of other non-fatal traumatic injuries to his face, head, and neck, and to his groin and genital areas.[232] Child 2 was not able to be revived. He was pronounced dead after his life support was withdrawn at the Royal Children's Hospital on 28 June 2016.

2.84 Medical examination following the fatal incident found that it was highly likely that Child 2's injuries were caused '*by acceleration-deceleration and rotational forces*', consistent with shaking. Child 2 was also observed to have bruising to his face and skull, meaning '*that there had been at least five separate blunt force impacts to the face and skull*'. In addition, Child 2 had non-fatal injuries to his neck, groin and genital region, all of which were believed to have been caused by Mr BJ. Injuries sustained to Child 2's groin were suspected to be caused by blunt force trauma, whilst the injuries observed to his neck area were thought to be from the use of a ligature. Child 2 was also found to have '*either ingested, inhaled or had environmental exposure to methylamphetamine*'.

[232] *DPP v Lindsey (Sentence) [2018] VSC 239* (22 May 2018) at [3].

CCS Review of Mr BJ's CCOs

2.85 On 29 August 2016, CCS completed an Internal Management Review Report (**Internal Review**) of Mr BJ's Corrections Victoria file. This Internal Review identified significant failings in relation to the management of Mr BJ's CCOs, summarised as follows:

- Weekly supervision appointments were not scheduled with Mr BJ despite his '*high risk*' status.
- The CCS worker did not efficiently implement the conditions of Mr BJ's CCOs, and these conditions were not monitored appropriately.
- Several of Mr BJ's non-compliances were not investigated by the case manager within the specified timeframes.
- Compliance management and intervention options were not adequately implemented.
- The case manager could have considered a compliance meeting, case management review meeting or a senior officer caution as additional options to address Mr BJ's non-compliance.
- Mr BJ's case manager did not undertake any risk assessments or discuss his drug use and criminal offending with him.
- Mr BJ was not adequately case managed and several opportunities to investigate or challenge his behaviour were missed.
- During the course of his engagement with CCS, Mr BJ did not undergo a urine screen despite being charged with drug possession during the course of his CCOs and this being a condition of his CCOs.
- The E*Justice notification sent to Community Correctional Services (**CCS**) on 5 November 2015 in response to Mr BJ's imprisonment was not followed up and it

appears that CCS were unaware that Mr BJ was in custody until he informed them on 17 December 2015.

- A number of absences were not identified or followed up in a timely manner by Mr BJ's case manager. As a result, Mr BJ was not held accountable for failing to meet the obligations of his CCOs.

2.86 Quantitatively, the Internal Review found that seven of the eight organisational standards were not complied with. The Internal Review also found that the file had failed to comply with policies and procedures and had an overall compliance rate of 33.33 per cent. The available evidence suggests that there was significant mismanagement of Mr BJ's CCOs and escalating behaviours.

2.87 On 22 May 2018, in the Supreme Court of Victoria, Mr BJ was found guilty of Child 2's murder and was sentenced to 34 years imprisonment, with a non-parole period of 27 years.[233]

IDENTITY OF THE DECEASED

2.88 Child 2 was visually identified by his mother on 27 June 2016. Identity is not in dispute and requires no further investigation.

MEDICAL CAUSE OF DEATH

2.89 On 29 June 2016, Dr Michael Burke, a Senior Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, performed an autopsy on the body of Child 2.

2.90 Upon review of all the evidence from autopsy and post-mortem CT scans, Dr Burke provided a written report dated 8 December 2016, which concluded that Child 2's death was due to a head injury and that Child 2 had evidence of severe traumatic brain and spinal injury complicated by bradycardia arrest and a secondary hypoxic-ischaemic injury.

[233] *DPP v Lindsey (Sentence) [2018] VSC 239* (22 May 2018).

2.91 Dr Burke noted that post-mortem CT scans showed thin fresh subdural haemorrhage along the left side of the tentorium cerebelli measuring 2 mm in thickness and extending superiorly along the falx cerebri. Dr Burke confirmed that clinical MRI brain and spine examination showed bilateral retinal haemorrhages, global hypoxic ischaemic brain injury associated with subdural haemorrhage and cessation of blood flow within the cerebral tentorial brain. No fractures of the skull or vertebral bodies were identified. Dr Burke concluded that Child 2 died from head injuries given the distribution and severity of the injuries sustained which were indictive of non-accidental injury. I accept Dr Burke's opinion.

CHILD 3

BACKGROUND

2.92 Child 3 was 15 years old when she passed away on 1 March 2017. Child 3 was the oldest child of Mr CB and Ms CA. Ms CA also passed away on the same date along with her partner Mr CC as a result of a fire deliberately lit by Ms CA's former partner, Mr Darren Clover. Child 3 identified as Aboriginal on her paternal side.

2.93 Ms CA was 16 years old when she gave birth to Child 3, who is survived by three siblings, CD, CE and CF, who were born in 2002, 2004 and 2008 respectively.

2.94 Seven reports were made to Child Protection in relation to Child 3 prior to her passing, the first occurring when she was five months old, and the last commencing in 2011 and remaining open at the time of her passing. The risk issues identified related to exposure to parental drug use and family violence, mental health concerns, environmental concerns, neglect and sexual abuse.

2.95 Child 3 was placed in out of home care in 2012 and at the time of her passing was on a Care by Secretary Order. This order conferred parental responsibility for Child 3 on the (then-named) Department of Health and Human Services (**DHHS**), continuing the Department's custody and guardianship of Child 3 that had commenced in 2012.

2.96 Initially Child 3, together with her brother CD, had been placed with their maternal aunt and uncle, but in March 2014 Child 3 was placed in foster care due to quality-of-care concerns in this kinship placement, including alleged physical and emotional abuse.[234]

2.97 On 5 December 2014, it was reported that Child 3 spoke of self-harming and suicide at school.[235] On 27 January 2015 Child 3's carers advised the case manager she had been posting naked photographs on Facebook, which was reported to Child Protection.[236] A report was made to Victoria Police on 4 February 2015. On 5 February 2015, a care team meeting was held with representatives from Child Protection, Berry Street, Westcare (the foster care agency at the time), the Australian Childhood Foundation, and Child 3's school. The incident was discussed during the care team meeting, and the outcome actions included that Child 3 would receive cyber safety training through the school. In a subsequent care team meeting on 2 March 2015, it was confirmed that Child 3 had completed the cyber safety training.[237] At this time Child 3 was engaged with Take Two therapist, Sylvia Azzopardi, who worked with the foster care agency and Child Protection to safety plan around this and other behaviours.[238]

2.98 From mid-2015, Child 3 started to abscond regularly from care and from school. Child Protection applied for warrants where Police assistance was required to locate and return Child 3 to placement. In June 2015 Child 3 and CD's foster placement broke down due to her absconding, and Ms Azzopardi provided detailed guidance to Child Protection about supporting Child 3 through this.[239]

2.99 On 8 October 2015, Child 3 reported a sexual assault by a fellow (older) student when she had missed class to spend time with him.[240] The school facilitated Child 3 speaking with SOCIT, and reported this to Westcare, who relayed it to Child Protection.[241] On 12 October there was a further incident where it is alleged Child 3 stole a school staff

[234] Inquest Brief Part 2, v2.4 at [4537].
[235] Inquest Brief Part 2, v2.4 at [4551].
[236] Inquest Brief Part 2, v2.4 at [4528].
[237] Inquest Brief Part 2, v2.4, statement of Kirstie Lomas, [5348]-[5349].
[238] Inquest Brief Part 2, v2.4 at [4530].
[239] Inquest Brief Part 2, v2.4 at [4477] – [4479].
[240] Inquest Brief Part 2, v2.4 at [4231] – [4235].
[241] Inquest Brief Part 2, v2.4 at [1155] to [1156].

member's phone and also brought alcohol to school.[242] An urgent care team meeting was convened on 14 October, including the school, Child Protection, Westcare, Ms Azzopardi and Child 3's carer to safety plan for Child 3 given these incidents.[243]

2.100 On 16 November 2015, Westcare advised Child Protection that Child 3 and CD had recommenced contact with their mother by phone.[244] In December 2015, in the context of her placement breaking down, Child 3 had a text conversation with her Westcare case worker in which part of the conversation included her writing that '*Well firstly ur ruining our childhood with our mother!!! Two why is it taking so long to see our mother!!!!... I wnt to go back to mum! (sic.)*'

2.101 Prior to November 2015, Child 3 had had no contact with her mother since the age of 11 or 12. It also appeared that Child 3 had had no contact with her father since she was nine, when she reported that he had sexually abused her.[245]

2.102 It appears the final case plan developed for Child 3 was on 12 February 2015.[246] That case plan was not reviewed or updated prior to her death on 1 March 2017. The Uniting Case Manager, Ms CN, gave evidence that she could not recall a case plan being provided in the initial stages of case management, or when it was provided. However, once Bridges had access to the CRIS system, the case plan was accessible.[247] Case plans were required to be reviewed at minimum prior to the conclusion of twelve months, but also when a child's circumstances changed significantly,[248] as they did for Child 3 in 2015 and 2016. Following amendments to the *Children Youth and Families Act 2005* that took effect from 1 March 2016, case plans are now required to be prepared by Child Protection and provided to children and parents within 21 days of substantiation.[249] The significant changes to Child 3's circumstances that could have prompted a case plan review at the time included her increasing absconding, alleged illicit drug use including ice, the

[242] Inquest Brief Part 2, v2.4 at [1150].
[243] Inquest Brief Part 2, v2.4 at [1148].
[244] Inquest Brief Part 2, v2.4 at [4175].
[245] Inquest Brief Part 2, v2.4 at [4759].
[246] Inquest Brief Part 2, v2.4 at [4724].
[247] CN oral evidence, Inquest transcript of evidence for 15 February 2023, page 7.
[248] 'Case planning - advice' document ID number 2047.
[249] 'Case planning - advice' Document ID number 2047.

recommencement of the relationship with her mother after three years of no contact, and incidents of self-harm and sexual exploitation.

2.103 Evidence within the inquest brief suggests that on 18 December 2015, Ms CA was assaulted by Mr CQ at a bus stop in the presence of her on and off partner Mr CQ. On this occasion, Mr CQ allegedly grabbed Ms CA and pulled out a chunk of her hair.[250] Mr Richardson indicated that he and Ms CA went to Footscray Police Station after this incident and made statements,[251] however there is no evidence of these statements in the police records provided to the Court.[252] Later on the day of this alleged incident, Mr Richardson assaulted Mr CQ in central Melbourne and was charged over this incident.[253]

2.104 On 28 December 2015, following a period of more than a month during which Child 3 had not returned to placement, Child 3 was located at the home of her mother's partner in Geelong. She was returned to her carer's home, but absconded again the next day on 29 December, and was not located until 2 January 2016. Following this, she was placed with Uniting Care foster carer Ms CG, where she remained until her passing.[254]

2.105 Uniting Care Werribee Support and Housing provided Bridges Adolescent Community Placements and foster care at the time of Child 3's placement.[255] Uniting had approximately twenty staff at that time, providing foster placements, support and case management for children and young people in out of home care.[256]

2.106 Uniting commenced involvement with Child 3 when she was referred for placement with Ms CG after hours on 4 January 2016 following the breakdown of her previous foster

[250] Statement of Mr CR, Inquest Brief Part 2, v2.4 at [496].
[251] Ibid.
[252] The Chief Commissioner of Police has confirmed there is no record of this report, by correspondence dated 14 April 2022.
[253] Victoria Police, Police records of D Clover, Inquest Brief Part 2, v2.4 at 1002; Statement of Mr CR, Inquest Brief Part 2, v2.4 at [497].
[254] Statement of CG, 23 April 2017, paragraph 6 in Inquest Brief Part 2, v2.4 at [237].
[255] Referred to in these submissions as Uniting Care for ease of reference. Uniting CareCare Werribee Support and Housing provided Bridges Adolescent Community Placements and foster care until the 2017 Uniting Care Merger – in which Uniting Care Care Werribee Support and Housing (one of the 25 founding Uniting Care Agencies) merged to form one organisation called Uniting Care (Victoria and Tasmania) Ltd, statement of Phillip Yew, 1 July 2022, paragraph 8, Inquest Brief Part 2, v2.4 at [5685]-[5686].
[256] Statement of DK, dated 1 July 2022, paragraph 3, Inquest Brief Part 2, v2.4 at [6092].

care placement.[257] Ms CN was the primary support worker at Uniting Care.[258] On 16 May 2016 Uniting took over case management of Child 3 in a contracted capacity. Up until that date, Child Protection had held case management responsibility. Once case contracted, Uniting provided updates to Child Protection through quarterly reporting, and also by phone and email when any issues or concerns were raised.[259] Uniting remained Ms CG's primary point of contact.

2.107 With respect to providing information to foster carers, at the time of a referral and ongoing, Ms CN described it as '*all relevant information to the carer that she needed to know to ensure that the child was supported well in that placement*.'[260] The placement just prior to Ms CG had broken down due to Child 3's absconding and abusive behaviours and Ms CN believed Ms CG would have been told of this.[261] Ms CG reflected that it may have been of assistance to her if she had have known more about Child 3's past, prior to placement, and that it took some time for Child 3 to disclose traumatic incidents she had experienced.[262] Ms CG would also have liked to have had more information about Child 3's mother. She said she had not known Ms CA was known to be an injecting drug user, nor had she been provided any risk information about Mr CQ, which would have helped in her assessing the risks posed by Child 3 spending time with them.[263]

2.108 At the time of placement referral to Ms CG, it was noted that Child 3 had absconded from her previous placement, which led to its breakdown. Ms CN could not recall being provided with a safety plan to manage this by Child Protection at the time of referral.[264] She could not recall any specific discussions about responding to the absconding at that time either.[265]

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[257] Statement of CN, 16 June 2022, paragraph 9 & 13, Inquest Brief Part 2, v2.4 at [5378]-[5379].
[258] Which included face-to-face and home visits, CN oral evidence, Inquest transcript of evidence for 15 February 2023, page 2; Statement of CN, 16 June 2022, paragraph 14, Inquest Brief Part 2, v2.4 at [5379].
[259] Statement of DK, 1 July 2022, paragraph 16, 17, Inquest Brief Part 2, v2.4 at [6095]; see also Inquest Brief Part 2, v2.4, statement of Kirstie Lomas, [5351]-[5355].
[260] CN oral evidence, Inquest transcript of evidence for 15 February 2023, page 3.
[261] CN oral evidence, Inquest transcript of evidence for 15 February 2023, page 4.
[262] Statement of CG dated 23 June 2022, Inquest Brief Part 2, v2.4 at [9749].
[263] Statement of CG, dated 23 June 2022, Inquest Brief Part 2, v2.4 at [9749]-[9750]; Oral evidence of CG, Inquest transcript of evidence for 17 February 2023, pages 131-132.
[264] Statement of CN, 16 June 2022, paragraph 14, Inquest Brief Part 2, v2.4 at [5379].
[265] CN oral evidence, Inquest transcript of evidence for 15 February 2023, page 8.

2.109 Child 3 was also referred to the High-Risk Youth Panel on 4 January 2016,[266] but it is unclear from the CRIS records if this was pursued or what further intervention this may have prompted.[267]

2.110 On 5 January 2016, Child Protection requested a consultation with Lakidjeka, operated by VACCA.[268] Child 3 was reported to have proudly identified as Aboriginal. Throughout the file her interest in her cultural background was well-documented.[269] When VACCA sought further information from Child Protection, no further contact was made.[270] Child Protection case notes reflect a further attempt was made on 8 and 12 July 2016,[271] but the VACCA records do not reflect this, and no response was provided.[272] No formal consultation occurred.

2.111 Concessions have been made by VACCA regarding inadequate record-keeping in Child 3's file.[273] VACCA's evidence is that there have been significant systemic improvements in their case recording practices since the relevant time.[274]

2.112 Consultations with Lakidjeka are initiated by Child Protection.[275] Barriers to fulfilling requests for consultation cited by VACCA include the very high caseloads within Lakidjeka, estimated at more than one hundred per practitioner.[276] Lakidjeka case manager, Ms CM, provided a statement during the inquest noting systemic barriers to effective consultations at the relevant time including:

- Child Protection only consulting during initial intake and investigation, and not at the point of all '*significant decisions*' being made;[277]

[266] Inquest Brief Part 2, v2.4 at [3909].
[267] Statement of Kirstie-Lee Lomas, dated 28 June 2022, paragraph 23, Inquest Brief Part 2, v2.4 at [5350].
[268] VACCA are the lead Aboriginal child and family service provider in Victoria. VACCA also operate Lakidjeka, the Aboriginal Child Specialist Advice and Support Service, providing expert consultation to CP when they are responding to notifications, investigating allegations of abuse or neglect, and when CP make significant decisions in relation to Aboriginal children.
[269] See for example in Inquest Brief Part 2, v2.4 at [4477], [4784].
[270] Inquest Brief Part 2, v2.4 at [5247]. [3958], [1713] Statement of CM, dated 22 July 2022, Exhibit 12.
[271] Inquest Brief Part 2, v2.4 at [3676] & [3675].
[272] As acknowledged by Belinda Jose in her statement dated 26 November 2021.
[273] Statement of Belinda Jose, 26 November 2021, paragraph 10b & 12 Inquest Brief Part 2, v2.4 at [5247]-[5248].
[274] See paragraphs 11 & 12, statement of Belinda Jose, 26 November 2021, Inquest Brief Part 2, v2.4 at [5247]-[5248].
[275] Statement of Belinda Jose, 26 November 2021, paragraph 9e, Inquest Brief Part 2, v2.4 at [5246].
[276] Statement of Belinda Jose, 26 November 2021, paragraph 9h, Inquest Brief Part 2, v2.4 at [5246].
[277] Statement of CM, 22 July 2022, paragraph 11b, Exhibit 12.

- Consultations and planning not occurring in a timely manner,[278] nor via the dedicated ACSASS consultation phone line;[279]
- Consultation not being sought where Aboriginality remains unconfirmed;[280]
- Child Protection applying a limited understanding of '*family*' in trying to identify suitable placement options;[281] and,
- Inadequate record keeping by Child Protection of consultations they report have been undertaken.[282]

2.113 Child 3 continued to abscond after being placed with Ms CG, often to spend time with her mother.[283] When the referral to Uniting Care was accepted, Ms CN had understood there had been a time when Child 3 had not seen her mother, but that they had recently reconnected.[284] Ms CN could not recall being provided with any safety plan upon referral, though absconding had been an issue at previous placements.[285] With respect to responding to such incidents, Uniting would consult with Child Protection who would make the determination about whether Child 3 should be reported missing, a safe custody warrant applied for, and whether a media release be prepared.[286]

2.114 On 22 February 2016, Child Protection met with Ms CA, and Child Protection practitioner, Ms CO, noted she had subsequently told Ms CA that any contact with Child 3 or CD had to be arranged through Child Protection and needed to be planned, and that Ms CA had agreed with this.[287] Ms CG advised Child Protection that '*Child 3 wishes to have contact with her mother, and historically this issue has caused Child 3 to abscond from placement. I have supported Child 3's desire to have contact with her mother and have requested this process be facilitated in a positive and constructive manner so that it*

[278] Statement of CM, 22 July 2022, paragraph 11c, Exhibit 12.
[279] Statement of CM, 22 July 2022, paragraph 11f, Exhibit 12.
[280] Statement of CM, 22 July 2022, paragraph 11d, Exhibit 12.
[281] Statement of CM, 22 July 2022, paragraph 11e, Exhibit 12.
[282] Statement of CM, 22 July 2022, paragraph 11g, Exhibit 12.
[283] CN notes there were seven incident reports lodged in relation to absconding, statement dated 16 June 2022, at paragraph 16, Inquest Brief Part 2, v2.4 at [5379].
[284] CN oral evidence, Inquest transcript of evidence for 15 February 2023, page 12.
[285] CN, statement dated 16 June 2022, at paragraph 14, Inquest Brief Part 2, v2.4 at [5379].
[286] CN, statement dated 16 June 2022, at paragraph 16, Inquest Brief Part 2, v2.4 at [5379]
[287] Inquest Brief Part 2, v2.4 at [3796].

can have the best possible outcome for Child 3… Despite being aware of this request, no efforts have been made to link Child 3 with her mother.'[288]

2.115 Uniting Team Leader, Ms DK, noted Uniting would have been Ms CG's primary point of contact[289] but that Uniting Care can escalate any concerns she had with Child Protection.[290]

2.116 On 23 May 2016, Take Two closed its involvement with Child 3 due to her non-engagement.[291]

2.117 Ms CN believed there were two specific meetings between herself and Ms CA in the lead up to the development of the safety plan. Ms CN could not recall the origin of the note documenting the meetings[292] and there were no contemporaneous case notes.[293] The first of these meetings also included Mr Darren Clover and occurred at the Uniting office on 20 June 2016.[294] Ms CN had noted Mr CQ appeared substance affected and sleepy, and relayed this to Child Protection.[295] The purpose of the meeting was to build rapport with Ms CA, to reinforce her not breaching contact conditions, and to encourage her to support Child 3 to remain in placement.[296] Ms CN did not consider it appropriate to press for information from Ms CA or Mr CQ as to the nature of their relationship or seek details about him at that time.[297] Ms DK's evidence was that if he had come onsite at Uniting, for staff security his identity and relationship to the client would have been clarified.[298] If that information was collected, there is no evidence it was relayed to Child Protection.

2.118 On 19 July 2016, Uniting provided its first quarterly report to Child Protection outlining that Child 3 had been absconding to her mother's house, and attempts made by Uniting Care to provide structure around that contact. The most recent case plan was dated 12

[288] Inquest Brief Part 2, v2.4 at [9755].
[289] DK oral evidence, Inquest transcript of evidence for 16 February 2023, pages 75-76.
[290] DK oral evidence, Inquest transcript of evidence for 16 February 2023, page 38.
[291] Take Two Closure Report commences in Inquest Brief Part 2, v2.4 at [4758].
[292] Statement of CN, 16 June 2022, paragraph 22, Inquest Brief Part 2, v2.4 at [5381].
[293] CN oral evidence, Inquest transcript of evidence for 15 February 2023, page 13.
[294] Statement of CN, 16 June 2022, paragraph 22, Inquest Brief Part 2, v2.4 at [5381]; DK also recalled this visit but not when it occurred, Statement of DK, 1 July 2022, paragraph 30, Inquest Brief Part 2, v2.4 at [6097].
[295] Statement of CN, 16 June 2022, paragraph 30 & 33, Inquest Brief Part 2, v2.4 at [5383].
[296] CN, statement dated 16 June 2022, at paragraph 22, Inquest Brief Part 2, v2.4 at [5381] and "BD-2" [5406].
[297] Statement of CN, 16 June 2022, paragraph 30, Inquest Brief Part 2, v2.4 at [5383].
[298] DK oral evidence, Inquest transcript of evidence for 16 February 2023, pages 60-61.

February 2015, at which point contact was to be supervised and organised through Child Protection.[299] Ms CN's view was that Child 3 would continue to seek out contact regardless of it being approved or not.[300]

2.119 The second meeting between Ms CN and Ms CA occurred at a Watergardens café on 20 July 2016,[301] and Ms CN's recollection was the purpose was to encourage Ms CA to support Child 3 to return to placement. She also spoke with Ms CA about Child 3's mid-week absconding and its disruption to Child 3's school routine.[302]

2.120 Ms CN initiated the development of a safety plan, in her view, as a harm minimisation tool, and the plan was discussed with Child 3, Ms CA and carer, Ms CG.[303] Ms CN initiated the development of this plan around Child 3's absconding, to provide a consistent response and to encourage her to return to placement.[304] At the time the safety plan was created, Uniting did not have a standard risk assessment template (as it now does). Ms CN prepared the safety plan without reference to any standard template. Overall responsibility for risk assessment and management was shared between Uniting and Child Protection, so that the safety plan required both Uniting and Child Protection's involvement.

2.121 Ms CN provided the plan she developed to Child Protection[305] and the plan documented that Child 3 would spend Sunday to Thursday night in placement and Friday to Sunday with her mother.[306] The plan also listed the parties involved, along with the concerns with respect to the contact with her mother, and actions related to the concerns.[307] Communication chains indicated Child Protection practitioner, Ms CP approved the plan on 1 August 2016, but Team Manager Ms CK did not endorse it as required.[308] Ms CG

[299] This case plan is located in the Inquest Brief Part 2, v2.4 at [4724].
[300] CN, statement dated 16 June 2022, at "BD-2", Inquest Brief Part 2, v2.4 at [5406].
[301] Statement of CN, 16 June 2022, paragraph 23, Inquest Brief Part 2, v2.4 at [5381].
[302] CN, statement dated 16 June 2022, at "BD-2", Inquest Brief Part 2, v2.4 at [5406].
[303] CN, statement dated 16 June 2022, at paragraph 20 Inquest Brief Part 2, v2.4 at [5381] and "BD-2" [5406].
[304] Statement of CN, 16 June 2022, paragraph 19, Inquest Brief Part 2, v2.4 at [5381].
[305] Statement of CN, 16 June 2022, paragraph 26, Inquest Brief Part 2, v2.4 at [5382].
[306] Inquest Brief Part 2, v2.4 at [5420].
[307] Inquest Brief Part 2, v2.4 at [5418].
[308] Statement of Kirstie-Lee Lomas, dated 28 June 2022, paragraph 38, Inquest Brief Part 2, v2.4 at [5356]; Statement of CN, 16 June 2022, paragraph 26, Inquest Brief Part 2, v2.4 at [5382].

gave evidence that, in her view, it is a child's right to have contact with their family and it was a matter of finding a safe way to facilitate it.[309]

2.122 Child 3 and Ms CA did not comply with the contact plan and Child 3 refused to disclose where she was staying in the first week after it was settled.[310] It appears little was done to verify where Child 3 was staying when spending time with her mother. Ms DK believes Ms CN did inform Child Protection that Ms CA resided with Mr CQ, and Child Protection could have undertaken any checks required given this was a Child Protection responsibility.[311] Ms CN could not recall being asked by Child Protection to pursue information about where Child 3 was staying or who else was present when with her mother.[312] Uniting did not pursue this and did not visit the address on the safety plan.[313] If contact was not occurring at Mr CQ's, Uniting did not establish where it was occurring.[314]

2.123 Uniting documented their concerns about Mr CQ appearing substance affected, but the available evidence suggests that no steps were taken to further assess this, in relation to risk assessment around Child 3's contact with Ms CA.

2.124 Ms CN gave evidence that the safety plan remained in place unaltered until Child 3's passing.[315] Uniting took the view that they could not stop Child 3 absconding, and the safety plan was a tool to manage that risk.[316] Ms DK's view was the plan captured what Child 3 herself thought she could manage, and also what each person's expectations were.[317]

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309 Oral evidence of CG, Inquest transcript of evidence for 17 February 2023, page 121; the 'safety plan' was reflective of Uniting Care and Ms CG supporting Child 3's desire to spend time with her mother, Oral evidence of CG, Inquest transcript of evidence for 17 February 2023, page 137-138.
310 Incident report commencing in Inquest Brief Part 2, v2.4 at [3593].
311 Statement of DK, 1 July 2022, paragraph 33, 34, Inquest Brief Part 2, v2.4 at [6097]; CN oral evidence, Inquest transcript of evidence for 15 February 2023, page 19.
312 CN oral evidence, Inquest transcript of evidence for 15 February 2023, page 13.
313 CN oral evidence, Inquest transcript of evidence for 15 February 2023, page 14.
314 CN oral evidence, Inquest transcript of evidence for 15 February 2023, page 20.
315 Statement of CN, 16 June 2022, paragraph 28 & 29, Inquest Brief Part 2, v2.4 at [5382]-[5383].
316 Statement of DK, 1 July 2022, paragraph 35, Inquest Brief Part 2, v2.4 at [6097] Inquest Brief Part 2, v2.4 at [6097]; CN oral evidence, Inquest transcript of evidence for 15 February 2023, page 15.
317 DK oral evidence, Inquest transcript of evidence for 16 February 2023, pages 50-51.

2.125 Child 3 consistently absconded throughout the Uniting foster care placement, with Ms CN noting there were seven incident reports related to this issue.[318] Upon any report of her absconding, Uniting would defer to Child Protection to determine if a missing persons report should be filed, a warrant sought, or a media release prepared.[319] Uniting remained obligated to follow the guidelines regarding reporting periods under the mandatory reporting scheme,[320] and this was regularly undertaken with respect to Child 3.[321]

2.126 Ms CN expressed there may have been some hesitation in seeking a warrant as it could shut down communication channels between carers, services and a young person.[322] One reason is if a warrant is issued, there is then the risk the police would attend where that young person was.[323] Ms CG reflected that her understanding was that in Child 3's previous placement, the execution of safe custody warrants by police had caused her and her mother significant distress.[324] In terms of consideration of further responses to Child 3 absconding, secure welfare was not considered for Child 3, and Ms CN does not believe she met the criteria.[325]

2.127 The safety that was established for Child 3 was primarily that phone contact was occurring with the carer, and was therefore dependant on the carer assessing risk.[326] This dynamic is reflected in the statement of Ms CG where she stated '*I would only call in for safe custody warrants when Child 3 had disappeared for too long and I hadn't been able to contact her or she hadn't contacted me.*'[327] Uniting did not consider an alternative arrangement for contact, such as it occurring at the carer's home,[328] or funding accommodation for it to occur in a safer environment, as Uniting would supervise the contact in preference of a carer doing so.[329]

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318 Statement of CN, 16 June 2022, paragraph 16, Inquest Brief Part 2, v2.4 at [5380].
319 Statement of CN, 16 June 2022, paragraph 16 Inquest Brief Part 2, v2.4 at [5380].
320 Statement of DK, 1 July 2022, paragraph 18, Inquest Brief Part 2, v2.4 at [6095].
321 Statement of DK, 1 July 2022, paragraph 19, Inquest Brief Part 2, v2.4 at [6095].
322 CN oral evidence, Inquest transcript of evidence for 15 February 2023, page 17.
323 CN oral evidence, Inquest transcript of evidence for 15 February 2023, page 24.
324 Statement of CG, 23 April 2017 at paragraph 9, Inquest Brief Part 2, v2.4 at [238].
325 CN oral evidence, Inquest transcript of evidence for 15 February 2023, page 18.
326 CN oral evidence, Inquest transcript of evidence for 15 February 2023, pages 23-24.
327 Statement of CG, 23 April 2017 at paragraph 10, Inquest Brief Part 2, v2.4 at [238].
328 CN oral evidence, Inquest transcript of evidence for 15 February 2023, page 14.
329 CN oral evidence, Inquest transcript of evidence for 15 February 2023, page 14-15.

2.128 On 18 August 2016, Ms CG advised Bridges of threats made by a male to disseminate intimate pictures of Child 3. A report was made to SOCIT with Ms CN's support.[330] Ms CG's view was that during this time, and also when Victoria Police applied for an intervention order against Child 3's will (see below),[331] that Child 3 became more reticent about sharing this kind of information and so Ms CG had to rely on Child 3's friends to give her information regarding her whereabouts.[332]

2.129 On 31 August 2016, while being transported to the dental hospital, Child 3 made disclosures of her mother being kicked out of Mr CQ's home, them having to stay with friends, and being exposed to drug use by those friends. She also disclosed she was continuing to have contact with an 18-year-old boy to whom she had become pregnant. Child Protection were advised of the pregnancy on 13 September 2016.[333] Child 3 later decided to terminate the pregnancy. Child 3 did not wish to pursue making a statement (given their age difference), however Victoria Police determined they would pursue an intervention order against the father despite Child 3's wishes.[334]

2.130 The available evidence indicates that Ms CA had commenced an on and off relationship with Mr CC by October 2016.[335] Ms CA appears to have had on and off relationships with both Mr CC and Mr CQ in the several months leading up to the fatal incident.[336] Ms CA and Mr CC also purportedly attended the East Melbourne police station in late November or early December 2016 to report Mr CQ making repeated threats against them.[337] However, Victoria Police records for Ms CA and Mr CQ provided to the Court contain no record of these reports. The Chief Commissioner of Police confirmed there is no record of these reports, however noted that it was Ms Kiana Mallia who made a statement to this

[330] Inquest Brief Part 2, v2.4 at [3608].
[331] See for example Inquest Brief Part 2, v2.4 at [3215].
[332] Oral evidence of CG, Inquest transcript of evidence for 17 February 2023, pages 129-130.
[333] Statement of Kirstie-Lee Lomas, dated 28 June 2022, paragraph 40, Inquest Brief Part 2, v2.4 at [5357].
[334] Inquest Brief Part 2, v2.4 at [3226].
[335] Statement of S Merigan, 30 March 2017 Inquest Brief Part 2, v2.4 at [396]-[397]; Statement of F Groux, 12 April 2017 Inquest Brief Part 2, v2.4 at [230]; Statement of N Lane, 10 March 2017 Inquest Brief Part 2, v2.4 at [328]-[329]; Inquest Brief Part 2, v2.4, Statement of material facts, 2.
[336] Statement of S Merigan, 30 March 2017 Inquest Brief Part 2, v2.4 at [396]-[397]; Statement of F Groux, 12 April 2017 Inquest Brief Part 2, v2.4 at [230]; Statement of N Lane, 10 March 2017 Inquest Brief Part 2, v2.4 at [328]-[329].
[337] Statement of K Mallia, 15 July 2017 Inquest Brief Part 2, v2.4 at [377]-[378].

effect, but her statement acknowledged that she was seated behind Ms CA and Mr CC while they made the report, and that she did not know the outcome.[338]

2.131 On 30 November 2016, Ms CN was advised by Ms CG that one of Child 3's friend's mother was concerned about them using ice together, causing Ms CG to seek a meeting with Child Protection and Uniting.[339] During this period, Child 3's absconding increased and at times she refused to return to placement.

2.132 Ms CN acknowledged substance use was a risk issue known to Uniting,[340] but this was not an issue that Uniting specifically sought to address, even after disclosures were made to a Uniting worker indicating it had escalated.[341] Uniting were also aware of the risks of self-harm and suicidality.[342] Ms CN does not recall that there was a specific written plan in relation to this but she had discussed with Ms CG how to respond to this risk.[343] Child 3 had previously been supported by Ms Azzopardi from Take Two, but the service closed due to her non-engagement.[344] Child 3 had not wanted to be referred to any other mental health supports.[345]

2.133 There was a referral made for Child 3 in January 2017 to VACCA for the Koori Cultural Placement and Support Program,[346] and an intake meeting took place on 14 February 2017.[347] No cultural support plan was ever developed for Child 3. At the time the Guardianship to the Secretary Order was made in relation to Child 3 (December 2014), the *Children, Youth and Families Act 2005* (Vic) required the preparation of a cultural support plan.[348] Ms CG made a complaint to Child Protection regarding the absence of such a plan.[349]

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338 Chief Commissioner of Police, by correspondence dated 14 April 2022, it is noted she was not privy to the conversations or report made and she did not herself speak with police. The Chief Commissioner has urged the court not to rely on the statements made by Mr CR or Ms Mallia to draw any adverse conclusions against Victoria Police.
339 Inquest Brief Part 2, v2.4 at [3283].
340 Statement of CN, 16 June 2022, paragraph 35, Inquest Brief Part 2, v2.4 at [5384].
341 CN oral evidence, Inquest transcript of evidence for 15 February 2023, pages 19, 20, 21, 22 & 23, Oral evidence of CG, Inquest transcript of evidence for 17 February 2023, pages 118-119.
342 Statement of CN, 16 June 2022, paragraph 37, Inquest Brief Part 2, v2.4 at [5384].
343 CN oral evidence, Inquest transcript of evidence for 15 February 2023, pages 5-6.
344 See closure report, commencing at the Inquest Brief Part 2, v2.4 at [4758].
345 CN oral evidence, Inquest transcript of evidence for 15 February 2023, page 8.
346 Inquest Brief Part 2, v2.4 at [1704].
347 Inquest Brief Part 2, v2.4 at [1702]-[1703].
348 Section 176(2) of the Children, Youth and Families Act 2005 (Vic).
349 Inquest Brief Part 2, v2.4 at [9755].

2.134 The quarterly report by Bridges dated 19 July 2016 also noted the absence of a cultural support plan for Child 3. Nonetheless, Ms CN provided as much support as she was able in terms of linking Child 3 with appropriate cultural supports.[350] She notes no cultural plan was provided or developed to her knowledge for Child 3, despite her (and Ms CG's[351]) requests.[352]

2.135 In January 2017, Ms CA went to stay with an ex-partner Mr CS in Wonthaggi to cease heroin use, was briefly hospitalised for opiate withdrawal, and later commenced the methadone program.[353] In early February 2017, Ms CA returned to Melbourne to stay with Mr CQ. Child 3's partner, Mr CH, stated that he witnessed Mr CQ try to forcefully inject Ms CA with drugs, she resisted and asked him to intervene, which Mr CH did – Child 3 was present at this incident.[354] Ms CA had reportedly said she did not want to stay with Mr CQ, but needed a safe place for Child 3 to stay.[355] It appears Ms CA went to stay with Mr CC in the alcove in late February 2017.[356]

CIRCUMSTANCES LEADING TO THE FATAL INCIDENT

2.136 Mr CQ and Ms CA appeared to have had an off-and-on again relationship in the lead up to the fatal incident. Ms CA had also developed a relationship with Mr CC. There were multiple reports of family violence by Mr CQ, and threats made to both Ms CA and Mr CC.[357] This included Mr CQ making a throat-cutting gesture to Mr CC and telling Ms CA '*you will always be mine and no one will have you*.'[358]

2.137 On 18 February 2017, Ms CA attended a festival with Mr CQ and used the opportunity to get away from Mr CQ, going to stay with a friend, Ms CI.[359] It is believed Ms CA then

[350] Statement of CN, 16 June 2022, paragraph 45, Inquest Brief Part 2, v2.4 at [5386]; Statement of CG, dated 23 June 2022, Inquest Brief Part 2, v2.4 at [9748].
[351] Statement of CG, dated 23 June 2022, page 3, Inquest Brief Part 2, v2.4 at [9750].
[352] CN oral evidence, Inquest transcript of evidence for 15 February 2023, page 10. This was also noted in the Quarterly Report dated 19 July 2016 Inquest Brief Part 2, v2.4 at [5439].
[353] Statement of CS, 29 March 2017 Inquest Brief Part 2, v2.4 at [295]-[296].
[354] Statement of CH, 20 April 2017 Inquest Brief Part 2, v2.4 at [94].
[355] Statement of CI, 26 March 2017 Inquest Brief Part 2, v2.4 at [553].
[356] Statement of D Harvey, 12 April 2017 Inquest Brief Part 2, v2.4 at [248]; F Groux, 12 April 2017 Inquest Brief Part 2, v2.4 at [230].
[357] Statement of B Attard-Lees, 20 April 2017 Inquest Brief Part 2, v2.4 at [60]-[61]; Statement of S Merigan, 30 March 2017 Inquest Brief Part 2, v2.4 at [396]; Statement of CH, 20 April 2017 Inquest Brief Part 2, v2.4 at [94].
[358] Statement of Naomi Lane, 10 March 2017 Inquest Brief Part 2, v2.4 at [329].
[359] Statement of CI, 26 March 2017 Inquest Brief Part 2, v2.4 at [553].

went to stay in the alcove in Footscray where Mr CC had been squatting, and one witness states they saw Mr CQ threaten them both saying '*I'm going to burn you to your grave.*'[360] Another witness states he threatened '*I'm going to burn them'* and '*I'm going to kill them*.'[361]

2.138 On Friday 24 February 2017, Child 3 went to stay with Ms CA pursuant to her safety plan. Ms CG was under the impression that she was at Mr CQ's Delahey address, however Child 3 was staying with Ms CA and Mr CC in the alcove.[362]

2.139 On 25 February 2017, Mr CQ told another friend that he was going to burn Ms CA and Mr CC, and that he would '*do it properly*'.[363] Mr CQ was reportedly angry about a rumour he believed Ms CA had started amongst their community that he had taken explicit photographs of Child 3.[364]

2.140 On 26 February 2017, Child 3 ceased contact with Ms CG and did not return to her placement as per her safety plan.[365] On 28 February 2017, police searched for Child 3 at Mr CQ's address. Mr CQ told police that he had seen Ms CA and Child 3 earlier that day, and that they were staying near the McDonalds and the rope factory in Kinnear Street.[366] It was submitted on behalf of the Chief Commissioner that the information provided by Mr CQ to police was not precise enough to have been acted on and this submission is accepted.

2.141 Ms CN stated she was not aware of Ms CA or Child 3 spending time in Footscray or at Mr CC's squat. She also stated that she was not aware of Mr CQ having a history of violent or controlling behaviour, and only became aware of this following a conversation with Ms CG on 3 March 2017.[367]

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[360] Statement of Naomi Lane, 10 March 2017 Inquest Brief Part 2, v2.4 at [329].
[361] Statement of R Thornton, 25 March 2017 Inquest Brief Part 2, v2.4 at [649].
[362] DHHS – Child Protection, Records of Child 3, Inquest Brief Part 2, v2.4 at [3082].
[363] Statement of D Harvey, 12 April 2017 Inquest Brief Part 2, v2.4 at [247].
[364] Ibid.
[365] DHHS – Child Protection, Records of Child 3, Inquest Brief Part 2, v2.4 at [3082].
[366] Victoria Police Submissions and additional records provided to the Court and dated 14 April 2022, 91.
[367] Statement of CN, 16 June 2022, paragraph 41, Inquest Brief Part 2, v2.4 at [5385]; Ms DK concurs Uniting were not aware of this risk prior to Child 3's passing, statement of DK, 1 July 2022, paragraph 36, Inquest Brief Part 2, v2.4 at [6097].

2.142 On 1 March 2017, Ms CA and Mr CC told friends they suspected Mr CQ of stalking them, loitering outside of the alcove and listening to them, and trying to break into the alcove.[368] Later that day Ms CA, Mr CC and Child 3 passed away as a result of the effects of fire after Mr CQ deliberately set fire to the alcove while they were inside.[369] Toxicology reports indicate that all of the deceased parties had methylamphetamine and cannabis in their systems, and Ms CA and Mr CC also had heroin in their systems.[370] Mr CQ pleaded guilty to the murder of all three of the deceased and was sentenced to 30 years in prison with a non-parole period of 24 years.[371].

IDENTITY OF THE DECEASED

2.143 Child 3 was identified through fingerprint record comparisons on 3 March 2017. Identity is not in dispute and requires no further investigation.

MEDICAL CAUSE OF DEATH

2.144 On 2 March 2017, Dr Matthew Lynch, a Senior Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, performed an autopsy on the body of Child 3.

2.145 Upon review of all the evidence from autopsy and post-mortem CT scans, Dr Lynch provided a written report dated 1 June 2017, which concluded that Child 3's death was due to the effects of fire.

2.146 Dr Lynch noted that there was evidence of extensive superficial cutaneous thermal injury and large amounts of sooty material present on Child 3's body. There was also evidence of smoke inhalation with sooty material noted on the tongue and within the upper and more distal airways. Toxicology results taken from post-mortem blood samples evidenced hydrogen cyanide and carboxyhaemoglobin both gases which are produced in a fire and the detected concentration levels were fatal. Dr Lynch concluded that Child 3 died from the effects of fire. I accept Dr Lynch's opinion.

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368 Statement of S Merigan, 30 April 2017, Inquest Brief Part 2, v2.4 at [399]; Statement of R Thornton, 2 March 2017 Inquest Brief Part 2, v2.4 at [637].
369 VIFM Autopsy Report for Child 3, Inquest Brief Part 2, v2.4 at [12].
370 VIFM Toxicology Report for Child 3, Inquest Brief Part 2, v2.4 at [20].
371 *DPP v Clover* [2019] VSC 123, 26.

CHILD 4

BACKGROUND

2.147 Child 4 was 13 months old when she died on 5 June 2017. Child 4 was the youngest of four siblings born to Ms DA and Mr DB. Child 4's three older siblings, DC, DD and DE were aged almost 5, 4, and 2 years old respectively at the time of Child 4's death.[372]

2.148 Ms DA was born in Somalia and immigrated to Australia in 1999 with her parents and siblings. She met Mr DB while on holiday in Kenya, and they later married in January 2010.[373] Ms DA became pregnant shortly after but unfortunately miscarried at about three months gestation. Mr DB stated that this was the first time he noticed a decline in Ms DA's mental health, an issue he had not previously encountered, but something he needed to learn about over the course of their relationship through '*trial and error*.'[374]

2.149 In June 2012, Ms DA gave birth to their first son, DC, in Kenya, and Ms DA, Mr DB and DC returned to Australia later in 2012. Following the birth of their second child, DD, in August 2013, Ms DA learned that her mother had died during a holiday in Kenya of heart failure.[375] Mr DB states her mother's death had a profound impact on Ms DA and her behaviour, and he sought help for her at this juncture.[376]

2.150 In November 2013, Ms DA suffered her first mental health episode leading to involuntary inpatient treatment under the *Mental Health Act 1986*. Ms DA believed Mr DB was having an affair and at 5.00am on 12 November 2013, left the bed she was sharing with him and their two children to retrieve a knife. She then stabbed Mr DB in the face seven times, as Mr DB tried to protect the children.[377] The family were at that time residing in a bungalow nearby the maternal family, and Mr DB retreated to the main house where Ms DA's father and brother resided, and an ambulance and police were called.[378]

[372] Child Protection CRIS records, Intake Document, Inquest Brief Part 2, v2.4 at [7078].
[373] Statement of DB, dated 27 July 2017, Inquest Brief Part 2, v2.4 at [6430].
[374] Statement of DB dated 27 July 2017, Inquest Brief Part 2, v2.4 at [6430-6431].
[375] Statement of DA, dated 5 June 2017, Inquest Brief Part 2, v2.4 at [6415].
[376] Statement of DB dated 27 July 2017, Inquest Brief Part 2, v2.4 at [6432].
[377] Statement of DB, dated 27 July 2017, Inquest Brief Part 2, v2.4 at [6434].
[378] Statement of DB, dated 27 July 2017, Inquest Brief Part 2, v2.4 at [6435].

2.151 Ms DA was admitted to the Northern Hospital Emergency Department, and later Psychiatric Unit, where she was diagnosed with post-partum psychosis[379] and received a course of six episodes of electroconvulsive treatment.[380] This also precipitated the first report to Child Protection[381] and a police-initiated family violence intervention order excluding her from the family home.[382] Ms DA remained as an inpatient until 30 November 2013, when she was discharged on a Community Treatment Order (**CTO**).[383] Upon Mr DB's request, the intervention order was varied to allow Ms DA to return to reside in the family home.

2.152 Ms DA primarily received mental health treatment from her area mental health provider, NWMH, from this first episode in November 2013. Inpatient treatment was provided through the Northern Hospital Emergency Department as well as the Acute Inpatient Unit. Treatment in the community was provided by the Northern Area Mental Health Service (**NAMHS**).

2.153 The treating team included a consultant psychiatrist, a registrar, and a key clinician who collectively undertook clinical reviews each week.[384] Treating teams sat within a '*pod*' which was inclusive of disciplines including psychologists, social workers, and nurses.[385] The key clinician was likened to a case manager,[386] and in Ms DA's case this was a role primarily held by registered nurse (**RN**) DG. The key clinician held responsibility for a caseload of approximately 28 to 32 individuals, as well as rostered duties, as estimated by RN DG (who worked part-time).[387] In case notes, RN DG recorded this as a '*very high'* load.[388]

2.154 On 7 December 2013, Ms DA experienced a resurgence of her symptoms and attended her GP and was given a risperidone injection, and she was later readmitted to the

[379] Statement of Dr DL, dated 25 July 2022, at page 8, Exhibit 14.
[380] North West Mental Health records, Inquest Brief Part 2, v2.4 at [7797], [7776], [7765], [7754], [7742] & [7729].
[381] DFFH records, Inquest Brief Part 2, v2.4 at [7338].
[382] Victoria Police Records, Inquest Brief Part 2, v2.4 at [8695] – [8698].
[383] North West Mental Health records, Inquest Brief Part 2, v2.4 at [7451].
[384] Oral evidence of RN DG, Inquest transcript of evidence for 9 August 2022, page 904.
[385] Oral evidence of Dr DL, Inquest transcript of evidence for 10 August 2022, page 985.
[386] Oral evidence of RN DG, Inquest transcript of evidence for 9 August 2022, page 902.
[387] Oral evidence of RN DG, Inquest transcript of evidence for 9 August 2022, page 902.
[388] Inquest Brief Part 2, v2.4 at [9582].

psychiatric unit for three days.[389] Ms DA was then discharged on a CTO requiring her to take 3mg of risperidone each night. At a medical review on 17 December 2013, Ms DA complained that the medication made her feel sedated, and it is noted she cited her mother's death by heart failure (who took the same medication) for her concerns about physical side effects of the medication.[390]

2.155 Child Protection organised a family-led decision-making meeting on 27 December 2013 with Ms DA, Mr DB, the maternal uncle and maternal grandfather, along with a family friend.[391] At this meeting, plans around keeping the children safe, as well as supports required, were discussed, including a referral to Child First. A request was made by the family for Child Protection to support them to obtain childcare and housing, and there are letters of support for this on their file.[392]

2.156 The CTO was revoked on 10 January 2014 on the basis that Ms DA was willing to continue her treatment voluntarily.[393]

2.157 On 17 February 2014, Child First accepted the referral[394] and Child Protection indicated they would remain involved until Child First commenced working with the family.[395]

2.158 On 27 February 2014, Child Protection closed the case, having determined that their involvement was no longer required as Ms DA was engaging with community mental health supports and no further concerns for the children had been raised during the intervention.[396] Ms DA advised Child First that she did not need their assistance on 12 March,[397] so Child First closed their file on 19 March 2014.[398] While Ms DA did engage with NAMHS, she was not happy that the community team attended her home

[389] Statement of Dr DL dated 25 July 2022, at page 9-10, Exhibit 14.
[390] NWMH records, Inquest Brief Part 2, v2.4 at [7863].
[391] CRIS records, Inquest Brief Part 2, v2.4 at [7294]-[7296].
[392] DFFH records, Inquest Brief Part 2, v2.4 at [7287]; Statement of Kirstie-Lee Lomas, 21 June 2022, at paragraph 28, Inquest Brief Part 2, v2.4 at [9151].
[393] Statement of Dr DL dated 25 July 2022, at page 12, Exhibit 14; NWMH records, Inquest Brief Part 2, v2.4 at [7840].
[394] Child Protection records, Inquest Brief Part 2, v2.4 at [7273], Statement of Kirstie-Lee Lomas, 21 June 2022, at paragraph 29, Inquest Brief Part 2, v2.4 at [9151].
[395] As communicated to NWMH, Child Protection records Inquest Brief Part 2, v2.4 at [7827], though closure record completed on the same day, Inquest Brief Part 2, v2.4 at [7258].
[396] Statement of Kirstie-Lee Lomas, 21 June 2022, at paragraph 30, Inquest Brief Part 2, v2.4 at [9152].
[397] Child First records, Inquest Brief Part 2, v2.4 at [8716].
[398] Child First records, Inquest Brief Part 2, v2.4 at [8717].

unannounced, and indicated she would prefer to attend upon the clinic with Mr DB.[399] It is believed she self-ceased her medication in March 2014.[400]

2.159 Ms DA re-engaged with NAMHS while pregnant on 9 July 2014 due to experiencing anxiety, seeking a medication that would not harm the foetus.[401] She was prescribed 10mg chlorpromazine, though did not commence taking the medication.[402] Ms DA did not engage with the community team after this and requested to be discharged in September 2014.[403]

2.160 On 21 May 2015, Ms DA reported experiencing family violence at the hands of Mr DB and had taken DE, then two months old, to a refuge. Due to police concerns about her being non-responsive to her child, the crisis and assessment treatment team (**CATT**) were contacted to assess Ms DA.[404] Ms DA was admitted to the psychiatric unit on 23 May 2015 and remained there until 12 June 2015,[405] whereupon she was discharged under a CTO for six weeks.[406] A report was made to Child Protection on 21 May 2015, being the second in relation to this family.[407] Child Protection determined this was to be classified as a wellbeing report and closed the report on 26 May 2015.[408] A further referral to Child First was made, but the family again declined this service.[409]

2.161 On 10 June 2015, Child First initiated a section 38 consultation[410] with Child Protection as Ms DA had informed them that she remained an inpatient, and the children were being cared for by a maternal aunt. Child Protection determined that Child First should make further enquiries regarding her mental health and the care of the children and reconsult if

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399 NWMH records, Inquest Brief Part 2, v2.4 at [7832], [7822].
400 Statement of Dr DL dated 25 July 2022, at page 13, Exhibit 14, NWMH records, Inquest Brief Part 2, v2.4 at [7824].
401 Statement of RN DG dated 8 August 2017, Inquest Brief Part 2, v2.4 at [6685].
402 Statement of Dr DL dated 25 July 2022, at page 14, Exhibit 14, Statement of RN DG dated at 8 August 2017, Inquest Brief Part 2, v2.4 at [6685].
403 Statement of RN DG dated 8 August 2017, Inquest Brief Part 2, v2.4 at [6685]; NWMH records, Inquest Brief Part 2, v2.4 at [7803].
404 Child Protection records, Inquest Brief Part 2, v2.4 at [7256].
405 Statement of Dr DL dated 25 July 2022, at page 17, Exhibit 14.
406 Statement of Dr DL at dated 25 July 2022, at page 17-18, Exhibit 14.
407 Child Protection Intake Record commences in Inquest Brief Part 2, v2.4 at [7230]; Statement of Kirstie-Lee Lomas, 21 June 2022, at paragraph 31 and following, Inquest Brief Part 2, v2.4 at [9152].
408 Child Protection records, Inquest Brief Part 2, v2.4 at [7227].
409 Child First records, Inquest Brief Part 2, v2.4 at [8771], [8764], [8768].
410 Child and Family Information Referral and Support Teams (Child FIRST), services in The Orange Door, and registered family services, are able to consult with child protection at any time under section 38 of the *Children, Youth and Families Act 2005* (Vic).

required,[411] but determined that there were no immediate or significant risks of harm to warrant Child Protection involvement.[412]

2.162 Following the May admission, NAHMS had difficulty engaging Ms DA in the community. On 26 June 2015 at an attempted home visit, Ms DA expressed that she did not wish to engage with the team.[413] In late June 2015, Ms DA advised that she did not believe she needed to comply with the CTO or attend medical reviews.[414]

2.163 On 3 July 2015, Ms DA reported to police she believed her sister and brother had stolen their family's passports to use them for terrorist activities.[415] While police were in attendance, one of the children was locked in the house with infant DE screaming, and police were concerned Ms DA did not appear to be worried about this.[416]

2.164 On 9 July 2015, Child Protection received a fourth report, following the incident on 3 July.[417] Commencing on 14 July, Child Protection made enquiries with Child First, who confirmed the family had declined their service.[418] Child Protection also spoke with NWMH who provided information about Ms DA's inpatient stay, and subsequent CTO, which they were advocating should be extended for six months.[419] Child Protection also spoke with the Enhanced Maternal Child Health Nurse (**EMCHN**), who had concerns about the older children's development and Ms DA's attachment with the children.[420] However, on 20 July 2015, a determination was made to close at intake due to extended family support and the risks identified not meeting the threshold for Child Protection intervention.[421]

2.165 It is believed Ms DA self-ceased her medication in July or August 2015.[422] In early September 2015, Ms DA travelled to Somalia, where she stayed until late February or

411 Child First records, Inquest Brief Part 2, v2.4 at [7225]-[7226].
412 Statement of Kirstie-Lee Lomas, 21 June 2022, at paragraph 37 – 40, Inquest Brief Part 2, v2.4 at [9153]-[9154].
413 NWMH records, Inquest Brief Part 2, v2.4 at [7702].
414 NWMH records, Inquest Brief Part 2, v2.4 at [7698], [7697].
415 As reported to Child Protection on 9 July 2015, refer to their records in the Inquest Brief Part 2, v2.4 at [7217] to [7219].
416 Ibid.
417 Child protection records, Inquest Brief Part 2, v2.4 at [7194].
418 Statement of Kirstie-Lee Lomas, 21 June 2022, at paragraph 43, Inquest Brief Part 2, v2.4 at [9155].
419 Statement of Kirstie-Lee Lomas, 21 June 2022, at paragraph 45, Inquest Brief Part 2, v2.4 at [9155]-[9156].
420 Statement of Kirstie-Lee Lomas, 21 June 2022, at paragraph 46 & 48, Inquest Brief Part 2, v2.4 at [9156], [9157].
421 Statement of Kirstie-Lee Lomas, 21 June 2022, at paragraph 49, Inquest Brief Part 2, v2.4 at [9157].
422 Statement of Dr DL dated 25 July 2022, at page 21, Exhibit 14; NWMH records at [7666].

early March 2016.[423] The CTO remained in place until 24 January 2016 but despite ongoing attempts by RN DG to engage Ms DA, NAMHS were not able to monitor her compliance due to her absence.[424]

2.166 Despite her attempts, RN DG found it difficult to engage with Ms DA.[425] Her evidence was that Ms DA would only engage with the psychiatrist about her medication, or for support letters, but would not engage about her parenting.[426]

2.167 On 5 May 2016, Child 4 was born. Throughout Child 4's infancy, the MCHN service provided by Darebin City Council had some difficulty engaging with Ms DA. Maternal Child Health Services in each Council area employ qualified nurses to provide voluntary services to families. Their principal responsibilities include:

a) Assessing a child's health, development and wellbeing;

b) Listening to parenting experiences and any concerns; and,

c) Providing guidance, emotional support and education on childhood development and behaviour.[427]

2.168 Families are generally visited on a schedule that moves from a more intensive to a less intensive service, at birth, two weeks, one month, two months, four months, eight months, twelve months, eighteen months, two, and three and a half years.[428] Families can be referred to an enhanced service where additional support is required or a child is at risk of harm, but engagement remains voluntarily (unless court-ordered).[429] Ms Karamis, coordinator of the Darebin City Council service, understood that Ms DA had been referred to the enhanced service on '*numerous'* occasions but declined to accept the referral.[430] Darebin City Council MCHN, Ms DF, stated Ms DA told her she was upset that the

[423] GP records, Inquest Brief Part 2, v2.4 at [9620], [9619].
[424] NWMH records, Inquest Brief Part 2, v2.4 at [7659].
[425] Oral evidence of RN DG, Inquest transcript of evidence for 9 August 2022, page 906.
[426] Oral evidence of RN DG, Inquest transcript of evidence for 9 August 2022, page 908.
[427] Statement of Donna Karamis dated 27 June 2022 at page 1, Inquest Brief Part 2, v2.4 at [9655].
[428] Statement of Donna Karamis dated 27 June 2022 at page 1, Inquest Brief Part 2, v2.4 at [9655]; Statement of DF dated 14 July 2022 at page 1, Exhibit 8.
[429] Ibid, page 2.
[430] Ibid, page 3; Ms DF states she offered this directly and it was refused on 10 January 2017 in her statement dated 14 July 2022 at page 2, Exhibit 8.

enhanced service involved for their first child[431] had referred the family to Child Protection and therefore did not agree to such a referral again.[432]

2.169 Following Child 4's birth, the MCHN attended for the two week visit[433], and Ms DF attended for the eight week visit.[434] Before commencing with the family, Ms DF recalled noting a history of post-natal depression for Ms DA on file, but there were otherwise no '*red flags*' for Child 4 or Ms DA in the system.[435] The eight week visit was conducted on 28 June 2016 as a home visit as Ms DA found it difficult to attend the centre.[436] Ms DF did not recall any concerns about post-natal depression at that visit, and that Ms DA denied any previous diagnosis.[437] On reviewing the Council's, file Ms DF understands Ms DA did not attend the four week or three month checks.[438]

2.170 On 14 July 2016, Mr DB brought Ms DA into the Northern Hospital's Emergency Department due to a resurgence in her mental health symptoms, and she was admitted as an involuntary inpatient from 14 July to 2 August 2016.[439]

2.171 On 15 July 2016, while involuntarily being treated, NWMH records reflect that Ms DA assaulted a nurse who was assisting with her expressing breast milk by hitting her on her neck.[440]

2.172 On 2 August 2016, after discharge, the NAMHS community team conducted a home visit to supervise Ms DA taking her medication, which she stated was not needed.[441] At her medical review on 5 August 2016, NWMH clinician, Dr DM, recorded that Mr DB confirmed he was confident he could supervise Ms DA taking her medication.[442]

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[431] Oral evidence of DF, Inquest transcript of evidence for 8 August 2022, page 62.
[432] Statement of DF dated 14 July 2022 at page 2.
[433] Darebin Council records, Inquest Brief Part 2, v2.4 at [6921].
[434] Statement of DF at page 6-8; Statement of DF dated 14 July 2022 at page 1; Darebin Council records, Inquest Brief Part 2, v2.4 at [6917].
[435] Oral evidence of DF, Inquest transcript of evidence for 8 August 2022, page 50, and at page 73 the red flags for post-natal depression and child protection involvement were "closed".
[436] Statement of DF dated 14 July 2022 at page 1, Exhibit 8.
[437] Oral voce evidence of DF, Inquest transcript of evidence for 8 August 2022, page 52-53.
[438] Statement of DF dated 14 July 2022 at page 1, 2, Exhibit 8.
[439] Statement of Dr DM dated 22 July 2022, at page 7, Exhibit 13.
[440] NWMH records, Inquest Brief Part 2, v2.4 at [8174].
[441] NWMH records, Inquest Brief Part 2, v2.4 at [9584], [9602].
[442] NWMH records, Inquest Brief Part 2, v2.4 at [9592].

2.173 On 6 August 2016, Ms DA was readmitted upon a psychiatric relapse, presenting as anxious and reporting '*something is going to happen*' and '*I'm going to do something*'[443], and remained in the unit from 6 to 9 August 2016.[444] During this inpatient stay, Ms DA was commenced on a long-acting injectable form of risperidone.[445]

2.174 Following discharge, a six-month CTO was made. On review by Dr DM on 17 August 2016, Ms DA complained about the side effects of her medication and asked for it to be reduced, which was done, to 3mg and then 2mg.[446] Upon review on 31 August, Ms DA sought to move to oral medication alone. Upon Mr DB's assurance that he would ensure this was taken, Dr DM agreed for her to move from injectable to solely oral medication.[447] This was reduced to 1mg by 14 September,[448] and on 27 September 2016 the CTO was revoked.[449]

2.175 NWMH clinician, Dr DL, noted there was a consistent theme throughout the episodes of treatment of complaints by Ms DA about the side effects of her medication (risperidone) once she had stabilised and started being treated in the community. Though she was being treated under a CTO, she expressed a preference for being treated by her GP (and engage only voluntarily with NAHMS).

2.176 On 30 August 2016, Ms DA was scheduled to attend Child 4's four month check with the MCHN, however as she was running late Ms DF rescheduled to 5 September 2016, when Mr DB and Ms DA both attended.[450] At this appointment, Ms DA told Ms DF she had developed post-natal depression and was under the care of NWMH services.[451] Ms DF made observations of Ms DA's flat affect, and her and Mr DB's limited interaction with Child 4.[452] Ms DF gave them advice about being more interactive with Child 4, but that the '*mother said she didn't feel like it, the father said he didn't have time because he was*

[443] NWMH records, Inquest Brief Part 2, v2.4 at [8124].
[444] Statement of Dr DM dated 22 July 2022, at page 7, Exhibit 13.
[445] Statement of Dr DL dated 25 July 2022, at page 23, Exhibit 14.
[446] NWMH records, Inquest Brief Part 2, v2.4 at [9585].
[447] NWMH records, Inquest Brief Part 2, v2.4 at [9581].
[448] NWMH records, Inquest Brief Part 2, v2.4 at [9570]; Statement of Dr DL dated 25 July 2022, at page 26, Exhibit 14.
[449] Statement of Dr DL dated 25 July 2022, at page 30, Exhibit 14; NWMH records, Inquest Brief Part 2, v2.4 at [9566].
[450] Statement of DF dated 14 July 2022 at page 2, Exhibit 8.
[451] Statement of DF dated 14 July 2022 at page 2, Exhibit 8.
[452] Statement of DF dated 14 July 2022 at page 11, Exhibit 8; Darebin Council records, Inquest Brief Part 2, v2.4 at [6934], [6935], [6913], [6914]; Oral evidence of Ms DF, Inquest transcript of evidence for 8 August 2022, page 55.

caring for his wife and the other children.'[453] At that visit Ms DF noted a relatively low score for post-natal depression on the Edinburgh screening tool, but gave evidence that this may have demonstrated Ms DA not being completely truthful in her answers to Ms DF's questions.[454] Ms DF did not know of Ms DA's recent hospitalisation.[455]

2.177 On 13 September 2016, Ms DF relayed her concerns to RN DG.[456] Ms DF's concerns were not relayed to Child Protection by her or RN DG. Ms DF indicated she had chosen to report the concerns to RN DG because of the latter's regular contact with the family.[457] At her medical review on 26 October 2016, Ms DA requested that her care be transferred to her long-term GP, Dr Chan.[458] On 22 December 2016, Ms DA attended Dr Chan complaining of low mood and was prescribed sertraline 50mg daily. She attended the clinic again on 24 January 2017 and advised that she had taken sertraline for 4 days and then stopped but was agreeable to restart risperidone.[459] On 3 March 2017, she again saw Dr Chan saying she was feeling mentally unwell and was prescribed 1mg risperidone at night and Pristiq (desvenlafaxine) 50mg.[460] On 13 May 2017 Mr DB took Ms DA to Dr Chan, concerned about her relapsing, and a risperidone injection was administered.[461]

2.178 Ms DF was unable to meet with Ms DA for Child 4's eight-month or twelve-month review. Ms DF suggested a referral to the EMCHN service, in part due to their capacity to conduct home (rather than office) visits,[462] but Ms DA declined this.[463] Ms DF attempted a cold-call visit in May 2017 because of Ms DA's concerns about Child 4's growth and because Ms DA had not attended the eight or twelve months visits, but this

[453] Oral evidence of DF, Inquest transcript of evidence for 8 August 2022, page 55 which led to her reporting this to RN DG.
[454] Oral evidence of DF, Inquest transcript of evidence for 8 August 2022, page 53-54.
[455] Oral evidence of DF, Inquest transcript of evidence for 8 August 2022, page 54 she gave evidence she had only learning of this as a result of DB's evidence earlier in the day.
[456] Statement of DF dated 14 July 2022 at page 13, Exhibit 8; statement of RN DG dated 22 July 2022 at p16, Exhibit 11; NWMH records, Inquest Brief Part 2, v2.4 at [9574].
[457] Oral evidence of DF, Inquest transcript of evidence for 8 August 2022, page 56.
[458] Statement of Dr DL dated 25 July 2022, at page 32, Exhibit 14; NWMH records, Inquest Brief Part 2, v2.4 at [9561].
[459] GP records, Inquest Brief Part 2, v2.4 at [9617].
[460] GP records, Inquest Brief Part 2, v2.4 at [9617].
[461] GP records, Inquest Brief Part 2, v2.4 at [9616].
[462] Oral evidence of DF, Inquest transcript of evidence for 8 August 2022, page 61.
[463] Oral evidence of DF, Inquest transcript of evidence for 8 August 2022, page 58.

was unsuccessful.[464] Ms DF also relayed her concerns to NWMH for Child 4 on 23 May 2017, at which time she was advised Ms DA was an inpatient.[465.]

2.179 Ms DF confirmed at inquest that her concerns were never relayed to Child Protection by her. She stated a family's disengagement is not a reason to make a report to Child Protection in itself, and she did not otherwise believe Child 4 was at risk of harm.[466] On her review of the file, while Ms DA was in hospital the children were with the father and there had been no concerns raised about him, so again a report could not be justified in her view.[467] Ms DF was also of the view that her concerns did not require consultation[468] or escalation.[469]

2.180 Consideration of any mandatory report would usually involve a discussion with a superior, but this was not required.[470] Ms DF also took the view that had she consulted with a superior there would not have been anything they could have suggested in terms of anything else she might have done with respect to engaging the family.[471] Ms DF[472] and Ms Karamis[473] both did not believe there was an avenue for an informal sharing of information with Child Protection, though Ms Karamis thought this would be of assistance to maternal child health nurses.

2.181 Director of Child Protection, Shane Wilson, provided a statement that set out the DFFH position in relation to avenues for contacting Child Protection.[474] Mr DB reported that Ms DA's behaviour was escalating on 15 May 2017 and reported this to the hospital, who advised him to ring police. Mr DB did so while barricading himself and the children in one of the bedrooms until Ms DA left the family home. Police transported her to hospital to be assessed on 16 May, but she absconded from the Emergency Department.[475] She

464 Oral evidence of Ms DF, Inquest transcript of evidence for 8 August 2022, page 65.
465 Darebin Council records, Inquest Brief Part 2, v2.4 at [7597]; NWMH records, Inquest Brief Part 2, v2.4 at [9547].
466 Statement of DF dated 14 July 2022 at page 3, Exhibit 8.
467 Oral evidence of DF, Inquest transcript of evidence for 8 August 2022, page 69.
468 Oral evidence of DF, Inquest transcript of evidence for 8 August 2022, page 72.
469 Oral evidence of DF, Inquest transcript of evidence for 8 August 2022, page 70.
470 Oral evidence of DF, Inquest transcript of evidence for 8 August 2022, page 77.
471 Oral evidence of DF, Inquest transcript of evidence for 8 August 2022, pages 83 & 85.
472 Oral evidence of DF, Inquest transcript of evidence for 8 August 2022, page 77.
473 Oral evidence of Karamis, Inquest transcript of evidence for 8 August 2022, page 102.
474 Statement of Shane Wilson dated 15 December 2022, page 2.
475 Child Protection records, Inquest Brief Part 2, v2.4 at [7144]; Statement of Dr DL 25 July 2022 at paragraph 35, Exhibit 14.

was brought back to the hospital on 17 May by Mr DB and upon further attempts to abscond, she was physically restrained.[476] She was admitted to the psychiatric ward on 18 May, and a further attempt to abscond on 19 May required physical restraints.[477] Ms DA remained an inpatient until 25 May 2017.[478]

2.182 On 16 May 2017, a fifth notification was made to Child Protection. After receiving the report, Child Protection practitioner, Ms DI, then received a risk assessment ("L17") from police which contained very little by way of narrative, and no history with respect to family violence.[479] On consultation with her team manager, it was determined that Ms DI would seek an update on the mother's progress at hospital and discharge plan.[480]

2.183 Ms DI engaged in information gathering that was focussed on Ms DA's mental health.[481] Ms DI did not receive a hospital discharge plan given the investigation opened and closed before Ms DA was being prepared for discharge.[482]

2.184 Ms DI did not recall considering whether a Children's Court order should be pursued to ensure compliance with her medication regime, as this was not done at an intake level, though it was noted non-compliance was an issue throughout the Child Protection reports.[483] Intake try to make sure there is a safety plan or safety in place, but in this case, it was not formalised.[484]

2.185 On 18 May 2017, it was determined that Child Protection were not required to intervene and would instead make a further referral to Child First.[485] Child Protection closed their investigation on 22 May 2017 while Ms DA remained an involuntary inpatient.[486]

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476 Statement of Dr DL 25 July 2022 at paragraph 35, Exhibit 14; NWMH records, Inquest Brief Part 2, v2.4 at [7445].
477 NWMH records, Inquest Brief Part 2, v2.4 at [7435].
478 Statement of Dr DL 25 July 2022 at paragraph 3, Exhibit 14.
479 Oral evidence of DI, Inquest transcript of evidence for 15 December 2022, page 794.
480 Child Protection records, Inquest Brief Part 2, v2.4 at [7143].
481 Oral evidence of DI, Inquest transcript of evidence for 15 December 2022, page 796.
482 Oral evidence of DI, Inquest transcript of evidence for 15 December 2022, page 794-795; No discharge plan was obtained by Child Protection, Inquest transcript of evidence for 15 December 2022, page 799.
483 Oral evidence of DI, Inquest transcript of evidence for 15 December 2022, page 799.
484 Oral evidence of DI, Inquest transcript of evidence for 15 December 2022, page 799-800.
485 Child Protection records, Inquest Brief Part 2, v2.4 at [7129].
486 Child Protection records, Inquest Brief Part 2, v2.4 at [7122].

Although the referral was accepted by Child First,[487] the family had not engaged with Child First by the time of Child 4's death.

2.186 There was no evidence that Child Protection considered classifying Child 4 (or any sibling previously) a '*high risk infant*.'[488] This may have led to more detailed information gathering and risk assessment, and would have then required a higher level consult.[489] Child Protection Team Manager, Ms DJ, gave evidence that she could not recall the policies at the time around classifying infants as high risk, nor did she believe intake workers make that determination (then or now),[490] however in her statement she listed this as her responsibility.[491] Child Protection policies provided to the Court demonstrate that the high risk classification infant policy no longer applies to the intake phase.[492]

2.187 Child Protection did not formally assess, or consider assessing, the attachment and bonding between Child 4 and Ms DA.[493]

2.188 Ms DI could not recall any discussion about the father's capacity to parent in Ms DA's absence.[494] It was put that in her assessment Ms DI had not been provided information from the hospital about the father's presentation or the children's whereabouts.[495] There was, however, information contained within the intake report recorded by her to suggest the children were comfortable with their father, which had formed part of her assessment.[496]

2.189 The referral to Child First was the third referral for the family. In relation to the first referral, the family declined the service, and in relation to the second referral they did not engage.[497] Ms DI indicated Child Protection were aware of previous referrals as they were

[487] Child First records, Inquest Brief Part 2, v2.4 at [8784]; Child Protection records, Inquest Brief Part 2, v2.4 at [7128].
[488] On CRIS; Oral evidence of Ms DI, Inquest transcript of evidence for 15 December 2022, page 796.
[489] Statement of Kirstie-Lee Lomas, 21 June 2022, at paragraph 70, Inquest Brief Part 2, v2.4 at [9161].
[490] Oral evidence of DJ, Inquest transcript of evidence for 15 December 2022, pages 821 & 828.
[491] Statement of DJ dated 20 June 2022, at paragraph 10(a), Inquest Brief Part 2, v2.4 at [9137].
[492] Statement of Shane Wilson dated 28 January 2022, Inquest Brief Part 1, v2.2 at [4263-4264]; SW-67. This was effective from version 3 of this procedure, amended in 2018.
[493] Per Child Protection policy guidance "2425 Mental health assessments and treatment", as far as she could recall, Oral evidence of DI, Inquest transcript of evidence for 15 December 2022, page 796 & 804.
[494] Oral evidence of DI, Inquest transcript of evidence for 15 December 2022, page 797.
[495] Oral evidence of DI, Inquest transcript of evidence for 15 December 2022, page 798.
[496] Inquest Brief Part 2, v2.4 at [7174]; [7176]; [7140] Oral evidence of Ms DI, Inquest transcript of evidence for 15 December 2022, page 812 to 814.
[497] Child First records, Inquest Brief Part 2, v2.4 at [8798].

in the history.[498] Her view was that given the lag since the last referral, the family's circumstances may have changed, so the support might have been accepted if perhaps there were no other services involved.[499] The reasoning behind the referral was the potential benefit to Mr DB, but Ms DI conceded there was no assessment of him to form such a conclusion.[500] The file was closed before Ms DA's hospital discharge, and Ms DI did not believe there would have necessarily been any benefit to keep it open until discharge.[501] She confirmed there could be a re-report should any further issues arise.[502] Referrals to Child First may be classified as '*enhanced*', utilising community based Child Protection services to support engagement, but in this case it was not.[503] Ms DJ confirmed Child Protection would not stay open to ensure the family had engaged with Child First.[504]

2.190 In her statement, Ms DI noted the high caseloads at the time. Ms DJ estimated team managers would have been consulting on twenty to thirty cases a day,[505] formal supervision each fortnight with each front-line worker, along with informal supervision,[506] and from time to time covering other managers' loads.[507] She described it as a '*very difficult time*' but that the workloads remain at those levels today.[508]

2.191 Ms DA was permitted to go on escorted leave on 24 May 2017 to see her children.[509] After medical review on 25 May 2017, Ms DA was discharged on a community treatment order, and confirmed she would continue her medication.[510] Mr DB states he '*begged*' the hospital to administer her risperidone injectable before discharge,[511] however this was not

[498] Oral evidence of DI, Inquest transcript of evidence for 15 December 2022, page 800.
[499] Oral evidence of DI, Inquest transcript of evidence for 15 December 2022, page 801.
[500] Oral evidence of DI, Inquest transcript of evidence for 15 December 202, page 803.
[501] Oral evidence of DI, Inquest transcript of evidence for 15 December 2022, page 804.
[502] Oral evidence of DI, Inquest transcript of evidence for 15 December 2022, page 818.
[503] Oral evidence of DI, Inquest transcript of evidence for 15 December 2022, page 802-803; DJ, Inquest transcript of evidence for 15 December 2022, page 829-830.
[504] Oral evidence of DJ, Inquest transcript of evidence for 15 December 2022, page 833.
[505] Statement of DJ, dated 20 June 2022, at paragraph 11, Inquest Brief Part 2, v2.4 at [9137]-[9138].
[506] Oral evidence of DJ, Inquest transcript of evidence for 15 December 2022, page 835.
[507] Oral evidence of DJ, Inquest transcript of evidence for 15 December 2022, page 836.
[508] Oral evidence of DJ, Inquest transcript of evidence for 15 December 2022, page 836.
[509] Statement of Dr DL 25 July 2022 at paragraph 39, Exhibit 14.
[510] Statement of Dr DL 25 July 2022 at paragraph 40, Exhibit 14; NWMH records, Inquest Brief Part 2, v2.4 at [8033]; [6669].
[511] Statement of DB dated 27 July 2017, Inquest Brief Part 2, v2.4 at [6438].

done as it was not due until the following day.[512] Ultimately Mr DB took Ms DA to Dr Chan for him to administer the injection.[513]

2.192 On 27 May 2017, RN DG contacted the family but was only able to speak with Mr DB as Ms DA was caring for the children. Mr DB confirmed he believed Ms DA would be fine so long as she remained on her medication. He also advised RN DG that he would be returning to work the next week.[514] In oral evidence, RN DG confirmed that Mr DB felt confident Ms DA would be safe with the kids upon his return to work.[515] While there was not a formalised plan regarding support for Ms DA at that time, RN DG noted there were wider family supports available. RN DG's view was that it had been Mr DB who sought help when things had deteriorated previously[516] and she felt given their rapport had improved markedly, he would do so if needed.[517]

2.193 On 2 June 2017, Ms DA and Mr DB attended Dr DM for a medical review. Having arrived late, Dr DM was only advised of their attendance 50 minutes into their 60-minute appointment.[518] Ms DA told Dr DM she wished to reduce her oral medication. Dr DM warned Ms DA of the risks of reducing her medication, and that it should be weaned only gradually. In his statement Dr DL, the consultant overseeing Ms DA's treatment, noted that Dr DM agreed to the tapering of the medication in the context of her reporting an absence of symptoms and the need to treat psychiatric patients in the least restrictive manner possible.[519]

2.194 With respect to specific risk to the children, Dr DL gave evidence that this was considered throughout NWMH treatment episodes for Ms DA, and was compliant with the extant policy.[520] It was Dr DL's view that he had been appropriately consulted throughout and

[512] NWMH records, Inquest Brief Part 2, v2.4 at [8033].
[513] Statement of Dr DL 25 July 2022 at paragraph 45, Exhibit 14; Statement of RN DG, dated 22 July 2022 p9, Exhibit 11; GP records, Inquest Brief Part 2, v2.4 at [9616].
[514] NWMH records, Inquest Brief Part 2, v2.4 at [9544], [7594].
[515] Oral evidence of RN DG, Inquest transcript of evidence for 9 August 2022, page 911.
[516] Oral evidence of RN DG, Inquest transcript of evidence for 9 August 2022, page 912.
[517] Oral evidence of RN DG, Inquest transcript of evidence for 9 August 2022, page 977-978.
[518] Statement of Dr DM, dated 22 June 2017, Inquest Brief Part 2, v2.4 at [6690].
[519] Statement of Dr DL 25 July 2022 at paragraph 48-49, Exhibit 14.
[520] NWMH02.08.01 Identifying and Responding to Vulnerable and At Risk Children and Families (Sept 2015); NWMH19.01.05 NWMH Community Risk Assessment and Management (Oct 2015); Oral evidence of Dr DL, Inquest transcript of evidence for 10 August 2022, pages 1022-1023; Dr DM shared this view, Inquest transcript of evidence for 10 August 2022, pages 1072-1073; as did A/Prof Lakra, Inquest transcript of evidence for 11 August 2022, 1143.

that staff had not assessed elevated risk in the lead up to Child 4's death.[521] Dr DM undertook the final medical review and did not have any new concerns about Ms DA's presentation on that day.[522]

2.195 Ms DA's GP records were provided to the Court, and her primary GP, Dr Chan, responded to issues put to him. Dr Chan confirmed NWMH did not relay Ms DA's history of risk including assaults against her husband, which was also confirmed by NWMH.[523]

2.196 Following medical review on 2 June 2017, Dr DM advised Dr Chan that Ms DA would attend upon him for her injectable medication and that given she was on a treatment plan, NWMH would be checking to see if she had attended for that injection.[524] This was in an attempt to make sure she was attending for the injectable medication as the clinic were having difficulty with her attendance and sought to work with her and her GP to make sure this occurred.[525] Dr DM gave evidence that a discharge plan was not provided to Dr Chan,[526] and it would have generally been the Key Clinician's role to forward the discharge plan to a patient's GP to continue treatment.[527] It appears that a discharge summary was provided on one occasion to Dr Chan's clinic on 6 June 2017[528] but not otherwise.

2.197 Similarly, Dr DL confirmed that NWMH had not been told by Dr Chan's clinic that Ms DA had attended there and been prescribed antidepressant medication while she was subject to a CTO being monitored by NWMH.[529] Dr DL notes that usually a discharge summary is provided to a GP, which would indicate the existence of a CTO that might prompt consultation[530] – however in this case that had only occurred at the last discharge. There would not be an expectation of communication between a GP and the NWMH team

[521] Oral evidence of Dr DL, Inquest transcript of evidence for 10 August 2022, pages 1015-1017.
[522] Oral evidence of Dr DM, Inquest transcript of evidence for 10 August 2022, page 1074.
[523] Dr Waterdrinker's statement dated 16 November 2020 in response to correspondence by the Coroner's Court (dated 9 October 2020) – Exhibit 16.
[524] Inquest Brief Part 2, v2.4 at [6677].
[525] Oral evidence of Dr DM, Inquest transcript of evidence for 10 August 2022, pages 1049-1050.
[526] Oral evidence of Dr DM, Inquest transcript of evidence for 10 August 2022, page 1049.
[527] Oral evidence of Dr DM, Inquest transcript of evidence for 10 August 2022, page 1044.
[528] Inquest Brief Part 2, v2.4 at [9611] to [9613].
[529] It would have so been documented if that was the case, oral evidence of Dr DL, Inquest transcript of evidence for 10 August 2022, pages 995-996.
[530] Oral evidence of Dr DL, Inquest transcript of evidence for 10 August 2022, pages 998-999.

where they had closed engagement, as they did in October 2016.[531] If a GP had concerns it might require a re-referral, or assessment by CATT, which is reliant on that GP's clinical judgement.[532]

2.198 It was noted by Drs DM and DL that NWMH considered Ms DA's (and Mr DB's) cultural and religious views stood in the way of compliance with their medical recommendations. Dr DM noted that Ms DA's view was that the '*spirit possession*' could not be resolved by the medication but the underlying cause required a spiritual treatment.[533] Dr DL referred to the family holding '*multiple explanatory models*', both the medical model and other culturally-specific models, which may be contradictory.[534] Mental illness may carry more stigma among certain cultural backgrounds[535] and the clinicians need to work within this context. Dr DL's view is that to challenge those beliefs would have been counterproductive, but their role instead is to develop rapport and assist their development of insight into their illness.[536] Dr DM concurred, adding that spiritual beliefs can form part of a patient's holistic recovery.[537]

2.199 Ms DA's reluctance to take the medication on Mr DB's view was solely due to the side effects and not based on spiritual beliefs, nor concerns around her mother's death.[538] It was Mr DB's view they were asking for alternative medication but were not offered anything other than risperidone.[539] His evidence is she now had a '*proper*' diagnosis and her current medication, Abilify (aripiprazole) suited her much better.[540] He could not recall her being offered this medication by NWMH prior to Child 4's death.[541] Dr DM's evidence was that while Ms DA had contemplated trying alternative medication such as Abilify, it was her strong preference to just reduce her medication, rather than try new medications.[542] Dr DM also noted that trying new mediation carried its own risk, where

[531] Oral evidence of Dr DL, Inquest transcript of evidence for 10 August 2022, page 1002.
[532] Oral evidence of Dr DL, Inquest transcript of evidence for 10 August 2022, page 1003.
[533] Dr DM statement dated 22 June 2017, Inquest Brief Part 2, v2.4 at [6689].
[534] Oral evidence of Dr DL, Inquest transcript of evidence for 10 August 2022, page 1008.
[535] Oral evidence of Dr DL, Inquest transcript of evidence for 10 August 2022, page 1008.
[536] Oral evidence of Dr DL, Inquest transcript of evidence for 10 August 2022, page 1032.
[537] Oral evidence of Dr DM, Inquest transcript of evidence for 10 August 2022, page 1070.
[538] Oral evidence of DB, Inquest transcript of evidence for 8 August 2022, page 45.
[539] Oral evidence of DB, Inquest transcript of evidence for 8 August 2022, page 45.
[540] Oral evidence of DB, Inquest transcript of evidence for 8 August 2022, page 48.
[541] Oral evidence of DB, Inquest transcript of evidence for 8 August 2022, page 47.
[542] Oral evidence of Dr DM, Inquest transcript of evidence for 10 August 2022, page 1066,

it has been established the current medication is effective, even where there are side effects.[543]

CIRCUMSTANCES LEADING TO THE FATAL INCIDENT

2.200 On the morning of 5 June 2017, Mr DB left the family home for his first day back at work after a long period of leave supporting Ms DA. NWMH had been aware that Mr DB was returning to work but were of the belief that other family members were available to assist.[544]

2.201 Mr DB recalled phoning Ms DA to tell her that he had arranged for furniture to be delivered that morning, which occurred at about 8.30am. Mr DB recalled being concerned about Ms DA and how she was presenting, but he had returned to work because they could no longer afford for him to remain at home.[545]

2.202 Sometime following this delivery, Ms DA inflicted a fatal neck laceration to her daughter, Child 4. At about 10.30am, Ms DA called Mr DB to tell him Child 4 had died. Mr DB arranged for his brother-in-law to go to the family home, as well as police. Ms DA was subsequently arrested and later pleaded guilty to infanticide, for which she was convicted and sentenced to a 30-month CCO.

IDENTITY OF THE DECEASED

2.203 Child 4 was visually identified by her father on 7 June 2017. Identity is not in dispute and requires no further investigation.

MEDICAL CAUSE OF DEATH

2.204 On 6 June 2017, Dr Sarah Parsons, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, performed an autopsy on the body of Child 4.

[543] Oral evidence of Dr DM, Inquest transcript of evidence for 10 August 2022, page 1068.
[544] Oral evidence of Dr DL, Inquest transcript of evidence for 10 August 2022, pages 1007 & 1011.
[545] Statement of DB dated 27 July 2017, Inquest Brief Part 2, v2.4 at [6440], [6441].

2.205 Upon review of all the evidence from autopsy and post-mortem CT scans, Dr Parsons provided a written report dated 8 August 2017, which concluded that Child 4's death was due to incised injury to the neck.

2.206 Dr Parsons noted evidence of an incised injury on the right side of the Child 4's neck. There was also further evidence that all the vessels in the side of the neck were incised including the airway. Dr Parsons concluded that Child 4 died from incised injury to the neck. I accept Dr Parsons' opinion.

PART THREE – CONCLUSIONS AND COMMENTS

3.1 The evidence heard throughout the inquest into the deaths of these four children has demonstrated that there are significant and systemic issues that have and continue to have an impact on Child Protection's capacity to fulfill its mandate to protect and uphold the safety and wellbeing of children in Victoria. These concerns have been echoed in numerous reviews over the last decade and have been most recently outlined by the *Commission for Children and Young People's Annual Report 2022–2023* and the *Yoorrook for Justice Report into Victoria's Child Protection and Criminal Justice System (***Yoorrook Report**).

3.2 As demonstrated in the findings into the deaths of these four children, Child Protection have faced challenges in upholding the safety and protection of children known to their service. As emphasised in the evidence presented at inquest, many of these challenges remain and continue to compromise practitioners in fulfilling the core tenets of their role to:

a) Assess risk

b) Respond to risk

c) Engage with families to promote the safety and wellbeing of children.

3.3 I will explore these issues below, however, before doing so, I wish to reiterate that my criticisms are not directed at individual practitioners. The work of Child Protection

practitioners is difficult and riddled with challenges, making for demanding and tiring work. I recognise the dedication of these practitioners and applaud those who find the strength to undertake this work despite the enormously testing environment.

3.4 I will deal with this in two parts, the first being issues that are specific to the particular service contact relevant to each child and in the second part address the broader systemic issues that have some relevance to all cases.

CHILD 1 - STATUTORY FINDINGS AND COMMENTS

Relevant service contact

Child Protection

Cumulative harm assessment

3.5 The initial three reports made prior to Child 1's birth concerning her siblings were all closed at the intake phase. At the time that the third report was closed, a recommendation was made by Child Protection for further assessments to occur and a cumulative harm assessment to take place should a further report be received.

3.6 Despite this recommendation, the fourth report (the first following Child 1's birth) was also closed at the intake phase and without Child Protection having even spoken directly to the parents.[546] It was conceded by Deputy Area Manager Mallee Child Protection, North Division, DFFH, Ms AH in her evidence that there were a range of issues Child Protection could have explored with the family after this report, prior to closure.[547]

3.7 Indeed, the Principal Commissioner for Children and Young People, Ms Liana Buchanan noted that '*a more thorough risk assessment in relation to family violence and the potential for cumulative harm was warranted in response to the first report to Child Protection after Child 1 was born. This was the fourth report regarding the family and included many of the issues previously raised in relation to family violence, substance use and neglect. Ideally this case would not have been closed without further assessment of*

[546] Oral evidence of Tracey Beaton, 24 February 2022, 574-575.
[547] Oral evidence of AH, 16 February 2022, 184-185.

the family violence risks and the potential for cumulative harm.'[548] I agree with this observation by Ms Buchanan and consider it a missed opportunity to provide earlier intervention for the family.

3.8 It is noteworthy that despite the recommendations made at the closure of the third report and limited subsequent follow up by Child Protection upon receipt of the fourth report, the closure of the latter again included recommendations that given Child 1's young and vulnerable age, another report to Child Protection would require further investigation given it would be the fifth report in relation to the family.

3.9 Ms Beaton was asked whether a report received after a particular number of reports might trigger it to proceed to investigation. It was her evidence that whilst there was '*no magic number*', it is now the policy that after three reports in twelve months or five reports in a lifetime this would '*give rise for the concern of the cumulative impact of that particular issue and therefore would need to be assessed by a more senior practitioner in order to be able to determine whether it goes through for investigation or not.*'[549] This change in policy appears a reasonable approach to managing multiple reports. Child Protection should review this policy to ensure that it is operating effectively, and staff are complying with this policy.

3.10 The second report in relation to Child 1, and fifth for the family, did proceed to investigation and protective intervention.

3.11 There were significant concerns raised throughout the investigation of the fifth report regarding Ms AA's overall parenting capacity, her capacity to protect the children and assess risks to them, her ability to prioritise their needs above her own and engage with services effectively. Throughout their involvement, Child Protection's risk assessments of Ms AA were focused upon her ability to maintain the home environment and commence setting appropriate routines and boundaries for the children. It appears that as new information presented itself, Child Protection failed to use the changing dynamics and situation to inform current risk assessments. A cumulative harm assessment was not

[548] *Liana Buchanan, Commission for Children and Young People Expert Report dated 18 September 2023,* [26].
[549] Oral evidence of Tracey Beaton, 24 February 2022, 577.

conducted and, to echo Ms Buchanan's concerns, should have been.[550] This issue will be further addressed in my examination of thematic issues.

Assessment of risk posed by Mr AI

3.12 During the period of this open investigation Ms AA formed a relationship with Mr AI, and concessions have been made by Child Protection about lines of inquiry that could or should have been followed in terms of the risk posed by his presence in Child 1's life. The new relationship was first disclosed to Child Protection on 1 May 2015, and yet Mr AI's date of birth (to enable a criminal check to be completed) was not obtained until a month later.

3.13 Ms Beaton and Ms AH gave evidence that delays in conducting checks on Mr AI were partially due to Child Protection not initially having full identifying information about him. Ms Beaton confirmed that to obtain a criminal history check Child Protection needed a full name and date of birth.[551] Ms Beaton's view was that a check was completed fairly soon after all the necessary information was obtained.[552]

3.14 It was put to Ms AH that Child Protection could have attended Mr AI's residence to obtain his date of birth sooner as they had his full name and address on 13 May 2015. Ms AH proffered that it may not have been done because it was a new relationship; Child Protection were not aware if he was living there permanently (or just visiting); and the information was not clear to Child Protection.[553] However, it was put to Ms AH that Ms AA herself had provided information that should have caused Child Protection concern, including that he was on bail for violent offending, to which Ms AH conceded there were red flags.[554]

3.15 At the professionals meeting on 27 May 2015, it was documented that there was a determination that the children were not to spend any nights at Mr AI's residence. Child Protection were subsequently informed the family (including Mr AI) intended on

[550] Liana Buchanan, *Commission for Children and Young People Expert Report dated 18 September 2023,* [27].
[551] Oral evidence of Tracey Beaton, 25 February 2022, 711.
[552] Oral evidence of Tracey Beaton, 25 February 2022, 712.
[553] Oral evidence of AH, 16 February 2022, 241.
[554] Oral evidence of AH, 16 February 2022, 242.

travelling to Shepparton in the school holidays, which on its face appears to conflict with the earlier determination.[555]

3.16 Where there is an adverse criminal record check for a person having contact with a child, Child Protection policy requires the Child Protection worker to record in CRIS the rationale for either permitting or preventing contact with that person. [556] It was not clear on the record why these conflicting decisions occurred.[557]

3.17 Ms Beaton indicated information gathering was partially limited by Ms AA not being forthcoming with Child Protection about the nature of her relationship with Mr AI.[558] Ms Beaton's view was though Mr AI was described by Ms AA as a boyfriend, this was something that could be distinguished from a '*domestic partner*' and thus assessed differently.[559]

3.18 Ms Beaton did take the view that Child Protection could have taken further steps to understand the extent of Mr AI's involvement with Ms AA and her children. Though Child Protection had some awareness, her assessment was there should have been further investigation into this.[560] It was her view that Child Protection should not have accepted Ms AA's characterisation of the relationship, as on her view, she had not been forthcoming.[561] It was put to Ms Beaton that nonetheless Child Protection had sufficient information about Mr AI's role and contact with the children to warrant his risk being assessed, and she confirmed she made that concession.[562]

3.19 In a similar vein, Ms Buchanan also noted in her report that '*there was sufficient information available regarding [Mr AI's] role in the family, his family violence history and his use of inappropriate discipline against the children, as disclosed to Mallee Family Care on 9 June 2015, to warrant further assessment and more significant intervention*'[563].

[555] Oral evidence of AH, 16 February 2022, 248.
[556] 'Criminal history checks' Advice 1524, 23 May 2013, commencing at [4434].
[557] See transcript 16 February 2022, 248.
[558] Oral evidence of Tracey Beaton, 25 February 2022, 602.
[559] Oral evidence of Tracey Beaton, 25 February 2022, 597.
[560] Statement of Tracy Beaton, dated 28 January 2022, paragraphs 69, 70.
[561] Statement of Tracy Beaton, dated 28 January 2022, paragraph 72.
[562] Oral evidence of Tracy Beaton, 25 February 2022, 634-635.
[563] *Liana Buchanan, Commission for Children and Young People Expert Report dated 18 September 2023*, paragraph 30.

3.20 Given Mr AI's consistent presence in the lives of the family, assessments should have been conducted more rigorously as if he were a parent, as conceded by Ms AH.[564] If that had occurred, Child Protection could have sought his consent to share his adverse criminal record with Ms AA, and Mr AI might have been engaged with the Stronger Families program and other relevant services.[565] Interestingly, at the point of closure on 10 July 2015, CRIS reflects he was categorised as a stepfather.[566]

3.21 It was conceded by Ms Beaton that having been told Mr AI no longer had contact with his own children during the 2 June 2015 home visit,[567] searches might have been conducted to establish if there was any Child Protection involvement.[568] As Ms Buchanan stated in her report, this information should have resulted in checks being conducted to ascertain if Mr AI had been noted as a person responsible for harm in CRIS and if he had a child protection history interstate[569]. Whilst these checks were ultimately undertaken by Child Protection, it does not appear in the records that after receiving the results that Child Protection updated their risk assessment of Mr AI.

3.22 Ultimately it was conceded by Ms Beaton on behalf of Child Protection that more thorough checks and risk assessment could and should have been undertaken regarding Mr AI. Adverse criminal record checks were on the Child Protection record, and there was no evidence that the results of those checks were discussed with either Child 1's mother[570] or Mr AI.[571] Although Ms AA knew Mr AI had previously been charged for violent offending, there was no formal discussion with Child Protection about this risk factor, nor Ms AA's capacity to protect the children from that risk.[572] This was a missed opportunity on the part of Child Protection.

[564] Statement of AH, 24 January 2022, paragraph 54; Oral evidence of AH, 16 February 2022, 253-254.
[565] Oral evidence of AH, 16 February 2022, 253.
[566] See CRIS records at [483].
[567] See CRIS note [549]-[550].
[568] Oral evidence of Tracey Beaton, 25 February 2022, 616.
[569] *Liana Buchanan, Commission for Children and Young People Expert Report dated 18 September 2023* para-28.
[570] Statement of Tracey Beaton; Oral evidence of AH, 16 February 2022, 253.
[571] Statement of Tracy Beaton, dated May 2020, paragraph 55.
[572] Statement of Tracy Beaton, dated May 2020, paragraph 57.

3.23 The missed opportunity to conduct more thorough risk assessments of Mr AI is even more pronounced having regard to concerns relating to Ms AA's protective capacity known to Child Protection at the time.

3.24 On 2 April 2015, Child Protection had been informed that Ms AA was allowing the children to associate with a male neighbour known to police, and two of Child 1's siblings had been said to have returned home from the neighbour's house without all their clothes on and reporting that he had kissed them. The children subsequently disclosed to SOCIT behaviours consistent with grooming by the neighbour.

3.25 Although Child Protection did raise these concerns with Ms AA, it is submitted that she displayed a limited ability to understand the risks posed to her children when spending time with the neighbour. Whilst Ms AA agreed to no longer allow the children to have contact with him, she was noted to be minimising of the risks he posed and her own responsibility for the interactions and being dismissive of the concerns regarding the children having contact with him.

3.26 Furthermore, Ms AA had disclosed experiencing family violence within her relationship with Mr AB and it had been a theme in previous Child Protection reports. Taken together with Ms AA's apparent lack of concern regarding Mr AI's past as she allowed him to have increasingly more contact with the children, it is likely that she may have benefitted from further support and education on the impact of family violence on herself and the children, in addition to further conversations between Child Protection and herself to confirm her understanding of the potential risks of her relationship with Mr AI and to ascertain her ability to act protectively should Mr AI have begun to perpetrate family violence.

Decision not to file a Protection Application

3.27 Although Ms AA had been warned on a number of occasions about the potential for Child Protection to file a protection application if the protective concerns were not adequately addressed, '*after a consultation with the practice leader, Child Protection [decided it] would not seek a Children's Court order, but instead refer the family to Stronger*

Families'.[573] In responding to questions about why a referral to Stronger Families was preferred over seeking a protection order, Ms AH gave evidence that her '*thinking was around really partnering with [Ms AA] in giving her the widest possible support, the most intensive support*'.[574] It was then put to Ms AH during the inquest:

> *You have referenced wanting to work with the mother, working in partnership with her. But the reality is that she had not been able to make any change up until that point in time; any meaningful change. You would agree with that?---There'd certainly been some concern around her engagement, yes*.[575]

3.28 Ms Beaton was also asked to reflect on the decision by Child Protection to not seek a protection order. It was her evidence that if a family is cooperating with Child Protection, they risk being unsuccessful in any application for a protection order as such an order might be deemed unnecessary.[576] In this case, the children were not reporting any concerns, no injuries were noted, and it would be hard to determine what the '*tipping point*' might have been for there to be sufficient evidence for such an application.[577] Ultimately, Ms Beaton determined there was not sufficient evidence that Child 1 was in need of protection for an application to be issued.[578] Ms Beaton also pointed to Ms AA's willingness to remain engaged with Child Protection and MFC as forming part of the determination not to pursue a protection application.[579]

3.29 In her report, Ms Buchanan stated that '*Child Protection's decision-making appears to have been overly optimistic.… The decision not to pursue a protection application on 1 May 2015 appears to have been premature given there had been no improvement addressing protective issues (relating either to the home environment or [Ms AA's] ability to protect her children) and given there had been 'little progress toward the family's goals' with the Family Preservation Program.*'

[573] Statement of AH, paragraph 45.
[574] Oral evidence of AH 16 February 2022, 208.
[575] Oral evidence of AH 16 February 2022, 208.
[576] Oral evidence of Tracey Beaton, 25 February 2022, 621.
[577] Oral evidence of Tracey Beaton, 25 February 2022, 622.
[578] Statement of Tracy Beaton, dated 28 January 2022, paragraph 58.
[579] Oral evidence of Tracy Beaton, 25 February 2022, 646.

3.30 Ms Beaton conceded that had Child Protection obtained more information through a more thorough risk assessment, which she notes was a missed opportunity, such an application may have been warranted.[580] Such an application would not however, have necessarily prevented Child 1's death.[581] She also opined that statutory intervention may have impacted on the willingness of the parents to work with Child Protection.[582] Ms AH concurred that for the period of the fifth report, her view was that the risk assessment that a protection application not be pursued at the time was appropriate.[583]

3.31 I agree with Counsel Assisting's assessment that whilst it can be argued there was insufficient immediate risk for Child Protection to issue a Protection Application by Emergency Care, there were sufficient grounds and risk to have issued a Protection Application by Notice, which would have enabled the matter to be placed before the court and ensured a formal structure and safety plan was in place to further protect the children. This would also have held Child Protection accountable and to task when conducting further assessments as new information was gathered. I agree with Counsel Assisting that it appears that not all options were fully considered by Child Protection and more could have been done to understand and mitigate the risk.

Closure Decision

3.32 The case closure decision[584] had been made in the context of the children engaging in counselling, having improved their school and childcare attendance, the environmental concerns having been addressed, and the ongoing engagement with MFC.

3.33 The central risk mitigation strategy at the time of closure on Ms Beaton's account was the family's engagement with Stronger Families.[585] It was recorded that MFC and other services were to monitor any ongoing risks.[586]

[580] Statement of Tracy Beaton, dated 28 January 2022, paragraph 58; 66.
[581] Statement of Tracy Beaton, dated 28 January 2022, paragraph 63.
[582] Statement of Tracy Beaton, dated 28 January 2022, paragraph 64.
[583] Oral evidence of AH, 16 February 2022, 187-188
[584] See CRIS record at [482].
[585] Statement of Tracy Beaton, dated 28 January 2022, paragraph 73.
[586] Oral evidence of Tracey Beaton, 25 February 2022, 713-714.

3.34 Despite this, fulsome details of Mr AI's prior offending were not shared with MFC, other than in a general sense.[587] It was submitted by Counsel Assisting, and I concur, that Child Protection should not have expected to rely on MFC to monitor the risk posed by Mr AI without providing them all of the relevant information held. It is likely that MFC may have been more focused on assessing the risk posed by Mr AI had they been provided with all the relevant information.

3.35 The risk posed by Mr AI was known to and documented by Child Protection[588] and nonetheless the evidence of the Child Protection witnesses was that closure was appropriate.[589] Ms Beaton acknowledged the primary focus of the Child Protection intervention had been the environmental concerns in the home, after the immediate risk of inappropriate discipline by Mr AB had been addressed.[590] On Ms Beaton's assessment there was a lack of focus on Ms AA's capacity to effectively parent her children or prioritise their needs over her new relationship with Mr AI.[591] Ms Beaton conceded in hindsight that Child Protection could have delayed case closure until all substantiated protective risks were thoroughly addressed.[592]

3.36 At the point of Child Protection closing the file, it appears the risk assessment contained in the Closure Summary indicated all of the risk factors remained unresolved at that point,[593] to which Ms AH indicated a belief that this was an administrative error given the worker at the time provided a narrative which indicated vast improvement on a number of risk issues.[594]

3.37 Ms Beaton acknowledged on her review of the file that there was an absence of focus more broadly by Child Protection and agencies involved with the family on addressing the lack of progress of Child 1's mother and father in changing their behaviour over time to address the cumulative harm for the children.[595] The parents over time each exposed

[587] Oral evidence of Tracy Beaton, 25 February 2022, 631-632.
[588] Oral evidence of AH, 17 February 2022, 335-336.
[589] Oral evidence of AH, 17 February 2022, 337.
[590] Statement of Tracy Beaton, dated May 2020, paragraph 26, 58.
[591] Statement of Tracy Beaton, dated May 2020, paragraph 74.
[592] Statement of Tracy Beaton, dated 28 January 2022, paragraph 51(d).
[593] See CRIS records at [489-491].
[594] See CRIS records at [493-4]; Oral evidence of AH, 16 February 2022, 256-258.
[595] Statement of Tracy Beaton, dated May 2020, paragraph 63.

the children to actual or potential harm due to the family violence, substance abuse, and environmental concerns.[596]

3.38 In relation to the alleged perpetration of family violence by Mr AB, Child Protection had referred him to several services and actions were taken to ensure the safety of the children and Ms AA, which ultimately lead to the risk that he posed to the children at time of closure to have been reduced.

3.39 By way of comparison, Child Protection did not implement any of these strategies or assessments in relation to Mr AI, despite having clear and confirmed information, prior to closing the case, that Mr AI was a known perpetrator of family violence, and was heavily involved in the family home and parenting the children.

3.40 It is also noted that observations of the change in home environment were made over a very short period of time and should have been considered alongside the significant amount of time during which Ms AA demonstrated little to no change with significant struggles in her overall parenting, despite two separate intensive support services assisting her. Child Protection failed to question and further explore the motivation of such a sudden and dramatic improvement in the home environment and in her overall engagement with both Child Protection and Stronger Families.

3.41 Child Protection practice advice at the time stated that:

> *'Critical decisions about the need for protective involvement with a family should not be based only on apparent cooperation by the parents. Parental cooperation, including acceptance of support services, should not be assumed to guarantee the child's safety and wellbeing, especially in a context of serious harm or risk of harm. Parents may articulate a willingness to cooperate that is not evidenced in their actions or behaviour. Parents agreement may also be indicative of their desire to avoid more formal and intrusive court-based intervention.[597]'*

[596] Statement of Tracy Beaton, dated May 2020, paragraph 64.
[597] 'Protective intervention phase – advice', document ID number 2041, version 2, effective from 1 March 2016 to 1 July 2018, exhibited at 'SW-19' in Statement of Shane Wilson, dated 28 January 2022, Inquest Brief Part 1, v2.2.

3.42 At the time of closure, Ms AA had engaged minimally with Child Protection and Stronger Families. There were several occasions whereby Ms AA had demonstrated ongoing parenting issues, avoided home visits, and rescheduled visits including the closure visit. I have concluded that the decision to close the case without monitoring Ms AA's improvement for a longer period of time to ensure that changes could be sustained was a missed opportunity to promote a safer framework for the family.

Steps taken by DFFH after Child 1's passing

3.43 In the immediate aftermath of Child 1's death, Ms Beaton attended a reflective practice session with the practitioners in the case in Mildura to review various points of decision making. The outcome of the session were specific trainings in that region in aspects of Child Protection practice including cumulative harm assessment and working with families where there is a risk of family violence.[598]

3.44 Following Child 1's passing, Child Protection provided targeted professional development and specialist training to practitioners in the Mallee region. This included training with respects to risk assessment, case practice when intervening where family violence is alleged, and the use of a cumulative harm framework.[599] The Court was also provided with the Quality Improvement Plan for the Mallee Region enacted after Child 1's passing.[600]

3.45 Ms Beaton noted that Child Protection conceded the assessment of risk to Child 1 (and siblings) had been episodic rather than taking a sufficiently broad view of cumulative harm.[601] Specific trainings have since been delivered in the Mallee on this issue.[602] Ms AH gave evidence about the '*Mallee Action Plan*' as to steps taken in the region arising out of Child 1's passing. It is critical that there is ongoing training and oversight undertaken

[598] Oral evidence of Tracey Beaton, 24 February 2022, 521-522.
[599] Statement of Tracy Beaton, dated May 2020, paragraph 76; See also Statement of Tracy Beaton, dated 28 January 2022, paragraph 86.
[600] Exhibit 2.
[601] Oral evidence of Tracey Beaton, 24 February 2022, 551-552.
[602] Oral evidence of Tracey Beaton, 24 February 2022, 552.

to ensure protective workers understand and are demonstrably compliant with the policy with respect to cumulative harm.

Mallee Family Care MFC

3.46 Following receipt of the fifth report to Child Protection, a referral for the family was made to MFC's FPP. The FPP was an intensive placement prevention program designed to work with families at imminent risk of having children removed from their care.[603] The 12-week program worked toward addressing protective concerns with targeted and intensive supports, guided by intervention goals identified by the family.[604] The case workers usually had a case load of two families, given the intensity of the support.[605]

3.47 In this case, the FPP closed at eight weeks and there was a referral made to the Stronger Families program, and Ms AF was allocated to the family.[606] While Stronger Families was designed as a longer-term program, case workers had higher caseloads, at approximately eight families each[607] and thus less time for each family.[608] Though there had been little progress in Ms AA addressing the environmental concerns in the home, Ms AF indicated it was thought to be appropriate because of it was a longer-term engagement and brokerage was available.[609]

3.48 Only one professionals meeting was convened during MFC's involvement, on 27 May 2015. Ms AH's view was that this was not compliant with the guidelines that required MFC to form and convene a care team[610] and meetings should have been occurring more regularly.[611] On Ms AH's view, MFC should also have followed up on engagement with services the family had been referred to, such as family violence counselling[612], which it appears was not done, or not recorded.[613]

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[603] Statement of AG, undated, paragraph 14 at [5843].
[604] Statement of AG, undated, paragraph 15 at [5843].
[605] Statement of AG, undated, paragraph 16 at [5844].
[606] Statement of AF, undated, paragraph 17, 18 at [5691].
[607] Oral evidence of AF, 14 February 2022, 17.
[608] Oral evidence of AF, 14 February 2022, 20.
[609] Oral evidence of AF, 14 February 2022, 21.
[610] Referring to guideline 5.4.7 of Exhibit 1 in her oral evidence 230-231.
[611] Oral evidence of AH, 16 February 2022, 229.
[612] Oral evidence of AH, 16 February 2022, 236-237 & 17 February 2022, 289.
[613] See transcript 17 February 2022, 289.

3.49 Ms Buchanan commented that MFC:

> *[S]hould have been more proactive in ensuring it had all relevant information about the family and [Mr AI], and in sharing more information with Child Protection. Ideally, given Stronger Families was having frequent contact with the family and needed comprehensive information to inform its work with the family, Stronger Families could have been more active in seeking information from Child Protection. For example, it would have been appropriate to seek information about why a professionals meeting convened on 27 May 2015 decided the children were not to sleep at [Mr AI's].*[614]

3.50 Furthermore, Ms Buchanan noted that at the time that Child Protection closed engagement, the express understanding was that MFC and other services would monitor any changes to risk for the family.[615] Counsel Assisting submitted that the necessary corollary to this understanding is that changes would be communicated back to Child Protection, yet this was not done, such as in relation to Mr AB's later concerns about Mr AI. MFC do not agree with this conclusion and submit that there was no report back requirement ever imposed on MFC, and that Ms Buchanan only suggested that '*ideally*' information should have been communicated back to Child Protection. Further MFC submitted that the evidence supports a conclusion that it did not hold sufficient conclusive information in relation to the concerns raised by Mr AB about Mr AI's drug use that warranted a report back to Child Protection[616].

3.51 This debate highlights the lack of clarity that was inherent in the contractual arrangements and the understanding about the information reporting requirements and obligations, and this is an unsatisfactory situation. Simply the understanding and expectations around information sharing and risk assessment and management must be clear and well understood and not the subject of debate years after a tragic event.

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[614] *Liana Buchanan, Commission for Children and Young People Expert Report dated 18 September 2023* paragraphs 32-33.
[615] *Liana Buchanan, Commission for Children and Young People Expert Report dated 18 September 2023* paragraph 34.
[616] Submissions of Mallee Family Care 5-7.

3.52 Mr AG from MFC indicated that two changes had flowed from learnings. The first was that MFC would make sure referrals received from Child Protection were reflective of the work the service would do with the family, and that it would be amended prior to accepting a referral if need be. The second was that if a family was not progressing, MFC would clarify how long this could continue before a re-report would be warranted.[617] In terms of oversight of the contractual relationship between MFC and Child Protection, Mr AG indicated this is a quantitative rather than qualitative measure, and so certainly not on a case practice level.[618]

3.53 It seems that there was a degree of uncertainty in role clarity and responsibility in the interactions between MFC and Child Protection. Ms Buchanan identified two such examples as being: '*When information about [Mr AI's] criminal history was known and a professionals meeting noted that the 'children are not to sleep over at [Mr AI's] home' there was no clarity about who would communicate this to Child 1's mother [and] (b) As indicated above, there was a lack of coordination to ensure Child Protection's risk assessments were informed by comprehensive information and that Mallee Family Care knew enough to be able to exercise effective judgement about what to communicate to Child Protection*'.[619]

3.54 Child Protection procedures at the time required that there be a documented closure plan where community services or organisations (in this case Stronger Families) were involved and that all roles, responsibilities and agreements were to be clearly and accurately recorded. There is no indication in the available records that such a plan was completed or documented in this case. The absence of such a plan reflects a missed opportunity to provide greater support and assistance to the family.

3.55 Having carefully reviewed all the material and submissions from Counsel Assisting, I have concluded that MFC made reasonable efforts to support and communicate relevant information noting that the roles and responsibilities were not as clearly defined as they could have been and that this created gaps. The changes that were implemented following

[617] Oral evidence of AG, 15 February 2022, 141.
[618] Oral evidence of AG, 15 February 2022, 125-126.
[619] *Liana Buchanan, Commission for Children and Young People Expert Report dated 18 September 2023* at [36].

review that Mr AG gave evidence about go some way to manage these gaps but may not be a complete answer and the requirements and communication arrangements should be reviewed periodically to ensure that service gaps are not emerging.

CHILD 2 - STATUTORY FINDINGS AND COMMENTS

Relevant service contact

Child Protection

Steps taken by Child Protection to engage with Child 2's mother in the unborn phase

3.56 Though Child 2 had been identified as a '*high risk infant*' during the unborn phase, the case advice at the time did not require pre-birth meetings. Since Child 2's passing this policy has been revised (in November 2017) to include:

a) Guidance as to when a case conference for an unborn child should occur, most particularly these are required in all complex and high-risk cases, including previous child protection intervention and parental substance abuse.

b) Guidance for Child Protection staff when they become aware of a subsequent pregnancy where a child has previously been removed, to include consideration of making an unborn report.[620]

3.57 This revision of the policy would appear to be reasonable and appropriate.

3.58 Ms Beaton conceded consultation was not undertaken with a practice leader or principal practitioner about the assessment and plan in relation to Child 2, nor was he placed on the high-risk infant schedule.[621] Had he been placed on the schedule this would have triggered greater oversight by more senior practitioners.[622]

3.59 It is the view of Ms Buchanan, that the pre-birth phase presented a missed opportunity for Child Protection to engage Ms BA with supports. It was documented by Child Protection

[620] Statement of Tracey Beaton, 29 September 2020, paragraph 22 at [3762].
[621] Statement of Tracey Beaton, 29 September 2020, paragraph 28 at [3764].
[622] Statement of Tracey Beaton, 29 September 2020, paragraph 29 at [3764].

that she did not have identification or access to Centrelink payments, rendering her particularly vulnerable. Ms Buchanan also notes she may have been open to a referral to C2K, available pre-birth, which she did subsequently engage with.[623]

3.60 Ms Buchanan also notes that coordination might have occurred between the professionals with the aim to coordinate post-birth efforts.[624] The potential benefits of this in Child 2's case have been identified and acknowledged by Child Protection in their evidence.[625] The professionals that might support Ms BA post-birth including Child Protection and VACCA, as well as the maternal child health services, could have discussed (with or without Ms BA's participation) the risk issues, her vulnerabilities, as well as concrete steps that could have been taken to set her up for Child 2's birth such as supporting her to obtain identification and Centrelink payments.

Information Gathering by Child Protection

3.61 Though Child 2 had been classified as a '*high-risk infant*', due to difficulties engaging Ms BA as outlined in the findings of fact, Counsel Assisting were of the opinion that Child 2's circumstances were not sufficiently investigated to establish safety, particularly during the second period of investigation.

3.62 Ms Beaton conceded on behalf of Child Protection that if, viewing this matter in hindsight, a protection application had been made at the time of Child 2's birth, it is likely Child 2 and his mother would have been more intensively monitored and supported.[626] Additionally, she noted the first home visit on 24 December 2015 should have involved more thorough assessments of the home environment and the other persons in the home (including criminal records checks).[627]

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623 *Liana Buchanan, Commission for Children and Young People Expert Report dated 18 September 2023*, para 39 a.
624 *Liana Buchanan, Commission for Children and Young People Expert Report dated 18 September 2023* par 39 b.
625 Statement of Tracey Beaton, 29 September 2020, paragraph 24 at [3763] 18-19 at [3761]; Statement of Tracey Beaton, 28 January 2022, paragraph 100, 105 & 106; Oral evidence of Tracey Beaton, Inquest transcript of evidence for 24 February 2022, pages 553-554.
626 Statement of Tracey Beaton, 28 January 2022, paragraph 97; Ms Buchanan also identified this as an opportunity for improved practice by Child Protection at paragraph 40 (a).
627 Statement of Tracey Beaton, 28 January 2022, paragraph 117.

3.63 The investigation was allocated to advanced Child Protection practitioner, Ms BG, on 11 January 2016, and a home visit was scheduled for 19 January, a 26-day lag from the first home visit, which Ms Buchanan identified as inconsistent with the extant guideline for high-risk infants.[628] I agree with this observation, particularly given the circumstances and risk issues in this matter, 26 days is clearly too long.

3.64 At the unannounced office visit attended by Ms BA and Mr BC on 3 February 2016, although Mr BC disclosed previous ice use, criminal charges and a previous corrections order, intervention orders and mental health issues, Child Protection did not assess him as a protective risk at that time.

3.65 Ms Buchanan identified this, and I agree, as a missed opportunity,[629] which was acknowledged by Ms Beaton.[630]

3.66 Ms Buchanan's view was that the decision to close the first period of investigation on 14 April 2016 appeared premature, as Ms BA had only just started her engagement with C2K, additional risks to Child 2 had been disclosed to Child Protection during this period of investigation, and Ms BA had not yet obtained access to Centrelink payments rendering her financially dependent on Mr BC and his family.[631] Ms Beaton acknowledged this view could be taken, however she confirmed her view that the decision not to file a protection application was reasonable and in line with policy.[632]

3.67 Following the re-report on 18 April 2016, Ms Buchanan's view was that Child Protection initially responded appropriately to the urgent nature of the risks to Child 2 and established that Ms BA was staying in suitable accommodation, at least temporarily. However, Child Protection were not able to establish whether Ms BA was engaged in illicit substance use as she did not submit for drug screening despite requests.[633] Child

[628] Statement of Ms Buchanan, paragraph 40(b).
[629] Statement of Ms Buchanan, paragraph 40(d).
[630] Statement of Tracey Beaton, 28 January 2022, paragraph 119(a), (c) & (g).
[631] Statement of Ms Buchanan, paragraph 41.
[632] Statement of Tracey Beaton, 28 January 2022, paragraph 98.
[633] Ms Beaton acknowledges in her statement made 28 January 2022, at paragraph 119(b).

Protection also did not conduct any subsequent home visits after the 20 April visit to the temporary accommodation, and only observed her and Child 2 at their office.

3.68 I have concluded that the information gathering by Child Protection was insufficient, particularly given the categorisation of Child 2 as a high-risk infant and the circumstances of the re-report, as steps were not taken to directly verify if their accommodation was safe or appropriate. Child Protection seemingly relied on information from C2K, and Ms Beaton acknowledges that Child Protection should have addressed this issue more urgently and should have been less reliant on C2K.[634]

Information Sharing between Child Protection and VACCA

3.69 Part of the determination to close the first period of investigation was that Ms BA had engaged with C2K, and that this community service would continue to monitor Child 2's safety. The initial referral to C2K had not noted family violence risk nor illicit substance use.

3.70 There were missed opportunities for Child Protection and C2K to be more proactive in engaging with Ms BA, despite her resistance, in order to ensure Child 2 was insulated from the risks identified, for example by offering material aid through brokerage or flexible support funding.[635]

3.71 Ms Buchanan identified that Child Protection may have been too reliant on C2K to assess the risk to Child 2, particularly during the second period of investigation. She noted it is not clear that C2K understood their role in assessing risk.[636] In evidence, Ms Beaton identified this as a shortfall in the information gathering by protective workers.[637] Child Protection had identified Child 2 as a child in need of protection when a warrant was obtained at the commencement of the second period of investigation. Despite identifying that need for protection, steps were not taken by Child Protection to utilise coercive powers in the face of Ms BA evading attempts to conduct a home visit or verify whether illicit substances were a

[634] Statement of Tracey Beaton, 28 January 2022, paragraph 119(d), (e) & (f).
[635] Statement of Ms Buchanan, paragraph 49.
[636] Statement of Ms Buchanan, paragraph 50.
[637] Statement of Tracey Beaton, 28 January 2022, paragraph 119(d).

continuing issue placing an incredibly vulnerable infant at significant risk. In my view this was an opportunity by Child Protection and should not have been missed.

Policy compliance by Child Protection

3.72 A case plan was not prepared for Child 2, despite guidelines requiring this be done 21 days after substantiation. It was noted that Ms BF discussed the absence of a case plan for the family at her first supervision session post allocation, 29 days after substantiation. Ms BF suggested this may be because they wanted to develop that case plan through the AFLDM process.[638]

3.73 The relevant '*High-risk Infant*' advice[639] requires that a care team meeting should have been convened for a case plan to be developed. Such a case plan would have required consideration and documentation of the immediate and future risks to the child's safety, stability and development, the causes of that risk, and strategies to address these including each team member's role in doing so.

3.74 Such a meeting may have clarified the roles and responsibilities of C2K and Child Protections, including contact with the family and monitoring of risks, which appear otherwise unclear and thus led to insufficient information gathering. Ms Buchanan identified that as a result of the lack of a coordinated approach, there were significant shortfalls in terms of Child Protection and C2K adequately monitoring and addressing risk to Child 2, particularly between April 2016 and his passing in June 2016.[640]

3.75 Ms BF also acknowledged that no AFLDM meeting was conducted, despite it also being required within 21 days of substantiation. She did discuss this with Ms BA on 8 June 2016, and a consultation was subsequently scheduled for 14 June,[641] however it was not able to be attended to prior to Child 2's death.[642]

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[638] Oral evidence, BF, Inquest transcript of evidence for 23 February 2022, 465 & 480-481.
[639] See Child Protection Manual, *High-risk Infants* versions 1 and 2 (covering the relevant period) at Inquest Brief Part 1, v2.2 at [5177] and [5181].
[640] Liana Buchanan, Commission for Children and Young People Expert Report dated 18 September 2023, paragraph 51.
[641] CRIS records, Inquest Brief Part 1, v2.2 at [2712].
[642] Statement of BE 28 January 2022, paragraph 59, Inquest Brief Part 1, v2.2 at [4222].

VACCA – ACSASS & CRADLE TO KINDER

3.76 Child Protection were unable to engage with ACSASS in the unborn phase and following Child 2's birth, and ACSASS were unable to attend the first home visit. Consultation did not occur until 23 March 2016, at which point closure of the file was endorsed.[643] Ms Buchanan notes it is unclear if this occurred because of a lack of resourcing,[644] though in relation to Child 3, Ms Jose stated that during this time period (2015-2017) the average case load for ACSASS was said to be over 100 children per case practitioner.[645]

3.77 There was a referral made in January 2016 to the culturally appropriate intensive postnatal support service C2K provided by VACCA. While C2K is available in the unborn phase, in this case a referral was only made after Child 2 was born.[646] Due to staff shortages, this did not commence in earnest until Ms BI was allocated following her recruitment in late March 2016.[647] Thereafter, Ms BI conducted a total of nine visits, with others being cancelled.[648]

3.78 Two of the goals of Ms BI's work with Ms BA was to assist her to obtain identification and housing. From Ms BI's first meeting with Ms BA on 5 April, their work toward the goals that had been discussed[649] faced challenges including significant instability in Ms BA's housing.[650] Ms BD also identified that Ms BA had a significant distrust of Child Protection and the welfare system more broadly, which is an understandable response when viewed through a cultural lens.[651] VACCA sought to build a working relationship with Ms BA by working at her pace, while bearing in mind the needs of the child – a delicate balance.[652] Ms BD further agreed that the long term goal of engagement was held in mind in how Ms BA was approached, and that the literature evidences that a strong client relationship is more effective in bringing about change for clients.[653]

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[643] Statement of BE 28 January 2022, paragraph 35.
[644] Statement of Ms Buchanan, paragraph 45 and 46.
[645] Statement of Belinda Jose dated 26 November 2021, at paragraph 9(h), Inquest Brief Part 2, v2.4 at [5246].
[646] Oral evidence of BD, Inquest transcript of evidence for 21 February 2022, pages 365-367.
[647] Oral evidence of BD, Inquest transcript of evidence for 21 February 2022, page 375.
[648] Statement of BD, 30 November 2021 at paragraph 9.a.
[649] With Ms BH, Inquest Brief Part 1, v2.2 at [3590].
[650] Statement of BD, 30 November 2021 at paragraph 9.d.
[651] Statement of BD, 30 November 2021 at paragraph 9.d.
[652] Statement of BD, 30 November 2021 at paragraph 9.d.
[653] Oral evidence of BD, Inquest transcript of evidence for 21 February 2022, pages 396-397.

3.79 VACCA became aware that Ms BA did not have identification and could not obtain Centrelink payments, and thereafter made attempts to rectify this.[654] This was not able to be resolved prior to Child 2's passing. Likewise, VACCA offered assistance with obtaining accommodation on 31 May and 2 June 2016, however Ms BA did not ultimately follow up with this.[655]

3.80 VACCA conceded, in relation to information gathering, that C2K staff could have been more persistent in pursuing their enquiries as to Ms BA's living circumstances and that any concerns should have been escalated more formally to Child Protection. Ms BD cited two occasions when C2K's concerns were relayed to Child Protection regarding her housing instability – on 18 April 2016 and 3 June 2016.[656] In oral evidence Ms BD's view was that Child Protection should have acted urgently on the information relayed by Ms BI on 3 June 2016, but that VACCA may have, equally, raised concerns at a more senior level and/or been more assertive.[657] Ms BD also took the view that Child Protection were too reliant on VACCA for information gathering[658] rather than the worker undertaking her own home visits, assessing where Ms BA was living and who she was living with.[659]

3.81 Ms BD expressed the view that in hindsight Ms BI may have been overly optimistic about the relationship she had formed with Child 2's mother, as it later became clear she had not been as open and honest as was thought at the time.[660] Though Ms BI had identified vulnerability to family violence in Ms BA's history, C2K had not taken steps to engage Ms BA in family violence counselling or other supports.[661] Ms Buchanan's view was that it was not clear that throughout their engagement that C2K was able to provide the level of intensive, proactive support required to ensure Child 2's wellbeing.[662] I agree with Ms Buchanan's assessment.

[654] Statement of BD, 30 November 2021 at paragraph 9.e.
[655] Statement of BD, 30 November 2021 at paragraph 11.
[656] Statement of BD, 30 November 2021 at paragraph 13.b.
[657] Oral evidence of BD, Inquest transcript of evidence for 21 February 2022, pages 385.
[658] Statement of BD, 30 November 2021 at paragraph 15.b.
[659] Oral evidence of BD, Inquest transcript of evidence for 21 February 2022, page 386.
[660] Oral evidence of BD, Inquest transcript of evidence for 21 February 2022, page 401.
[661] Oral evidence of BD, Inquest transcript of evidence for 21 February 2022, pages 413-414.
[662] Statement of Ms Buchanan, paragraph 47.

3.82 Ms BD notes that Child Protection are the statutory authority, and that VACCA work in a voluntary only capacity which limits the work they can undertake and information they can seek.[663] Child Protection were aware of Ms BA's transience and that it was not clear who she was residing with, nor the risks they posed.[664] Ms BD does concede that good practice should include assessing and considering what is known and not known to allow for comprehensive information gathering.[665] Conducting comprehensive risk assessments was not included in the mandatory training for the initial roll out of the C2K programs,[666] and remains absent from the current iteration of child and family intensive supports.[667]

3.83 VACCA conducted an internal review following Child 2's passing, and a number of practice reforms have flowed from that. The C2K program is now integrated with the Stronger Families programs to better manage caseloads, and the team leader role was increased from part-time to full-time.[668] Ms BD also gave evidence that it caused the program to reflect on the high-risk factors prevalent among this client cohort, and thus greater supports such as reflective practice sessions were put in place to better support staff.[669] She noted at the time VACCA was not an organisation that had integrated family violence risk assessments into all aspects of their services, rather this was seen as a task undertaken by specialist organisations.[670] The changes that VACCA have implemented appear to address the gaps identified by the internal review.

CHILD 3 - STATUTORY FINDINGS AND COMMENTS

Relevant service contact

<u>Child Protection</u>

Case planning

[663] Statement of BD, 30 November 2021 at paragraph 12.c., 13.d.; Oral evidence of BD, Inquest transcript of evidence for 21 February 2022, page 386.
[664] Statement of BD, 30 November 2021 at paragraph 13.b.
[665] Statement of BD, 30 November 2021 at paragraph 13.d.
[666] Statement of BD, 30 November 2021 at paragraph 15.c.
[667] Statement of BD, 30 November 2021 at paragraph 15.d.
[668] Statement of BD, 30 November 2021 at paragraph 18.a; Oral evidence of BD, Inquest transcript of evidence for 21 February 2022, page 392.
[669] Oral evidence of BD, Inquest transcript of evidence for 21 February 2022, page 392.
[670] Oral evidence of BD, Inquest transcript of evidence for 21 February 2022, page 390.

3.84 The *Children, Youth and Families Act 2005* (Vic) (**CYFA**) states that case plans are prepared by Child Protection and contain all significant decisions made by Child Protection which relate to the present and future care and wellbeing of a child, including the placement of, and contact with, the child.[671] Case plans play a critical role in promoting comprehensive risk assessments and ensuring Child Protection's decision-making is in the best interests of a child.

3.85 In this particular case, Ms Buchanan noted that '*[Child 3] required active, consistent and intensive support in the out-of-home care system. This was true from when [Child 3] first entered care, given the considerable history of Child Protection reports (seven in ten years with the first being when she was 5 months old) and her reported experience of sexual abuse. The need for support and strong coordinated case management increased after her initial placement in kinship care between 2012 and March 2014 resulted in allegations of physical and emotional abuse and became more acute as her high-risk behaviours and the risks she faced escalated from December 2014*.'[672] It is noted that against this background, the failure of Child Protection to review or update Child 3's case plan from its final iteration in February 2015 to the time of her passing is of considerable concern.

3.86 The CYFA required that Child 3's plan be reviewed no later than February 2016 (at a minimum), but the available evidence suggests that this did not occur.

3.87 Ms Lomas conceded on behalf of DFFH that case planning remained a Child Protection responsibility even after Child 3's case was contracted to Uniting in May 2016.

3.88 Child 3's case plan should have been reviewed by Child Protection during the year preceding her passing given the multiple changes in her circumstances, including her increased absconding from placement, reduced attendance at school, incidents of self-harm and sexual exploitation, and reconnection with her mother whom she had no contact with for the three years prior.

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[671] *Children Youth and Families Act* 2005 (Vic), Section 166.
[672] *Liana Buchanan, Commission for Children and Young People Expert Report dated 18 September 2023* [53], [54].

3.89 Indeed, Ms Lomas conceded that further case planning '*may have facilitated more rigorous information gathering and risk assessment.*'[673] I have concluded that Child Protection's failure to review Child 3's case plan from February 2015 until her passing represents a missed opportunity to promote Child 3's safety. Appropriate reviews of Child 3's case plan, triggered by the significant changes in her circumstances, may have prompted Child Protection to more appropriately assess and respond to the multiple increasing risks faced by Child 3, from a global perspective, as opposed to responding to individual crises as they arose.

3.90 Child Protection policy states that contact arrangements must be recorded in a contact plan and reflected in the child's case plan. Contact arrangements should be reviewed regularly and endorsed by a case planner and supervisor. A safety plan is also required in relation to contact plans and should include risk factors, indicators of risk and rules around the conduct and presentation of persons approved for contact.[674] The evidence supports a conclusion that this policy was not adhered to in this case. Child 3's last case plan did not reflect her renewed contact with Ms CA, and it was never reviewed. Child 3's contact and safety plans were not comprehensive and contained no actions to be undertaken by Child 3's care team to expressly monitor or mitigate the multiple risks posed to Child 3 associated with her contact with Ms CA, such as her substance misuse and known history of relationships involving family violence. Further, the contact and safety plans were not endorsed by a case planner or supervisor.

Risk management

3.91 The safety plan that had been prepared represented a plan that Child 3 spend significant unsupervised time with Ms CA without adequate risk assessments being conducted. This would appear to be a failure to comply with the policy in regard to determinations on who may have contact with children in care.[675]

[673] Statement of Kirstie-Lee Lomas, dated 28 June 2022, paragraph 63.
[674] DHHS Child Protection Contact Advice 1 July 2016.
[675] Policies applicable at the time exhibited to the Statement of Shane Wilson, SW-127 & SW-128 - at [5631] and following.

3.92 The Child Protection Manual at the time was clear that '*[o]nly people given contact rights by a court order or approved for contact by child protection may have contact with a child in care*', and that '*[p]eople not approved for contact should not be permitted to have contact with the child.*'[676] The relevant policy further states that an assessment must be completed on any person seeking to have contact with a child in out-of-home care. This assessment should include consideration of a national police check, consideration of '*personal risk factors including drug and/or alcohol abuse, violence, untreated mental health issues*' and '*additional assessment and consideration by the child protection case planner and/or a regional Principal Practitioner*' where the person requesting contact has been assessed as responsible for harm to a child. The policy also states that the selection of a venue for contact should be based on assessment.[677]

3.93 Child Protection had previously assessed that Ms CA was responsible for causing harm to Child 3 and were aware of ongoing factors impacting Ms CA's suitability for unsupervised contact with Child 3 including chronic substance misuse and transience. Despite this, outside of conducting a criminal record check for Ms CA, there is no indication that Child Protection or Bridges attempted any further assessment of Ms CA's suitability for contact with Child 3.

3.94 Child 3's last case plan stated that Child Protection would work with Ms CA to '*create a positive access plan*' should she seek contact with Child 3 again and set out tasks for Ms CA to complete, such as engaging with alcohol and other drug services, undertaking supervised urine tests as requested, participating in family violence counselling and not exposing Child 3 to the effects or use of drugs and alcohol. There is no evidence that after Child Protection and Bridges became aware that Child 3 was once again having access with her mother, that they sought to engage her in any services as identified in the case plan.

3.95 Child Protection were also aware of Ms CA's on/off relationship with Mr CQ. The significance of this was that by association Child 3 would also have contact with Mr CQ

[676] DHHS Child Protection Contact advice 1 July 2016.
[677] Ibid.

when seeing her mother. Ms Lomas noted that information provided to Child Protection by Bridges about Mr CQ included their suspicions that Mr CQ was substance affected when he visited their office in July 2016, and that when Child 3 absconded, she would frequently attend Mr CQ's residence in Delahey. Further, it was suspected that both Ms CA and Mr CQ were abusing drugs and Mr CQ was a perpetrator of family violence.[678] Yet despite their knowledge that Child 3 was staying at Mr CQ's home during contact with her mother, neither Child Protection nor Bridges appear to have conducted any assessment of his suitability to have contact with Child 3.

3.96 Ms Lomas noted that whilst Child Protection was aware that Child 3's mother had reunified with her partner, Mr CQ, his surname was not known until after the fatal incident. Without full details, it was asserted that Child Protection were not able to gather information about the specific risk posed by him to Child 3.[679] It does not appear that Child Protection made any real effort to ascertain his full name during their involvement, either by direct inquiries or asking Uniting to follow this up. It is noted that a criminal record check would have revealed Mr CQ's extensive criminal history including charges and convictions related to drug trafficking and possession, assault, and weapons offences.

3.97 Failing to make further inquiries about Mr CQ's identity and the extent of his involvement in Child 3's life was a missed opportunity by Child Protection to take steps to assess his potential risk to Child 3 and manage any risks, which might have involved strictly limiting contact or putting in measures to make contact safe. Ms Lomas conceded practice may have been enhanced if Child Protection were more assertively engaged in this safety planning.[680]

3.98 It appears from the communication chain between Uniting (Bridges) Case Manager CN and Advanced Child Protection Practitioner Ms CP that Child Protection were only minimally engaged in the safety plan developed for Child 3. Child Protection should have been more actively involved in assessing and managing risk, particularly given all of the information Child Protection had about Child 3's history of trauma and abuse. In the

[678] Statement of Kirstie-Lee Lomas, dated 28 June 2022, paragraphs 37, 42.
[679] Statement of Kirstie-Lee Lomas, dated 28 June 2022, paragraph 66.
[680] Statement of Kirstie-Lee Lomas, dated 28 June 2022, paragraph 71.

event risk was identified and needed to be mitigated, Ms Lomas stated that providing practical supports and referrals would have been a Uniting responsibility.[681]

3.99 However, even when Child 3's case was contracted to Uniting, the case contracting agreement required Child Protection to retain responsibility for significant decisions requiring actions outside the parameters of the current case plan, such as significant changes to contact arrangements.[682] Clearly the renewed contact between Child 3 and Ms CA represented a departure from the case plan in place. I accept Counsel Assisting's submission that the failure to review the case plan by Child Protection was a significant missed opportunity to promote safety for Child 3 and potentially explore other safe means of contact with Ms CA.

3.100 I readily acknowledge and accept that it would have been very hard to have restricted Child 3's contact with her mother given her age. However, it is not clear whether imposing consequences was tried or anything more assertive, actions to provide boundaries, or alternative contact proposals were considered, for example it may have been possible to arrange contact for Child 3 with her mother in a motel rather than at Mr CQ's house. This is clearly the intention of the relevant Child Protection advice.[683]

3.101 Despite Child 3 being referred to the High Risk Youth Panel on 4 January 2016, it does not appear that this referral was pursued.[684] Had Child 3 been classified as a high-risk adolescent, this would have likely led to greater scrutiny of the management of risks as documented and more appropriate referrals for support being explored.

Culturally appropriate services

3.102 In the period proximate to Child 3's passing, Child Protection made only limited attempts to consult with VACCA and make enquiries about her cultural background. Although Child Protection had uncertainties regarding verification of Child 3's Aboriginality, given she had herself identified as Aboriginal, Child Protection should have ensured appropriate

[681] Statement of Kirstie-Lee Lomas, dated 28 June 2022, paragraph 72.
[682] See case contracting agreement cited in Kirstie Lee Lomas statement 28 June 2022 at para-31.
[683] 1102 Contact.
[684] Statement of Kirstie-Lee Lomas, dated 28 June 2022, paragraph 23.

consultation was undertaken while this was clarified. Ms CG's evidence was that Child 3's Aboriginality was something she clearly communicated to those around her.[685]

3.103 Had Child Protection ensured Child 3's case plan was being appropriately reviewed, issues such as her access to her culture might have been more thoroughly addressed. Ms Lomas conceded that practice may have been enhanced had this planning taken place, to ensure Child Protection practices were compliant with the CYFA.[686]

3.104 It is noted that Child Protection did contact Lakidjeka ACSASS on a few occasions to seek further information about Child 3's Aboriginality and to request a consult. Ultimately however, Child Protection failed to consult with Lakidjeka at all from 2014 to the time of Child 3's passing. This is despite the CYFA requiring consultation with ACSASS at significant decision-making points such as when Child 3 recommenced contact with Child 3's mother in November 2015; Child 3 was placed in Ms CG's care in January 2016; and case management for Child 3 was contracted to Uniting in May 2016. The evidence supports the conclusion that the failure to adhere to policy requirements to consult with Lakidjeka represented a missed opportunity to provide intervention and support to Child 3 through a culturally appropriate lens.

VACCA

3.105 In the eighteen months leading up to Child 3's passing, Child Protection attempted contact with VACCA in January 2016, July 2016, and January 2017.

3.106 In January 2016, Child Protection contacted VACCA for assistance with finding a new placement for Child 3, but VACCA were unable to assist. Child Protection also left a message seeking a consult with Lakidjeka in relation to Child 3, which Lakidjeka tried to subsequently follow up with no response.

3.107 In July 2016, Child Protection attempted to contact VACCA twice in relation to Child 3's lack of a cultural support plan. It does not appear that VACCA responded.

[685] Statement of CG, 23 April 2017.
[686] Statement of Kirstie-Lee Lomas, dated 28 June 2022, paragraph 74.

3.108 In January 2017, Uniting submitted a referral to VACCA's Koori Cultural Placement and Support program, for assistance with completing a cultural support plan for Child 3. Whilst the program began to proactively engage with Child 3's care team following this referral, they were still attempting to meet with Child 3 at the time of her passing.

3.109 It appears the required consultation under the Protocol between Child Protection and VACCA was not complied with in this instance.

3.110 Furthermore, there were significant gaps in VACCA's record keeping, for example, VACCA had no record of attempts made by Child Protection to contact Lakidjeka on 8 or 12 July 2016. It appears that deficiencies in record keeping likely contributed to VACCA not having a comprehensive understanding of and timely response to Child 3 and her history of trauma and abuse. It is noted that VACCA has conceded that record keeping in Child 3's case was not ideal, but that since 2016 there have been significant changes to case noting and file recording including a new electronic case management system CSNet.[687]

Uniting (Bridges)

3.111 Bridges completed a safety plan and weekly school and contact plan dated 1 August 2016 which included Child 3 spending Thursday, Friday, and Saturday nights at Ms CA's home. It is unclear as to when Bridges became aware that Ms CA was staying with Child 3 at Mr CQ's Delahey address, however this address is listed as Ms CA's address on the safety plan.

3.112 The safety and contact plan developed by Bridges stated that Child 3 and Ms CA should remain in contact with Ms CG when together; that Ms CA should inform Bridges if Child 3 left her residence and did not return overnight; and that Child 3 would be reported missing if she was not at her placement or her mother's address or did not keep in contact with care team members. The only risk clearly articulated in the safety plan was that associated with Child Protection's historical concerns about Ms CA's substance use. The safety plan noted that Ms CA's criminal history check did not return any results related to her substance

[687] Statement of Belinda Jose, dated 26 November 2021, paragraph 12.

misuse, and listed no further actions aimed at monitoring or mitigating this or any of the other risks known to Child Protection and Bridges at this time. The contact plan consisted solely of a table indicating when Child 3 was expected to attend school and where she would stay overnight on each day.

3.113 The records provided to the Court indicate that Child 3 and Ms CA did not adhere to the Bridges safety plan. On 2 August 2016, the day after it was written, Child 3 was not at Ms CA's address when Ms CG came to collect her as planned. Child 3 was reported missing to police, and they did not locate her until 14 August 2016, when she was found at a friend's house. Bridges records indicate that they were unable to contact Ms CA by phone whilst Child 3 was missing.

3.114 On 13 October 2016 Bridges asked to meet with Child Protection to discuss Child 3's safety plan after they learned that Ms CA was again residing with Mr CQ following a period of separation and transience.[688] At this time, Bridges became aware that Ms CA was not taking adequate steps to ensure Child 3 was not exposed to her substance misuse, although the details of this concern are not recorded. Child Protection offered to schedule a care team meeting to discuss these issues six weeks later,[689] but there is no record of this meeting occurring.

3.115 It appears from her statement to police shortly after Child 3's passing that Ms CG had been aware of Mr CQ's controlling behaviours, but it is not clear when the behaviours emerged or became known to her.[690] In trying to identify the time period, Ms CG could recall an escalation when Ms CA travelled to Wonthaggi to withdraw from drug dependence[691] which occurred in December 2016 or January 2017. Ms CG recalled another instance where she had collected Child 3's purse from Ms CA in St Kilda when Ms CA said she was hiding from Mr CQ.[692] It does not appear this information was relayed to Uniting prior to Child 3's passing.[693] Ms CG's recollection was she would have been discussing this with Uniting

688 Statement of CK, dated 12 April 2017.
689 Email from CP to CN on 14 October 2016 at Coronial Brief Part Two page 3362.
690 Ms CG could not recall when she became aware of the nature of the relationship, though referred to the issues in the police statement - Oral evidence of CG, 17 February 2023, 125.
691 Oral evidence of CG, 17 February 2023, 125.
692 Oral evidence of CG, 17 February 2023, 125-126.
693 See, for example, the statement of CG, 23 April 2017 at paragraphs 17, 34, 35, 36 & 37.

but she could not recall specific conversations.[694] Ms CG did not believe Mr CQ posed a direct risk to Child 3,[695] even after her last conversation with Ms CA, prior to her and Child 3 passing, when Ms CA told her Mr CQ had trashed the squat where she was staying.[696]

3.116 Ms DK's assessment was that Uniting had kept Child Protection sufficiently informed of all key information relating to Child 3 and her welfare that they were obliged to.[697] With respect to risk assessment, Ms DK notes this was a collective responsibility and involved information collected from various sources and managed through collective strategies tailored to an individual's circumstances.[698] Ms DK notes that Child Protection's SAFER framework now provides risk assessment templates,[699] however external agencies have not yet been provided training on the SAFER framework.[700] Uniting have developed their own internal tools.[701]

3.117 Through Mr Yew, Uniting tendered three recently published policy documents that speak to some of the improvements at Uniting related to issues in this case. The first, '*Receiving and Contracting Checklist*'[702] was noted to prompt workers to obtain all relevant documents prior to (or noting a due date) case contracting including a case plan.[703] The '*Activity Risk Assessment*' guides case managers to assess risk of a particular activity.[704] Finally the '*Young Person Risk Assessment Tool*' provides a broader assessment for risks posed to a young person, providing a structured approach to this process as compared with the process at the relevant time.[705]

3.118 Having reviewed all the evidence, I am satisfied that Ms CG took reasonable steps to manage a very challenging situation with a teenager who was reluctant to take direction and would abscond readily if she didn't agree with the arrangements. Bridges and Ms CG

694 Oral evidence of CG, 17 February 2023, 126.
695 Oral evidence of CG, 17 February 2023, 139.
696 Oral evidence of CG, 17 February 2023, 142-143.
697 Statement of DK, 1 July 2022, paragraph 17.
698 Statement of DK, 1 July 2022, paragraph 20.
699 Statement of DK, 1 July 2022, paragraph 20, 22, 44.
700 Statement of DK, 1 July 2022, paragraph 22.
701 Statement of DK, 1 July 2022, paragraph 21.
702 Exhibit 22.
703 DK oral evidence, 16 February 2023, 107-108, referring to exhibit 22.
704 DK oral evidence, 16 February 2023, 108, referring to exhibit 23.
705 DK oral evidence, 16 February 2023, 108-110, referring to exhibit 24.

were working closely together to try and find solutions that managed the many risks that caring for Child 3 presented. Both accepted that despite what was put in place or directions given, Child 3 was going to spend time with her mother and the Safety Plan that was initiated by Bridges and Ms CG attempted to manage this situation. I accept that their efforts were well intentioned and reasonable in the circumstances.

3.119 The evidence also supports the conclusion that Child Protection for the most part left the management of Child 3 with Bridges and Ms CG. They were not as engaged as they could have been or in fact should have been. Child 3 was in Child Protection's care, and they left the day-to-day arrangements to others with irregular and minimal involvement. I will deal with the broader issue of Responding to Children Absconding from Care in more detail later in this finding.

CHILD 4 STATUTORY FINDINGS AND COMMENTS

Relevant service contact

Child Protection

3.120 Prior to Child 4's birth, between 2013 and 2015, her family were the subject of four reports to Child Protection, none of which progressed to protective intervention. After the first of these on 6 February 2014,[706] Child Protection offered to support the family to engage with Child First, however they ultimately refused the service. At the time of the second report to Child Protection, the earlier instance of the family declining the support of Child First was considered and discussed on 26 May 2015,[707] but nonetheless a further referral was made to Child First on 28 May 2015 and the family again declined the service.[708] On Ms Buchanan's view, closure at this juncture was premature given the family previously declining engagement with Child First, Ms DA was yet to be discharged, and given the seriousness of the incident leading to the previous report.[709]

[706] Statement of Kirstie-Lee Lomas, 21 June 2022, at paragraph 29.
[707] Statement of Kirstie-Lee Lomas, 21 June 2022, at paragraph 35.
[708] Child First records, Inquest Brief Part 2, v2.4 at [8771], [8764], [8768].
[709] Liana Buchanan, Commission for Children and Young People Expert Report dated 18 September 2023, paragraph 66, noting it appears the date is noted in error here.

3.121 On 10 June 2015, Child First initiated a section 38 consultation with Child Protection as Ms DA had informed them that she remained an inpatient, and the children were being cared for by a maternal aunt. Child Protection determined that Child First should make further enquiries regarding her mental health and the care of the children and reconsult if required,[710] but that there were no immediate or significant risks of harm to warrant Child Protection involvement.[711] Ms Buchanan's opinion is that Child Protection were overly reliant on Child First to gather information and assess risk on this occasion.[712]

3.122 On 9 July 2015, Child Protection received a fourth report, following the incident on 3 July, detailed above in the background to this matter. Commencing on 14 July, Child Protection made enquiries with Child First, who confirmed the family had declined the service.[713] Child Protection also spoke with NWMH who provided information about Ms DA's inpatient stay, and subsequent CTO, which they were advocating should be extended for six months.[714] Child Protection also spoke with the EMCHN, who had concerns about the older children's development and Ms DA's attachment with the children,[715] however a determination was made to close at intake due to extended family support and the risks identified not meeting the threshold for Child Protection intervention.[716] Ms Buchanan opined that further action at this stage would have been warranted,[717] and Ms Lomas conceded that in hindsight, Child Protection practice may have been enhanced in response to the first, second and fourth reports if there had been more detailed information gathering and assessments.[718]

3.123 The final report received by Child Protection was on 16 May 2017, the L17 obtained by Ms DI contained very little detail. Ms Buchanan noted it was not clear if Child Protection accessed information about previous incidents of family violence on this occasion.[719] But given the evidence before the Court, it does not appear so. Ms DI was asked how this

[710] Child First records, Inquest Brief Part 2, v2.4 at [7225]-[7226].
[711] Statement of Kirstie-Lee Lomas, 21 June 2022, at paragraph 37 – 40.
[712] Liana Buchanan, Commission for Children and Young People Expert Report dated 18 September 2023, paragraph 67.
[713] Statement of Kirstie-Lee Lomas, 21 June 2022, at paragraph 43.
[714] Statement of Kirstie-Lee Lomas, 21 June 2022, at paragraph 45.
[715] Statement of Kirstie-Lee Lomas, 21 June 2022, at paragraph 46 & 48.
[716] Statement of Kirstie-Lee Lomas, 21 June 2022, at paragraph 49.
[717] Liana Buchanan, Commission for Children and Young People Expert Report dated 18 September 2023, paragraph 68.
[718] Statement of Kirstie-Lee Lomas, 21 June 2022, at paragraph 50.
[719] Liana Buchanan, Commission for Children and Young People Expert Report dated 18 September 2023, paragraph 70(b)&(g).

might contrast to access to information at the current time, she gave evidence that Child Protection can now search the portal directly and therefore obtain a history against the name entered.[720] Child Protection are thus no longer dependent on police relaying information about family violence risk, which is a clear improvement in terms of access to information.

3.124 Child Protection did not formally assess, or consider assessing, the attachment and bonding between Child 4 and Ms DA as required by the extant policy *Mental Health Assessments and Treatment*.[721] Ms DI conceded in hindsight that this should have been considered.[722] Ms Lomas stated Child Protection may have enhanced their response if information was gathered about the impact of Ms DA's mental health on her capacity to care for the children and engage with services.[723] Ms Lomas also conceded an assessment about the father's capacity to parent in Ms DA's absence could have enhanced Child Protection's response.[724] Each of these deficits were noted by Ms Buchanan,[725] and have been acknowledged by Child Protection.

3.125 Intake generally do not speak directly with parents[726] as was the case at the time of this final report. It is noted there had been three referrals to Child First, none of which led to engagement by the family, and this is one of the factors noted by Ms Buchanan that led her to conclude closure at this point may have been premature.[727] Contact with Mr DB may have supported or facilitated service engagement.[728]

3.126 It was Ms Lomas' conclusion that in hindsight, the final report may have more appropriately been progressed to investigation so that there could have been more scrutiny about the safety of the children. This would likely have led to greater coordination

[720] Oral evidence of DI, 15 December 2022, 794.
[721] Per CP policy guidance "2425 Mental health assessments and treatment", as far as she could recall, Oral evidence of DI, Inquest transcript of evidence for 15 December 2022, page 796 & 804.
[722] Oral evidence of DI, Inquest transcript of evidence for 15 December 2022, page 796.
[723] Statement of Kirstie-Lee Lomas, 21 June 2022, at paragraph 68(a).
[724] Statement of Kirstie-Lee Lomas, 21 June 2022, at paragraph 68(b).
[725] Liana Buchanan, Commission for Children and Young People Expert Report dated 18 September 2023, paragraph 70(d)&(e).
[726] Oral evidence of DI, Inquest transcript of evidence for 15 December 2022, page 797; 814-5 and Ms DJ, Inquest transcript of evidence for 15 December 2022, page 825.
[727] Liana Buchanan, Commission for Children and Young People Expert Report dated 18 September 2023, paragraph 70(i).
[728] Put to DI, Inquest transcript of evidence for 15 December 2022, page 815-7.

between services, and monitoring of family's circumstances.[729] Ms Buchanan noted Child Protection had not spoken with the MCHN.[730] Ms DA also remained an inpatient so no discharge plan was known to Child Protection.[731] Child Protection was not aware of the risk of relapse or likely compliance with her medication regime,[732] or any assessment of the impact of the family's cultural background and values and their impact on their receptiveness to supports.[733]

3.127 Since Child 4's death, Child Protection have implemented the SAFER risk assessment framework – Ms DJ was of the view that this is a more comprehensive framework than the extant '*Best interests case practice model*.'[734] It is incorporated into the data entry process (through CRIS), with visual, practice prompts, as a '*guided professional practice model*', with more robust and thorough information gathering to assist in the determination of level and likelihood of risk.[735] The tool does not, however, prompt outcomes like an '*enhanced*' rather than standard referral to Child First.[736]

Intervention by the Area Mental Health Service – NWMH and whether risk information was sufficiently relayed to Child Protection.

3.128 Ms DA primarily received mental health treatment from her area mental health provider, NWMH, from her first episode in November 2013 up until Child 4's death. RN DG agreed that an inherent part of her role was undertaking risk assessments in relation to children, and something that was done consistently for this family, and that she would have reported to Child Protection if an escalation of risk was detected.[737] With respect to the concerns regarding the high caseloads, as noted in particular by RN DG,[738] Associate

[729] Statement of Kirstie-Lee Lomas, 21 June 2022, at paragraph 73.
[730] Liana Buchanan, Commission for Children and Young People Expert Report dated 18 September 2023, paragraph 70(a).
[731] Liana Buchanan, Commission for Children and Young People Expert Report dated 18 September 2023, paragraph 70(b).
[732] Liana Buchanan, Commission for Children and Young People Expert Report dated 18 September 2023, paragraph 70(d).
[733] Liana Buchanan, Commission for Children and Young People Expert Report dated 18 September 2023, paragraph 70(h).
[734] Oral evidence of Ms Chahine, Inquest transcript of evidence for 15 December 2022, page 822-3.
[735] Oral evidence of Ms Chahine, Inquest transcript of evidence for 15 December 2022, page 824-5 & 831.
[736] Oral evidence of Ms Chahine, Inquest transcript of evidence for 15 December 2022, page 832.
[737] Oral evidence of RN DG, Inquest transcript of evidence for 9 August 2022, page 953-975.
[738] Inquest Brief Part 2, v2.4 at [9582].

Professor (**A/Prof**) Vinay Lakra indicated that since the time of Child 4's death there has been a service redesign to assist to reduce those loads.[739]

3.129 Consultant Psychiatrist Dr DL gave evidence around the decision making in relation to Ms DA, and how NAMHS's approach was compliant with the requirement under the *Mental Health Act 1986* to treat in the least restrictive manner.[740] Although he agreed in his oral evidence that Ms DA being readmitted due to relapses increased the risk of future relapses, his view was that this was just one aspect of considering the trajectory of her illness - each episode required the approach of treatment in the least restrictive manner.[741] He added that consideration of the cyclical nature of ceasing medication and relapse might lead practitioners instead to consider altering the mode of treatment, if there had been past non-compliance for example.[742]

3.130 Dr DL noted there was a consistent theme throughout the episodes of treatment of complaints by Ms DA about the side effects of her medication – risperidone – once she had stabilised and started being treated in the community. Though she was being treated under a CTO, she expressed a preference for treatment by her GP (and to engage only voluntarily with NAHMS). Dr DL assessed that she was being sufficiently compliant to seek revocation of her CTO at his first consultation with her on 10 January 2014 in line with the requirement under the *Mental Health Act 1986* for treatment in the least restrictive manner.[743] Part of the reasoning for this was her acknowledgement of her presenting symptoms, her willingness to engage and to continue her medication. Dr DL believes she ceased taking her medication in March 2014. It is noted she self-ceased shortly after each treatment episode.

3.131 With respect to monitoring deterioration, NWMH were heavily reliant on Mr DB, and appropriately so as he had sought their help when Ms DA required hospitalisation in the past. While Dr DM noted they had concerns that he did not support maintenance

739 Oral evidence of A/Prof Lakra, Inquest transcript of evidence for 11 August 2022, 1131.
740 Oral evidence of Dr DL, Inquest transcript of evidence for 10 August 2022, page 991.
741 Oral evidence of Dr DL, Inquest transcript of evidence for 10 August 2022, page 991-992.
742 Oral evidence of Dr DL, Inquest transcript of evidence for 10 August 2022, page 1004.
743 Statement of Dr DL dated 25 July 2022 at paragraph 12.

treatment, in the acute phase he was reliable in seeking help.[744] While NWMH held concerns about Mr DB's willingness to support Ms DA to take medication during the maintenance phase, Dr DM's view was that he was reliable when she was acutely unwell and would seek the assistance of services.[745] Mr DB was a significant support to Ms DA, and cared for the children when she was hospitalised. NWMH had supported him to obtain extended leave when needed.[746] Following the final hospitalisation proximate to the fatal incident, the family felt they could no longer afford for him to remain on leave and the incident occurred on his first day back at work.

3.132 NWMH had been aware that Mr DB was returning to work but were of the belief that other family members were available to assist.[747] This is one aspect of the discharge planning that Counsel Assisting submitted might have deserved closer scrutiny, given all of the information available to NWMH – though how the family might have been better supported given the adversity to voluntary engagement is not clear. Dr DM proposed there might have been a more detailed discussion with Ms DA and Mr DB about their plans when he had returned to work, for example.[748] A/Prof Lakra's assessment of the file was that NWMH did not hold any information that there were risks identified that would cause the service to have had more frequent reviews – this determination is made by the treating team.[749] However, if the criteria for involuntary treatment is not met, the service are limited in what they can assert, or do with a patient which was considered in this case.[750] A/Prof Lakra was not aware of any policy or approach used today that would be different from the time of Child 4's death in terms of engaging service-avoidant patients.[751]

3.133 With respect to specific risk to children, Dr DL gave evidence that this was considered throughout NWMH treatment episodes for Ms DA, and was compliant with the extant

[744] Oral evidence of A/Prof Lakra, Inquest transcript of evidence for 11 August 2022, 1121-1123.
[745] Oral evidence of Dr DM, Inquest transcript of evidence for 10 August 2022, page 1040.
[746] Oral evidence of Mr DB, Inquest transcript of evidence for 8 August 2022, page 47; Statement of RN DG dated 8 August 2017, Inquest Brief Part 2, v2.4 at [6684].
[747] Oral evidence of Dr DL, Inquest transcript of evidence for 10 August 2022, page 1007 & 1011.
[748] Oral evidence of Dr DM, Inquest transcript of evidence for 10 August 2022, page 1075.
[749] Oral evidence of A/Prof Lakra, Inquest transcript of evidence for 11 August 2022, 1125.
[750] Oral evidence of Dr DL, Inquest transcript of evidence for 10 August 2022, page 1013.
[751] Oral evidence of A/Prof Lakra, Inquest transcript of evidence for 11 August 2022, 1129.

policy.[752] It was Dr DL's view that he had been appropriately consulted throughout and that staff had not assessed elevated risk in the lead up to Child 4's death.[753] Dr DM undertook the final medical review and did not have any new concerns about Ms DA's presentation on that day.[754]

3.134 A/Prof Lakra provided the Court with the NWMH policy '*Dependant Care Planning*' introduced after Child 4's death. In his view, this policy requires a more thorough assessment, and sharing, of this information about a patient's family responsibilities and support, representing a systemic improvement.[755] It is evident that the service did have good knowledge of this family constellation, and so it is unlikely this policy document would have led to a different approach to providing Child 4's mother and her family with supports.

3.135 An internal review of NWMH's service provision was undertaken following Child 4's death.[756] Dr Waterdrinker, then NAMHS Director of Clinical Services, summarised for this Court that this review found no directly causative systemic factors in the care provided to Child 4's mother.[757] The review noted Ms DA presented as acutely psychotic at each Northern Psychiatric Unit admission, and listed the history of family violence and other risks.[758] While acknowledging the difficulties NWMH had with engaging the family in the community, it found gaps in communication between NWMH and other services, and a lack of service coordination through joint meetings, for example. It posed the question of whether the service might have led this service coordination given their level of knowledge about the situation and the potential that a more assertive approach might have prevented the ultimate tragedy.[759] A/Prof Lakra's reflection on this review was that it was only a speculative conclusion, made with hindsight, and on his view it was not an

[752] Oral evidence of Dr DL, Inquest transcript of evidence for 10 August 2022, page 1022-1023; Dr DM shared this view, Inquest transcript of evidence for 10 August 2022, page 1072-1073; as did A/Prof Lakra, Inquest transcript of evidence for 11 August 2022, 1143.
[753] Oral evidence of Dr DL, Inquest transcript of evidence for 10 August 2022, page 1015-1017.
[754] Oral evidence of Dr DM, Inquest transcript of evidence for 10 August 2022, page 1074.
[755] Oral evidence of A/Prof Lakra, Inquest transcript of evidence for 11 August 2022, 1104.
[756] Team-based review, Inquest Brief Part 2, v2.4 at [9493 – 9500].
[757] In Dr Waterdrinker's statement dated 16 November 2020 in response to correspondence by the Coroner's Court (dated 9 October 2020) – Exhibit 16.
[758] Inquest Brief Part 2, v2.4 at [9496].
[759] Inquest Brief Part 2, v2.4 at [9498].

opportunity missed in terms of NWMH's role with Ms DA and her family.[760] A/Prof Lakra, on his review of the file, identified no missed opportunities at all which would have had a bearing on this case.[761]

3.136 The Team Based Review made recommendations including ensuring the 91-day reviews[762] are completed – there is a comment that these can assist in longitudinal analysis of risk rather than short-term episodic treatment. Longitudinal analysis may have led to a greater reliance on treatment orders to ensure continued engagement. The review also noted the missed opportunity with respect to NWMH engaging with Ms DA's GP, who she preferred to receive treatment from, as well as communication with Child Protection so that the needs of at-risk children are known and actioned.[763] The review also recommended referral to a high-risk panel to engage senior clinicians in supporting decision making and care provision. The input of Forensic Mental Health Specialists where a mental health consumer had significantly harmed others could have also assisted.[764]

3.137 In correspondence with the Court, it was put to Dr Waterdrinker that given Ms DA's history, there had been insufficient follow up after her final discharge prior to Child 4's death – being one consultation over the course of 11 days. It was Dr Waterdrinker's assessment that given Ms DA's presentation at the medical review on 2 June 2017, and compliance with her medication regime, the service had not assessed the presence of any psychotic symptoms and so this was reasonable aftercare. In addition, when more assertive intervention had been attempted previously, through use of the Targeted Brief Intervention Team, Ms DA had made clear this was unwelcome.[765] A/Prof Lakra took the view that a more assertive approach might well have meant Ms DA disengaged altogether.[766]

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[760] Oral evidence of A/Prof Lakra, Inquest transcript of evidence for 11 August 2022, 1111.
[761] Oral evidence of A/Prof Lakra, Inquest transcript of evidence for 11 August 2022, 1115.
[762] It was clarified that these occur if the patient remains in the service continuously for 91 days, Oral evidence of A/Prof Lakra, Inquest transcript of evidence for 11 August 2022, 1116.
[763] Inquest Brief Part 2, v2.4 at [9500].
[764] Inquest Brief Part 2, v2.4 at [9500].
[765] Dr Waterdrinker's statement dated 16 November 2020 in response to correspondence by the Coroner's Court (dated 9 October 2020) – Exhibit 16.
[766] Oral evidence of A/Prof Lakra, Inquest transcript of evidence for 11 August 2022, 1142-1144.

3.138 Dr Waterdrinker[767] and A/Prof Lakra took the view that NWMH receive training and are sufficiently skilled in taking cultural and religious factors into account when planning treatment. This is not specifically noted in the treatment plan[768] other than providing psychoeducation, however, and it was conceded no specific cultural consultant was engaged for this family, be it an interpreter or other support.[769] NWMH staff gave evidence that the psychoeducation provided was culturally respectful and sensitive, but not intended to challenge their beliefs around the aetiology of Ms DA's symptoms.[770] A/Prof Lakra was of the view that there are currently greater resources available to staff to support this aspect of care (but at the level of planning - not on a patient by patient basis).[771]

3.139 Compliance with NWMH policies is monitored through audits. However, A/Prof Lakra acknowledged that resources applied to such monitoring needs to be weighed against their use in providing front line services, so there are necessary limitations.[772]

3.140 Ms Buchanan identified a number of incidents within NWMH's knowledge that should ideally have been communicated to Child Protection.[773] In cross examination, she clarified that it was not her evidence that the incidents necessitated a *mandatory report* as such, but that ideally the risk information be communicated.[774] Ms Buchanan also noted that NWMH did not hold formal discharge meetings in the context of Ms DA's role as primary caregiver to four young children. It appears from the file that the only occasion on which a discharge summary was provided to Ms DA's GP was following the final admission.[775] Counsel Assisting suggested that in light of the information held by NWMH, and the

[767] Dr Waterdrinker's statement dated 16 November 2020 in response to correspondence by the Coroner's Court (dated 9 October 2020) – Exhibit 16.
[768] Dr Waterdrinker's statement dated 16 November 2020 in response to correspondence by the Coroner's Court (dated 9 October 2020) – Exhibit 16.
[769] Oral evidence of RN DG, Inquest transcript of evidence for 9 August 2022, page 951; The oral evidence of Dr DL was it was felt they had enough cultural supports, Inquest transcript of evidence for 10 August 2022, page 1010.
[770] Oral evidence of RN DG, Inquest transcript of evidence for 9 August 2022, page 947 to 949.
[771] The oral evidence of RN DG was that webinars are now far easier to access, Inquest transcript of evidence for 9 August 2022, page 950.
[772] Oral evidence of A/Prof Lakra, Inquest transcript of evidence for 11 August 2022, 1104-1105.
[773] Liana Buchanan, Commission for Children and Young People Expert Report dated 18 September 2023, paragraph 75.
[774] Oral evidence of Ms Buchanan, Inquest transcript of evidence for 5 October 2023, page 78.
[775] Inquest brief Part 2, v2.4 at [9611] to [9613].

relapse history, service coordination initiated by NWMH might have been more thoroughly attended to.

3.141 NWMH were primarily focused on managing Ms DA through a very complicated treatment and management phase. They were very focused on assessment and treatment of her condition. It is entirely understandable that the engagement with other services in non-mandatory reporting circumstances may not have been prioritised. NWMH should, if it has not already done so, take steps to ensure that service co-ordination training is given to staff reinforced by clear policy guidelines and compliance is audited regularly. I note that NWMH do have in place training with a focus on cultural and religious factors.

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3.142 At the four month check of Child 4, MCHN Ms DF had concerns about Ms DA's affect and limited interaction with Child 4.[776] Ms DF did not know of Ms DA's recent hospitalisation.[777] On 13 September, Ms DF relayed her concerns to RN DG, who advised Ms DF of Ms DA's post-natal depression and that she was under the care of NWMH.[778] Ms DF's concerns were not relayed to Child Protection by her or RN DG. Ms DF indicated she had chosen to report the concerns to RN DG because of her regular contact with the family.[779] Ms Buchanan was of the view that Ms DF should have initiated a report to Child Protection.[780]

3.143 Ms Karamis provided evidence as to the Council's policy on mandatory reporting (a resource available to nurses) – that a report is to be made to Child Protection where they have '*formed a reasonable belief that a child has suffered or is likely to suffer significant harm as a result of abuse or neglect, and their parent has not protected or is unlikely to protect the child from harm of that type. A reasonable belief does not require proof*.'[781]

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776 Statement of DF at p11; Darebin Council records, Inquest Brief Part 2, v2.4 at [6934], [6935], [6913], [6914]; Oral evidence of DF, Inquest transcript of evidence for 8 August 2022, page 56.

777 Oral evidence of Ms DF, Inquest transcript of evidence for 8 August 2022, page 55, she gave evidence she had only learned of this as a result of Child 4's father's evidence earlier in the day.

778 Statement of DF dated 14 July 2022 at page 13, Exhibit 8; Statement of RN DG, dated 8 August 2017, at p16; NWMH records, Inquest Brief Part 2, v2.4 at [9574].

779 Oral evidence of Ms DF, Inquest transcript of evidence for 8 August 2022, page 57.

780 Statement of Ms Buchanan, paragraph 72; His Honour clarified the interpretation was relaying the information and not in the form of a mandatory report, see Inquest transcript of evidence for 5 October 2023, page 82.

781 Statement of Donna Karamis dated 27 June 2022 at page 3.

Ms DF was of the view that her concerns did not reach the threshold of a report to Child Protection, and she did not believe there was an informal channel to discuss her concerns.[782]

3.144 Ms DF outlined that the concerns could have been discussed with her superior, though again she did not consider it necessary or of assistance.[783] In terms of oversight, Ms Karamis' evidence was that maternal child health nurses are not directly supervised in their day-to-day work, rather clinical supervision was effectively available at the instigation of that nurse to support their clinical practice and abilities and work toward goals, or to escalate any concerns.[784] Monthly clinical supervision meetings were held which Ms Karamis said the nurses were required to attend[785] although Ms DF recalled many did not attend if it was their day off, but that she would.[786] A Team Leader is also available to oversee staff - at the time of Child 4's death there was one overseeing all nurses (approximately 32 according to Ms DF[787]), but upon the request of those nurses a second Team Leader has since been employed by the Council.[788]

3.145 The evidence from this service is that the concerns raised never reached the threshold of requiring a report to Child Protection, nor could the service had done anything more than it did, with the information that they had and as a voluntary service.[789] I accept the evidence of Ms DF that the concerns raised in her judgment did not reach the threshold for a report to Child Protection.

3.146 Counsel Assisting submitted that access to consultation with Child Protection would be of assistance to services like maternal child health nurses where concerns are held that do not reach the criteria of "significant harm." Ms Buchanan observed[790] that the MCHN

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[782] Oral evidence of DF, Inquest transcript of evidence for 8 August 2022, page 78.
[783] Oral evidence of DF, Inquest transcript of evidence for 8 August 2022, page 77.
[784] Statement of Donna Karamis dated 27 June 2022 at pages 1, 3, 4; Oral evidence of Ms DF, Inquest transcript of evidence for 8 August 2022, page 72.
[785] Oral evidence of Ms Karamis, Inquest transcript of evidence for 8 August 2022, page 90.
[786] Oral evidence of DF, Inquest transcript of evidence for 8 August 2022, page 72-73.
[787] Oral evidence of DF, Inquest transcript of evidence for 8 August 2022, page 72, though Ms Karamis believed it might have been less in her oral evidence, Inquest transcript of evidence for 8 August 2022, page 92; Oral evidence of DF, Inquest transcript of evidence for 8 August 2022, page 53 was that a Team Leader would only access the MCHN file "if they've got a reason to do so."
[788] Statement of Donna Karamis dated 27 June 2022 at pages 2, 3.
[789] Oral evidence of DF, Inquest transcript of evidence for 8 August 2022, page 83 & 84.
[790] Liana Buchanan, Commission for Children and Young People Expert Report dated 18 September 2023, paragraphs 71 to 73.

services missed the opportunity to relay their concerns to Child Protection, even if there was uncertainty regarding them reaching the threshold of imminent risk.

3.147 I agree with Counsel Assisting that consultation would be of assistance and with Ms Buchanan that there was a missed opportunity to convey information to Child Protection. Nevertheless, I accept the evidence of Ms DF that the concerns raised never reached the threshold of requiring a report to Child Protection and I consider that her assessment of this was reasonable in the circumstances.

PART FOUR - THEMATIC ANALYSIS AND RECOMMENDATIONS

Consultation regarding significant decision-making for Aboriginal children

4.1 In both the matters of Child 2 and Child 3, there were difficulties encountered in Child Protection consulting with ACSASS. There had been documented attempts in each case, and Ms Jose's evidence in Child 3's case was that at that time the average case load for ACSASS was over 100 children per case practitioner.

4.2 Such caseloads are clearly unmanageable. Funding of community-controlled organisations needs to be sufficient to ensure that caseloads are manageable and enables the organisation to provide timely and appropriate services commensurate with demand.

4.3 In Child 3's case, no cultural support plan had been prepared throughout Child Protection's involvement.

4.4 Counsel Assisting submitted that I make recommendations that:

a) Compliance with Child Protection's obligations to consult with ACSASS, and to produce cultural plans, be sufficiently monitored that non-compliance triggers oversight and enforcement of such obligations (whether through SAFER or other oversight mechanisms)[791].

[791] As has been addressed in the Yoorrook report at Recommendation 16, 22 and 26.

b) That I endorse Recommendation one of the Yoorrook report[792] and that Aboriginal controlled-organisations be funded sufficiently to be able to meet the demand to undertake these roles.

4.5 In response to these proposed recommendations, DFFH acknowledges and accepts the importance of ensuring compliance with Child Protection's obligations to consult ACSASS and produce cultural plans.

4.6 Child Protection advised that it is engaged in ongoing work to improve the approach to cultural support plans. In submissions to the Court, Child Protection advised that:

> *More specifically, in September 2023, the Aboriginal Children's Forum agreed that the approach to cultural plans should be reconsidered through the Aboriginal-led State-wide Cultural Planning Forum. It was further agreed that this state-wide forum would be an opportunity to discuss and agree on how the current model can be improved and redesigned to increase quality and compliance of initial and review plans and to support culturally appropriate implementation. This forum will be led by VACCA in early 2024.*

4.7 In relation to proposed recommendation (b) above, Child Protection confirmed that the "*Victorian Government is considering the Yoorrook recommendations and is expected to respond to them in due course. DFFH will work with Government to implement its commitments*."

Recommendation 1

a) Compliance with Child Protection's obligations to consult with ACSASS, and to produce cultural plans, and be sufficiently monitored that non-compliance triggers oversight and enforcement of such obligations (whether through SAFER or other oversight mechanisms)[793].

b) DFFH and VACCA to publish an update about the outcome of the Aboriginal-led State-wide Cultural Planning Forum, and any outcomes relevant to these findings.

[792] Retrieved from Yoorrook-for-justice-report.pdf (yoorrookforjustice.org.au).
[793] As has been addressed in the Yoorrook report at Recommendation 16, 22 and 26.

c) The Court endorses Recommendation one of the Yoorrook report[794] and that Aboriginal-controlled organisations be funded sufficiently to be able to meet the demand to undertake these roles.

Assessment of cumulative harm

4.8 Despite Child Protection recommending after the third report for Child 1's family that further assessments including a cumulative harm assessment be conducted, the fourth report (after Child 1's birth) was closed at intake phase without Child Protection having spoken directly to the parents. It is noted that while Ms Beaton has stated there is '*no magic number*' of reports that should trigger investigation,[795] the extant policy now requires investigation if there are three reports within 12 months, unless it is determined this is not warranted. Should there be five reports over a child's lifetime, a detailed case review is to be undertaken with a specific focus on cumulative harm if protective intervention is not undertaken.[796]

4.9 A cumulative harm assessment was not conducted in relation to Child 1 and, to echo Ms Buchanan's concerns, should have been.[797] Ms Beaton noted that Child Protection conceded the assessment of risk to Child 1 (and siblings) had been episodic rather than taking a sufficiently broad view of cumulative harm.[798] Ms Beaton gave evidence that specific training on this issue had been delivered in the region following Child 1's passing.[799]

4.10 Ms Lomas spoke to the improvements that the SAFER framework and integration into CRIS will have on assisting workers to make such assessments.[800] However, Ms Buchanan identified that there is some inconsistency in the practice advice whereby the specialist

[794] Retrieved from Yoorrook-for-justice-report.pdf (yoorrookforjustice.org.au).
[795] Oral evidence of Tracey Beaton, Inquest transcript of evidence for 24 February 2022, page 577; Ms Lomas' evidence confirms that now, following three reports in 12 months or five in a lifetime, this triggers a matter at intake to proceed to investigation (Inquest transcript of evidence for 20 April 2023, page 253-254), though she was unsure if that related to the family or each child separately (as would be relevant in Child 4's matter) (page 254).
[796] Re-reports advice, Document ID 2017, v5, 15 November 2019.
[797] *Liana Buchanan, Commission for Children and Young People Expert Report dated 18 September 2023* [27].
[798] Oral evidence of Tracey Beaton, Inquest transcript of evidence for 24 February 2022, pages 551-552; Ms Buchanan reports that she has observed this in a 'significant number' of her inquiries, at paragraph 88.
[799] Oral evidence of Tracey Beaton, Inquest transcript of evidence for 24 February 2022, page 552.
[800] Oral evidence of Ms Lomas, Inquest transcript of evidence for 20 April 2023, page 170.

advice on cumulative harm developed in 2012 remains available to practitioners, which she considers potentially confusing.[801] Child Protection clarified that, if used as intended, SAFER alone does provide the framework for identifying cumulative harm. The Best Interests Case Practice Model (**BICPM**) – the shared practice approach across the statutory and voluntary services – is still the extant guidance for responding to that harm.[802] The issue remains that there are multiple frameworks used to guide frontline practitioners.

4.11 Following on from the recommendations made by Ms Buchanan at paragraph 92 of her report[803] and the circumstances in Child 1's case, it appears the resources available under the SAFER framework (and prompted in CRIS) should be streamlined such that the current relevant policy is directly available to the practitioner accessing it. Ms Buchanan also proposes that CRIS prompt practitioners if and when one of the triggers as set out above is activated, and that criteria for cumulative harm assessments be clarified and documented. I agree with Ms Buchanan's assessment and recommendations. In their supplementary material, DFFH indicated there is a review underway of the structure of the Manual which may address this issue.

4.12 Counsel Assisting submitted that I should recommend:

a) The Child Protection Manual be structured so as to allow practitioners to easily access the singular policy and simple tool relevant to cumulative harm assessment being undertaken.

b) A prompt be created within CRIS where practitioners are required to undertake investigation or other oversight as required in the 'Re-reports advice'.

4.13 In relation to proposed recommendation (a) above, DFFH advised in their submissions that work is currently underway to reform and improve the Child Protection Manual. In this respect, DFFH referred to paragraphs [1]-[7] of the Annexure to its correspondence to the Court dated 24 November 2023, where detail was provided as to the project of

[801] *Liana Buchanan, Commission for Children and Young People Expert Report dated 18 September 2023* [91].
[802] Department of Families Fairness and Housing, supplementary material filed 24 November 2023, paragraph 27.
[803] *Liana Buchanan, Commission for Children and Young People Expert Report dated 18 September 2023* [92].

redesigning the Manual. As of June 2023, an independent consultant has been engaged in a redesign of the Manual, utilising a human centred design approach to allow users to more easily access information. The redesign will be delivered in four phases. DFFH considers this will address the systemic issues identified by the Principal Commissioner.

4.14 As to the specific suggestion of a tool regarding cumulative harm, DFFH considers that the creation of a new tool would be unnecessary given that, since the passing of the children the subject of the Cluster Inquest, DFFH has developed and implemented the SAFER framework. SAFER is described as a comprehensive risk assessment framework specific to the role and function of Child Protection. Where a particular Child Protection case requires assessment of cumulative harm, such an assessment will form part of the application of the SAFER framework.

4.15 The work that DFFH is doing to reform and improve the Child Protection Manual is to be commended, noting in doing this work the advantage of having a single policy and a simple tool should not be overlooked, and the suggested recommendation is appropriate.

4.16 In relation to part (b) of paragraph 4.12 above, DFFH advised that a prompt is already in existence within CRIS where practitioners are required to undertake investigation or other oversight as required in the '*Re-reports advice*'.[804] Where required, the prompt appears in the '*intake workspace*' on CRIS. When creating a new intake workspace entry for a new report, an alert appears for the practitioner that is visible across multiple pages in the client record. On the intake phase page, a red text banner message is presented to alert the practitioner that the client has had two or more intakes without investigations in 12 months and approval is required to move to closure phase. Practitioners are then supported with on-screen guidance in the risk assessment screen with references to cumulative harm. Practitioners are then further supported with additional prompts in the system when they are moving the case to the closure phase, with approval required from a team manager or above if the decision has been made to progress to closure of the case.

[804] The current version of the 'Re-reports advice' is accessible here: <https://www.cpmanual.vic.gov.au/advice-and-protocols/advice/intake/re-reports-advice>.

In light of this work having been done by DFFH I do not see a need for the recommendation as suggested by Counsel Assisting.

Recommendation 2

That Child Protection, as part of the work they are doing to reform and improve Child Protection Manual, incorporate easy access to a singular policy and simple tool relevant to cumulative harm assessment being undertaken.

Assessment of new partners of parents

4.17 In the cases of Child 2 and Child 3, the children's mothers' partners were found criminally responsible for the passing of the children. In relation to Child 1, her mother's partner had been charged for his involvement in causing Child 1's death, though was later acquitted.

4.18 Ms Buchanan noted, '*In a previous review of apparent filicide cases for which [the CCYP] had conducted child death inquiries between 2015 and 2019, 45 per cent (or five out of eleven children) were thought to have been killed by their mother's new male partner. In some of these cases, the adult male was known as a stepparent to the child, but not in all*.'[805]

4.19 The CYFA's definition of a parent includes someone who is the spouse of the father or mother of the child or is the domestic partner of the father or mother of the child. The Act further defines a 'domestic partner' as

a) a person who is in a registered domestic relationship with the person; or

b) a person to whom the person is not married but with whom the person is living as a couple on a genuine domestic basis (irrespective of gender).

[805] *Liana Buchanan, Commission for Children and Young People Expert Report dated 18 September 2023* [117].

4.20 There is no further guidance in the Act as to what constitutes '*living as a couple on a genuine domestic basis*'.

4.21 Where a person falls within the definition of a '*parent*' under the CYFA, then Child Protection policy requires them to be assessed for any potential risk to a child. SAFER includes the parent as one of the essential information categories across which practitioners are required to seek, share, sort and store information and evidence.

4.22 However, where a parent has commenced a new relationship with a person and that relationship does not fall within one of the categories of parent provided for in the CYFA, there is no requirement for that person to be assessed by Child Protection. Rather, there is guidance for practitioners to review risk assessments where a parent enters into such a new relationship.

4.23 I accept that the CYFA cannot and should not include an exhaustive list of situations where a new partner of a mother or father should be regarded as a parent. Child Protection practitioners, in their work with families, must adopt a proactive approach in ascertaining and understanding the significance of new partners in a child's life, and assessing any risk they may pose when caring for or having contact with a child.

4.24 In her report to the inquest, Ms Buchanan stated '*there is guidance encouraging practitioners to review a risk assessment when a parent starts a new relationship. However, neither the SAFER framework nor other guidance to practitioners contains any other reference to the relevance of new partners who are not yet considered to fall within the legal definition of 'parent' or caregiver.*'[806] Ms Buchanan expanded upon this statement in her oral evidence, noting '*the reality of some people's lives and the nature and speed at which relationships can change mean that ideally, Child Protection practitioners should be alert to any new partner who is raised or known about and should then make an assessment about what role that new partner has in relation to the child*

[806] *Liana Buchanan, Commission for Children and Young People Expert Report dated 18 September 2023* para-114.

and then from there, make a decision about how significant an assessment needs to be done in relation to that person.'[807]

4.25 Ms Buchanan ultimately recommended, to which Counsel Assisting agreed, that:

a) Guidance to practitioners should require (rather than just encourage) a review of risk assessment when a parent starts a new relationship; and

b) Guidance should be strengthened to ensure information about partners is collected at Intake.

4.26 In oral evidence in relation to (b) above, Ms Buchanan observed that '*inquiries will be more difficult to make at intake stage where usually there's no direct engagement with the parent*' as further evidence of the need to strengthen guidance at the intake phase.[808]

4.27 In addition, Counsel Assisting recommended that guidance be strengthened regarding the importance and regularity of following up with parents throughout their involvement with Child Protection about whether they may have commenced a new relationship and review risk assessments accordingly.

4.28 It was suggested that there may be a reticence to pry into the personal dynamics of a parent's relationship at the intake phase, in favour of building a rapport with the parent. The conundrum of balancing potentially intrusive lines of questioning against building a relationship with parents was put to Ms Buchanan, who responded that '*the work of a Child Protection practitioner involves asking many, many intrusive sensitive potentially troubling questions of parents… [and she didn't] think it can be a reason to resile from asking questions especially where there's some possibility that a new person in the parent's life and the child's life might pose a risk to the children.*'[809] Counsel Assisting also suggested that due regard should be given to such enquiries being made frequently given the dynamic nature of family relationships, as was borne out in the case of Child 2.

[807] Oral evidence of Ms Buchanan, Inquest transcript of evidence for 5 October 2023, page 35.
[808] Inquest transcript 5 October 2023, page 36.
[809] Inquest transcript of evidence for 5 October 2023, page 38.

4.29 In their submissions on this topic, DFFH directed me to the statement of Shane Wilson, dated 29 June 2022. There, Mr Wilson explained:[810]

> *... the SAFER children framework commenced on 20 November 2021, and it is the current risk assessment framework for Child Protection Practitioners in Victoria.*
>
> *Procedures relevant to the SAFER children framework and conducting the intake risk assessment, conducting the risk assessment and reviewing the risk assessment are attachments 'SW-55',[811] 'SW-56',[812] and 'SW-57'[813] to my January 2022 statement. Further, the SAFER risk assessment snapshot and snapshot guide are attachments 'SW-58'[814] and 'SW-59'[815] to my January 2022 statement.*
>
> *Specific to partners of parents, the reviewing the risk assessment procedure referenced above ('SW-57' to my January 2022 statement), effective from 20 November 2021, suggests a Child Protection Practitioner consult with their supervisor about reviewing the risk assessment following a change in household composition, such as, a new partner, in the Protective Intervention Phase.[816]*

4.30 Where relevant, a risk assessment of a parent's partner will form part of the risk assessment under the SAFER framework. This applies at each stage of Child Protection's involvement.

4.31 At the intake stage, the Child Protection practitioner is required to gather information about the family composition, including the child, siblings, parents, family members and caregivers. If the family composition includes a partner of the parent, this will be taken into account as part of the broader information gathering and intake assessment.

4.32 In the later stages of investigation or where a court order is in place, risk assessments will be conducted on an ongoing basis. Where a family's composition changes, a revised risk

[810] Statement of Shane Wilson dated 29 June 2022, [14]-[15].
[811] CB-1, 5134.
[812] CB-1, 5136.
[813] CB-1, 5138.
[814] CB-1, 5141.
[815] CB-1, 5143.
[816] CB-1, 5139.

assessment will be conducted to take account of the changes. As noted by Mr Wilson, this is reflected in the procedure, '*1808 Reviewing the risk assessment*', which applies when undertaking a review of risk assessment in protective intervention, protection order or closure phase.[817] That procedure provides that '*[t]he practice of analysis and assessment of risk is ongoing throughout child protection involvement.*'[818] It further provides, as one of the '*Case practitioner tasks*', that where there is a '*change in household composition, such as … new partner*', the practitioner '*consult with [their] supervisor about reviewing the risk assessment …*'.[819] Such an assessment would assume particular importance where preservation or reunification forms part of the case plan.

4.33 In summary, DFFH submitted that the current policy and procedure, which incorporates SAFER, is sufficient to ensure that the partners of parents who are involved with Child Protection are assessed and a review of the risk assessment occurs, where this is necessary, appropriate, and in the child's best interests.

4.34 Further, as to the recommendation that a risk assessment of a parent's partner should be mandatory, DFFH submitted that imposing such a requirement would not be appropriate. In some cases, there is no basis to conduct such an assessment or to continually follow-up parents about whether they have a new partner. DFFH provided an example where a child is subject to an order which grants parental responsibility to the Secretary and the case plan is one of permanent out of home care and non-reunification, and the child is not having any contact with their parent (and/or their parent's new partner), it may not be relevant or appropriate to assess a parent's new partner or to follow up with the parent about whether they have commenced a new relationship. In my view, this is not a particularly helpful example. In that example, there is no contact between the child and the parent and/or their new partner, and therefore the risk to the child is effectively mitigated.

[817] See SW-57, CB-1, 5138.
[818] Ibid.
[819] Ibid, CB-1, 5138-5139.

4.35 Having reviewed the submissions on this issue from both Counsel Assisting and DFFH, I accept that the SAFER Framework is intended to assess and manage the risk that may arise from a new partner. I do however remain concerned about the willingness of Child Protection staff to engage with a parent about a possible new partner or any other person regularly in the house and obtain all relevant information in a timely way. The evidence in this inquest did identify examples where inquiries and follow up were less than optimal. I note that in November 2024, the SAFER Framework will have been in operation for three years and it would be appropriate to conduct a review of the effectiveness of the framework in identifying and managing risk arising from a parent entering a relationship with a new partner.

Recommendation 3

a) That DFFH engage a suitably qualified consultant or an internal person to conduct a review of the operation and effectiveness of the SAFER Framework with particular reference to its identification and assessment of risk associated with a parent entering a relationship with a new partner or any other person who is regularly in the house.

b) That DFFH publicly report on the implementation and evaluation of the SAFER framework.

c) That DFFH ensure mandatory training for protective workers and supervisors incorporates a positive obligation on staff to be assessing the risk of any new partner that may potentially have any contact with the subject children, whether they are residing in the home or not, and incorporate assertive engagement such that the risk assessment is always prioritised, even when it may impinge upon the parent and partner's privacy.

Information gathering and sharing

4.36 The case closure decision in relation to Child 1[820] was made in the context of the children engaging in counselling, having improved their school and childcare attendance, and the

[820] CRIS record, Inquest Brief Part 1, v2.2 at [482].

ongoing engagement of MFC. Engagement with MFC was the central risk mitigation strategy[821] however fulsome details of Mr AI's prior offending had not been shared with MFC and the other services who were to monitor that ongoing risk.[822] Submissions have also been made about MFC not having convened sufficiently regular care team meetings or followed up with other services with which the family were engaged and support Ms Buchanan's comments in this regard. This role of MFC is addressed specifically later in this finding. Counsel Assisting submitted there should have been explicit discussions regarding MFC relaying any further risk information back to Child Protection, and role clarity and information sharing, as well as documentation of any understanding, appears to be a deficit in service provision here. The importance of role clarity cannot be overstated.

4.37 With respect to Child 2, it was the evidence of both VACCA and Child Protection that the protective workers were too reliant on the C2K program to gather information and respond to the risk to Child 2.[823] For example, in the second period of investigation, Child Protection did not conduct a home visit after 20 April 2016, only sighting Child 2 and Ms BA at the office. Ms Buchanan opined that it was not clear that C2K were able to provide the level of intensive, proactive support required to ensure Child 2's wellbeing.[824] In addition, when the referral was made to C2K, the history of family violence and illicit substance use was not identified.[825]

4.38 In relation to Child 4, Ms Buchanan outlined a number of deficits in information gathering on the part of Child Protection when the final intake report in relation to Child 4 was closed.[826] NWMH held information across their records from the episodes of treatment that, had Child Protection had access to all of that, may have impacted on the risk assessment made at the time of the final report. While an internal review conducted by NWMH identified a possible missed opportunity to lead service coordination,[827]

[821] Statement of Tracy Beaton, dated 28 January 2022, paragraph 73; Oral evidence of Tracey Beaton, Inquest transcript of evidence for 25 February 2022, pages 713-714.
[822] Oral evidence of Tracy Beaton, Inquest transcript of evidence for 25 February 2022, page 132.
[823] Statement of Tracey Beaton, 28 January 2022, paragraph 119(d); Statement of BD, 30 November 2021 at paragraph 15.b.
[824] *Liana Buchanan, Commission for Children and Young People Expert Report dated 18 September 2023*, paragraph 47.
[825] VACCA records, Inquest Brief Part 1, v2.2 at [3595-3596].
[826] See *Liana Buchanan, Commission for Children and Young People Expert Report dated 18 September 2023*, at paragraph 70.
[827] Inquest Brief Part 2, v2.4 at [9498].

Ms Buchanan identified that NWMH ideally should have communicated the risk information they held in relation to Ms DA's children.[828] Where the threshold for mandatory reports is not met, other routes of relaying such information to Child Protection rely on regular review and focus on information sharing. The need for ongoing training is clear. NWMH specific issues will be addressed later in this finding.

4.39 Ms Buchanan identified that a theme across the above cases is the lack of integration and coordination between Child Protection and the community services to which they refer clients.[829] In their supplementary material, DFFH noted there is currently a review underway of the operating model across the sector.[830] One explicit goal includes delivering a '*more contemporary, sustainable and integrated child and families service system*' (emphasis added).[831] Counsel Assisting submitted, and I concur, that there should be a particular focus on role distinction and coordination between services, as highlighted by DFFH,[832] in order to address the issues that have arisen in the matters being examined by this Court.

SAFER

4.40 Ms Lomas gave evidence as to the relatively newly implemented framework SAFER, which from November 2021 replaced the BICPM, guiding information gathering, risk assessment and management.[833] Ms Lomas noted that it was developed from similar principles and represents an evolution and not '*throwing the baby out with the bath water*'.[834] In their supplementary material, DFFH reiterated that the BICPM is still the guiding framework across the sector, but that SAFER is a statutory risk assessment framework developed specifically (and exclusively) for Child Protection.[835]

4.41 The Court was provided with a range of materials developed for the implementation of the framework including graphics demonstrating the role and mandate of protective

[828] *Liana Buchanan, Commission for Children and Young People Expert Report dated 18 September 2023* at [75].
[829] Statement of Ms Buchanan, paragraph 137.
[830] Department of Families Fairness and Housing, supplementary material filed 24 November 2023, paragraphs 14 to 21.
[831] Department of Families Fairness and Housing, supplementary material filed 24 November 2023, paragraph 17.
[832] Department of Families Fairness and Housing, supplementary material filed 24 November 2023, paragraph 18.
[833] Oral evidence of Ms Lomas, Inquest transcript of evidence for 20 April 2023, page 157 and following.
[834] Oral evidence of Ms Lomas, Inquest transcript of evidence for 20 April 2023, page 163-164.
[835] Department of Families Fairness and Housing, supplementary material filed 24 November 2023, paragraphs 22 to 32.

workers. Ms Lomas also elucidated how the CRIS is built in a way that reflects the SAFER framework, this is built into the data entry and management used by practitioners.[836] Ms Lomas also spoke to the integration of the mandated MARAM family violence risk assessment framework into information gathering that is prompted at each stage of an intervention, from intake and through investigation[837] regardless of whether family violence has been identified as an issue.[838] That assessment can be extracted from CRIS and shared with other agencies if required.[839] It was noted in the evidence in relation to Child 4 that the L17 provided at the time of the last report was sent by police and that protective workers are now able to access family violence history directly as a consequence of the FVISS reforms.[840] Ms Lomas also spoke to the broad utility of the L17 portal to access current and historical information with respect to family violence.[841]

4.42 Ms Lomas gave evidence that the framework assists practitioners to ensure risk assessments are continuously undertaken as new information comes to light, and asserted SAFER integration into CRIS supports this, and means the guidance is readily available to practitioners.[842] She also gave an example of some data that must be entered – for example an intake assessment must be completed before it can proceed to investigation and assessment or be closed.[843] It also allows Directors to generate various reports to oversee the work of practitioners.[844] Ms Lomas conceded that the implementation of SAFER has been a "journey" and they are looking at a five-year timeline, interrupted somewhat by COVID, with evaluation of it being an ongoing component – including outcomes.[845]

4.43 External agencies have not to date been trained on, nor is there any apparent intention to do so, the use of the SAFER tool. Ms Lomas noted this is because it was built for the statutory role of protection practitioners. Rather, external agencies provide information

[836] Oral evidence of Ms Lomas, Inquest transcript of evidence for 20 April 2023, page 162-163.
[837] Oral evidence of Ms Lomas, Inquest transcript of evidence for 20 April 2023, page 174.
[838] Oral evidence of Ms Lomas, Inquest transcript of evidence for 20 April 2023, page 175.
[839] Oral evidence of Ms Lomas, Inquest transcript of evidence for 20 April 2023, page 176.
[840] Oral evidence of Ms DI, Inquest transcript of evidence for 15 December 2022, page 794.
[841] Oral evidence of Ms Lomas, Inquest transcript of evidence for 20 April 2023, page 242.
[842] Oral evidence of Ms Lomas, Inquest transcript of evidence for 20 April 2023, page 179-180; page 206-208.
[843] Oral evidence of Ms Lomas, Inquest transcript of evidence for 20 April 2023, page 186.
[844] Oral evidence of Ms Lomas, Inquest transcript of evidence for 20 April 2023, page 187.
[845] Oral evidence of Ms Lomas, Inquest transcript of evidence for 20 April 2023, page 187-188.

that informs the risk assessment done by Child Protection.[846] That data can then be extracted and provided to external agencies.[847] Contracted agencies have only limited access to CRIS.[848] The BICPM program requirements set out in service and funding agreements guide the work of external agencies - there is no current or intended integration into SAFER,[849] and I understand there is no current intention to roll out SAFER beyond Child Protection's use.

4.44 Ms Buchanan's assessment is that some of the aspects of SAFER that are beneficial to the front-line work of Child Protection practitioners include its integration into the CRIS database. The system will trigger mandatory assessments at certain stages and also require certain information be entered and determinations endorsed before matters can progress through the system.

4.45 Ms Buchanan also opined that SAFER allows practitioners to access previous risk assessments more easily than was previously the case, as they are gathered under one tab. The framework also prompts (but does not require) workers to gather certain categories of essential information (including family violence). All Child Protection staff are trained in the framework, and resources have been developed to support its utilisation.[850] There has been significant investment in learning and development of staff.[851]

4.46 Ms Buchanan noted that given the recency of SAFER's implementation, she could not comment on whether there has been a significant improvement in information gathering by Child Protection practitioners.[852] In her oral evidence, she indicated she understood there was an internal review conducted in early 2022, and this evaluation showed there had been some improvement, but there was still more work to be done, as might be expected at the early stages of implementation.[853] It is not clear if there has been any subsequent internal review.

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[846] Oral evidence of Ms Lomas, Inquest transcript of evidence for 20 April 2023, page 188.
[847] Oral evidence of Ms Lomas, Inquest transcript of evidence for 20 April 2023, page 189.
[848] Oral evidence of Ms Lomas, Inquest transcript of evidence for 20 April 2023, page 189.
[849] Oral evidence of Ms Lomas, Inquest transcript of evidence for 20 April 2023, page 190.
[850] *Liana Buchanan, Commission for Children and Young People Expert Report dated 18 September 2023*, paragraph 80(d).
[851] Oral evidence of Ms Buchanan, Inquest transcript of evidence for 5 October 2023, page 21.
[852] *Liana Buchanan, Commission for Children and Young People Expert Report dated 18 September 2023*, paragraph 81.
[853] Oral evidence of Ms Buchanan, Inquest transcript of evidence for 5 October 2023, page 14-15.

4.47 Ms Buchanan noted, however, that information gathering in these cases where she has identified shortfalls, was not impeded by any legislative or policy hurdles or inadequacies.[854] Information gathering has long been central to Child Protection practice.[855] Rather, she noted, where there have been any deficits in information gathering, this occurs in the context of system and workload pressures which are not addressed by policy shifts like the implementation of SAFER.[856]

4.48 In Ms Buchanan's oral evidence, she emphasised that there have been significant shifts with respect to risk assessment and information sharing protocols, with the introduction of the MARAM, FVISS and CISS provisions and concomitant policies. These shifts, from her perspective, are very welcome and improve the capacity for services to share information about risk of family violence, or the risk to children's safety or wellbeing.[857] However there has long been capacity to share information and rather the workload and cultural issues remain as some of the key reasons that information was not shared.[858]

4.49 It is relevant that the Yoorook Commission recommended that '*The Victorian Government must ensure that an impact evaluation of the Child Protection Risk Assessment Framework (SAFER) is commenced within 12 months, and in the case of First Peoples children: a) is First Peoples led and overseen by a First Peoples governance group b) has methodology that includes a review of individual cases by the Commissioner for Aboriginal Children and Young People, and c) makes recommendations that include actions to reduce child protection practitioner racial bias when applying the Framework.*'[859]

4.50 Counsel Assisting submitted that I should consider making recommendations:

(a) That Child Protection undertake an impact evaluation of SAFER broadly, and to include the terms as set out in recommendation 13 of the Yoorrook Report; and

[854] *Liana Buchanan, Commission for Children and Young People Expert Report dated 18 September 2023*, paragraph 83.
[855] *Liana Buchanan, Commission for Children and Young People Expert Report dated 18 September 2023*, paragraph 82.
[856] *Liana Buchanan, Commission for Children and Young People Expert Report dated 18 September 2023*, paragraph 84.
[857] Oral evidence of Ms Buchanan, Inquest transcript of evidence for 5 October 2023, page 17-18.
[858] Oral evidence of Ms Buchanan, Inquest transcript of evidence for 5 October 2023, page 18.
[859] Yoorrook report at Recommendation 13, retrieved from Yoorrook-for-justice-report.pdf (yoorrookforjustice.org.au).

(b) Professional development reinforcing the importance of entering data into the CRIS system, and systems for oversight to ensure mandatory tasks are completed in a timely fashion and the system can be easily audited for compliance.

4.51 I note that the Victorian Government is yet to respond to the Yoorrook Report and in particular, recommendation 13. In the context of information sharing and the importance of risk assessment, I can see considerable merit in a review or impact evaluation of SAFER, particularly as it has now been in operation for coming up to three years. I also note that further relevant evidence around risk to children has been researched and developed since the introduction of SAFER.[860]

4.52 In relation to the proposed recommendation of Counsel Assisting, relating to professional development in part (b) of paragraph 4.50 above, in their submissions, DFFH acknowledged the importance of providing Child Protection practitioners with ongoing professional development. It is recognised that such development should include reinforcing the importance of entering data on the CRIS system, including as to mandatory tasks, and oversight of the same. The Office of Professional Practice within Child Protection has been refreshing practice learning programs. The new Practice Induction Program includes embedded learning opportunities regarding the use of CRIS and the importance of correct data entry in CRIS. Following the implementation of the new Practice Induction Program in May 2024, DFFH advised that further training programs will be developed for foundation, advanced and expert level Child Protection practitioners in key areas of practice.

4.53 In addition, a number of digital opportunities projects are aimed at supporting staff to identify clear timelines for mandatory actions in CRIS. The digital opportunities projects, particularly the new case practice overview page, provide new functionality that will

[860] For example, Filicides in a domestic and family violence context 2010–2018 FIRST EDITION | 2024. ANROWS-Research-Report-Filicides-in-a-domestic-and-family-violence-context-2010-2018.pdf (anrows-2019.s3.ap-southeast-2.amazonaws.com)

allow staff to see mandatory actions for completion in a case and support staff to access this required information in an efficient manner.

4.54 In relation to auditing of mandatory actions, some data fields in CRIS will have the capacity to be monitored through audit logs, which detail when the information was entered and by whom. These audit logs can be viewed by Child Protection practitioners.

Recommendation 4

(a) That Child Protection undertake an impact evaluation of SAFER broadly, and to include the terms as set out in recommendation 13 of the Yoorrook Report, noting my earlier recommendation at 3(a)

(b) Professional development reinforcing the importance of entering data into the CRIS system, and systems for oversight to ensure mandatory tasks are completed in a timely fashion and the system can be easily audited for compliance be expedited.

Case closure decisions

4.55 In respect of Child 1, Counsel Assisting submitted, and Child Protection has acknowledged, that case closure might have been delayed until all substantive risk issues were thoroughly addressed.[861] Counsel Assisting submitted that Child Protection failed to implement any of these strategies or assessments in relation to Mr AI, despite having clear confirmed information, prior to closing the case, that Mr AI was a known perpetrator of family violence, and was heavily involved in the family home and parenting the children. Additionally, Ms AA had failed at that point to have demonstrated change over a period of time despite repeated reports and the engagement of intensive supports.

4.56 The first period of investigation with respect to Child 2 was closed on 14 April 2016 and the reasons cited for closure include Ms BA's engagement with appropriate services

[861] Statement of Tracy Beaton, dated 28 January 2022, paragraph 51(d).

including the MCHN and C2K, and given that no new protective concerns had arisen.[862] Counsel Assisting submitted that I should concur with Ms Buchanan's assessment that the closure decision appeared premature, given Ms BA's vulnerabilities, the only recent engagement with C2K, as well as the additional risks to Child 2 that had been identified during the first period of investigation.

4.57 With respect to Child 4's family, there were three unsuccessful referrals to Child First (now The Orange Door) – with the family declining the service the first time, and non-engagement on the subsequent two.[863] In her oral evidence, the intake worker who managed the final report for Child 4 confirmed a report would not be kept open to see if a family engages.[864]

4.58 The current practice advice, as well as the protocol between Child Protection, the hubs and Integrated Family services, requires a case to remain open until the referral is accepted where there is significant concern for the wellbeing of a child.[865] Ms Lomas gave evidence that The Orange Door can now look at all of the family's circumstances to determine which service might be appropriate (limited by what is available in each region).[866] Child Protection workers are not required to ensure there is engagement from the family before closing the case. This creates a situation where Child Protection might only know if a family engaged (or not) or whether there has been any change, when there is a re-report.[867]

4.59 DFFH provided to the Court the operation guidance document between Child Protection, Integrated Family Service and The Orange Door. It recommends hub practitioners consult with community-based Child Protection practitioners following unsuccessful attempts to engage a family, or where a risk mitigation plan is not established.[868] Such consultation is not mandated by the policy, but I consider that this is an unsatisfactory situation, and the consultation should be mandatory. It is only if this consultation occurs that Child

[862] CRIS records, Inquest Brief Part 1, v2.2 at [2844-2845].
[863] Child First records, Inquest Brief Part 2, v2.4 at [8798].
[864] Oral evidence of Ms DJ, Inquest transcript of evidence for 15 December 2022, page 833.
[865] Concluding Intake – advice, Document ID number 2022, version 4, 20 November 2021 [SW-91].
[866] Oral evidence of Ms Lomas, Inquest transcript of evidence for 20 April 2023, page 255.
[867] Oral evidence of Ms Buchanan, Inquest transcript of evidence for 5 October 2023, page 29.
[868] Department of Families Fairness and Housing, supplementary material filed 14 June 2023, Question 10.

Protection are in a position to have the most up to date information and review the risk armed with this information.

4.60 Ms Buchanan identified[869] that in her assessment, this can be a persistent problem particularly in matters where there are repeated reports and complex risk issues like family violence and parental substance use are not addressed and become entrenched in children's lives.

4.61 Ms Buchanan made three recommendations regarding the interaction between Child Protection and voluntary services in how this issue might be addressed as part of the review of the operating model being undertaken by Child Protection. She proposed the review should aim to create greater integration between the voluntary and protective services, that referrals should be tracked and monitored by Child Protection, and there should be complimentary obligations on those services receiving referrals to report back to Child Protection on whether the family have engaged with the service and whether their needs have been met.[870] She noted that following a recent recommendation to DFFH, regarding keeping a case open until a family engages with a service, was described as an 'unmanageable' expectation, which creates a question as to whether such integration is practicable given resource constraints and competing pressures. This is something that might be the subject of the DFFH review of its Child Protection operating model, as has been foreshadowed.[871]

4.62 Persistent non-engagement with voluntary services does need to form part of the assessment for Child Protection in the determination about whether such a referral need be made and whether that would be a trigger to statutory intervention where risk issues remain persistent. It forms part of an assessment of whether a risk to a child is '*tolerable*' thus appropriate for a referral to a voluntary service, as opined by Ms Buchanan, particularly given an assessment has been made that there has been or is likely to be harm

[869] As outlined in the 2019 inquiry, Commission for Children and Young People, *Lost, not forgotten: Inquiry into children who died by suicide and were known to Child Protection'*, October 2019.
[870] Liana Buchanan, Commission for Children and Young People Expert Report dated 18 September 2023, paragraph 106.
[871] Oral evidence of Ms Buchanan, Inquest transcript of evidence for 5 October 2023, page 28-293-24.

to a child in order to acquit their responsibility to assess risk for that child[872] – '*I think that is, frankly, the least that Child Protection should be doing*'.[873]

4.63 Given voluntary community services are funded to provide a service there should be a corresponding obligation to provide information about engagement and whether the risks identified have been or are being mitigated.[874] The SAFER framework and CRIS hold the potential for better information sharing but may be a big undertaking from an IT perspective.[875] DFFH have also identified that SAFER is a framework developed exclusively for Child Protection.[876]

4.64 In their supplementary material, DFFH identified a current review underway of the operating model across the sector.[877] One aspect of that review includes understanding referrals to the voluntary system and their outcomes, at both a client and system-level, including improved data linkages.[878] Counsel Assisting suggested, and I agree, that this particular focus will ideally address the issue that arose in, in particular, Child 4's circumstances, to avoid re-referrals where service-avoidant families are not engaging.

4.65 In response to Counsel Assisting, DFFH confirmed that the Child Protection Manual is the primary point of reference for Child Protection practitioners and managers regarding statutory Child Protection policy, procedures and supporting advice. The Manual is not designed to provide policy guidance to services or to families.

4.66 In addition they advise that the current policy provides advice that '*[w]here the report has been classified as significant concern for the wellbeing of a child and a referral has been made to Child FIRST, a family service or a service agency, the intake must remain open until the referral is accepted or other action is taken.*'[879] Additionally, if a referral is declined due to insufficient information, Child Protection is required to ascertain if additional information is available and to determine if this should be provided. If there is

[872] Oral evidence of Ms Buchanan, Inquest transcript of evidence for 5 October 2023, page 30-31.
[873] Oral evidence of Ms Buchanan, Inquest transcript of evidence for 5 October 2023, page 31.21-22.
[874] Oral evidence of Ms Buchanan, Inquest transcript of evidence for 5 October 2023, page 32.
[875] Oral evidence of Ms Buchanan, Inquest transcript of evidence for 5 October 2023, page 33.
[876] Department of Families Fairness and Housing, supplementary material filed 24 November 2023.
[877] Department of Families Fairness and Housing, supplementary material filed 24 November 2023, paragraphs 14 to 21.
[878] Department of Families Fairness and Housing, supplementary material filed 24 November 2023, paragraphs 19.
[879] Concluding Intake – advice, Document ID number 2022, version 4, 20 November 2021 [SW-91], CB-2, 9367.

no available additional information, Child Protection is required to review the original intake to determine if further information should be sought from relevant service agencies or information holders. The key concern here is not whether a referral has been accepted, rather whether meaningful engagement results from that referral.

4.67 The Orange Door guidelines are currently under review and require extensive consultation with key stakeholders. It is anticipated that the guidelines will be completed in the first half of 2024.[880] It is not clear whether or not this has indeed occurred but if not, it would be my view that this should be expedited.

4.68 Counsel Assisting suggested that I make a recommendation that Child Protection update current policy regarding consequences of non-engagement with voluntary services including consideration of re-report if particular risks are identified.

4.69 I see the merit in Counsel Assisting's suggested recommendation and in some cases, re-reporting may be the only option, but all opportunities should be taken to properly understand the resistance to engagement and to ascertain if these barriers can be overcome.

Recommendation 5

Child Protection update current policy regarding consequences of non-engagement with voluntary services including consideration of re-report or not closing until engagement has been confirmed with Child Protection. In the event of non-engagement, focus on risk assessment and mitigation should be prioritised.

Unborn reports, pre- and post-birth planning for vulnerable infants

4.70 Two unborn reports were received for Child 2 regarding Ms BA's ice use, transience, lack of antenatal care, and the previous removal of a child.[881] A determination was made that a pre-birth meeting would not be convened given that intervention was likely to occur

[880] Submissions on behalf of DFFH in response to submissions of Counsel Assisting, dated 28 February 2024
[881] Child Protection CRIS records, Inquest Brief Part 1, v2.2 at [2979], [2965].

following birth, which Ms Buchanan identified as a missed opportunity in this case, given the potential that Child 2's mother might have engaged with services at this stage.[882] Ms Buchanan noted that she identified similar circumstances in five child death inquiries in the last five years.[883] I agree with Ms Buchanan's observations.

4.71 Ms Buchanan cited improvements to practice guidance in relation to unborn reports, in particular that protective workers should proactively enquire whether a child is Aboriginal and/or Torres Strait Islander, convene a case conference for all complex or high-risk cases, and undertake information gathering and assessments where a family violence risk is identified.[884] Although she identified that she has seen instances of positive practice in recent years, she was of the view that the advice should clarify the range of risk factors that should then mandate that a case conference be held.[885] She was also of the view that more should be done to engage with mothers at this stage and for flexible supports to be offered.[886]

4.72 The difficulty inherent during the unborn phase is the lack of jurisdiction to require any engagement by an expecting parent. However, as was noted by Ms Beaton for Child Protection, even where a parent will not engage, case conferences between professionals have the potential to coordinate a response once the child is born. The practice advice appropriately recognises that pre-birth may well be a point at which a parent is more motivated to address potential risks to the impending birth. As seen in this case, it may also be a time when there is an opportunity to address not only the risks but also the needs for expectant parents, like access to Centrelink and identification documents.

4.73 Child Protection, in submissions to the Court, articulated the limits of their jurisdiction and describe the current operating arrangements:

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[882] Liana Buchanan, *Commission for Children and Young People Expert Report dated 18 September 2023*, para 39 a
[883] Liana Buchanan, *Commission for Children and Young People Expert Report dated 18 September 2023*, paragraph 118.
[884] Liana Buchanan, *Commission for Children and Young People Expert Report dated 18 September 2023*, paragraph 119.
[885] Liana Buchanan, *Commission for Children and Young People Expert Report dated 18 September 2023*, paragraph 120; she also cites that case conferencing is particularly important for Aboriginal and Torres Strait Islander parents as identified by the Yoorrook Commission; In oral evidence of Ms Buchanan listed lack of stable housing, significant substance abuse issues, and family violence risks, Inquest transcript of evidence for 5 October 2023, page 40.
[886] Oral evidence of Ms Buchanan, Inquest transcript of evidence for 5 October 2023, page 39

DFFH's powers with respect to unborn children are set out in s 30(2) of the Children, Youth and Families Act 2005 (Vic). Practically, this limits what action Child Protection may take with respect to unborn children. Section 30(2) provides:

30 Response by Secretary to report

If the Secretary receives a report [about an unborn child] under section 29, the Secretary may—

(a) provide advice to the person who made the report;

(b) provide advice and assistance to the mother of the unborn child;

(c) refer the matter to a community-based child and family service or a service agency to provide advice, services and support to the mother of the unborn child.

The powers include, by virtue of s 30(2)(b), providing advice and assistance to the "mother of the unborn child". Notably, there is no reference to the provision of assistance to the father of the unborn child, or to the partner of the mother of the unborn child.[887]

Assistance to the mother of the unborn child, and any related family members, can only be provided with the mother's consent (that is, not by way of protective intervention). The current 'Unborn child reports' advice provides:[888]

An unborn child report cannot be determined to be a protective intervention report and does not entail a substantiation, SAFER risk assessment, investigation or protection application. If determined necessary, these may be completed after an intake report is made at the time of the child's birth.

The mother's verbal consent is required ... [w]here Child Protection wishes to involve the father of the unborn child or partner and extended family in a case conference or any assistance and service which may be provided to the mother.

[887] Compare with s 30(1)(b), which refers to the provision of advice and assistance to "the child or the family of the child".
[888] See: <https://www.cpmanual.vic.gov.au/advice-and-protocols/advice/intake/unborn-child-reports- advice>.

If a mother is not willing to work with Child Protection, she cannot be compelled to accept advice and assistance or services which she may be referred to.

4.74 According to DFFH, under the current advice, case conferences can take place without the consent or participation of the mother, with relevant professionals only, to determine the process for re-reporting closer to birth.[889] The advice provides:[890]

> *Where the mother is not consenting, Child Protection may decide to convene a case conference with the relevant professionals to determine the process for re-reporting closer to or at the time of the child's birth. In this instance, the unborn child report must be closed following the case conference as there is no role for Child Protection.*

4.75 Further, DFFH submitted that under the current advice, a case conference about an unborn child should occur in '*all complex and high risk cases*'.[891] The advice also acknowledges that '*[f]athers and extended family members play an important role in the lives of children*', and provides that '*[t]he father and extended family should participate in case conferences where appropriate, provided the mother consents to their involvement.*'[892]

4.76 In these circumstances, DFFH submitted that the existing advice already provides detailed and clear guidance on the steps open to Child Protection in the unborn phase, including as to how and when a case conference should be convened.

4.77 Counsel Assisting suggested a recommendation:

(a) That the '*Unborn Child Reports – advice*' clarify the circumstances that will mandate that a case conference be convened and include advice that Child Protection seek to identify and address any material or practical needs of the parents prior to birth.

[889] See: <https://www.cpmanual.vic.gov.au/advice-and-protocols/advice/intake/unborn-child-reports- advice>.
[890] Ibid.
[891] Ibid.
[892] Ibid.

4.78 I agree with Counsel Assisting's suggested recommendation and if implemented, it would ensure that there is clarity and clear guidance as to when a case conference is required.

Recommendation 6

That the '*Unborn Child Reports – advice*' clarify the circumstances that will mandate that a case conference be convened and include advice that Child Protection seek to identify and address any material or practical needs of the parents prior to birth.

High Risk Infants

4.79 Child 2 had been identified as a '*high risk infant*' in the unborn phase, but was not placed on the schedule, and thus higher-level consultations had not been required in his case. In the case of Child 4, there were two reports closed at intake, and Child 4 and her siblings were not considered for classification as a 'high risk infant'.[893]

4.80 Since these deaths, Child Protection has introduced new guidance in relation to high-risk infants, under the Infant Risk Assessment and Response Decision policy applicable until 24 months. A determination is made at substantiation about whether an '*Infant response*' or an '*Infant intense response*' is required, where an intense response mandates the matter be allocated, weekly visits be conducted, and a case conference or care team approach be employed, and there be oversight at a practice leader or principal practitioner level. Ms Lomas gave evidence that the '*My Views*' tool assists practitioners in assessing the appropriate response, in terms of risks identified.[894] She also indicated that it is her view that this policy shift has elevated practitioners to understand the vulnerability of infants where all require an '*infant response*' and there is specific training to reinforce this.[895]

4.81 While Ms Buchanan's assessment is that the policy is appropriate, she identified there have been issues with compliance with that policy identified by her office and by Child Protection's own audits. Ms Buchanan identified that ongoing and focussed professional

[893] On CRIS; Oral evidence of Ms DI, Inquest transcript of evidence for 15 December 2022, page 796.
[894] Oral evidence of Ms Lomas, Inquest transcript of evidence for 20 April 2023, page 213-216.
[895] Oral evidence of Ms Lomas, Inquest transcript of evidence for 20 April 2023, page 252-253.

development is required to ensure protective workers are compliant, and this needs oversight through both supervision and regular auditing.[896] She identified it as a '*prime*' area for audits in relation to compliance.[897]

4.82 Child Protection have recently published guidance in relation to assessing infants at the intake phase, in September 2022. Ms Buchanan noted that this guidance is unfortunately not easy to locate or linked to any intake assessment pages. She again recommended focussed and ongoing professional development in relation to assessing risk to infants at all phases including intake. It was also submitted that there needs to be easy access to all relevant guidance, and the streamlining and integration of policies in terms of access or integration into data input systems to facilitate compliance.

4.83 In their supplementary material, DFFH advised that from March 2024 there will be a new central point in CRIS for managing infant response compliance information, including all mandated oversight.[898] This appears to be an appropriate improvement for this highly vulnerable cohort.

4.84 Counsel Assisting suggested the following recommendations:

(a) That Child Protection ensure that staff undertake focussed and ongoing professional development in relation to assessment of risk to infants at each stage of intervention including intake assessments.

(b) That Child Protection ensure policy guidance is easily accessed by their staff, and where practicable, integrated into data input software, including for intake staff to support compliance with the extant policy.

4.85 In relation to recommendation (a), above, the Office of Professional Practice has been refreshing practice learning programs. Following the implementation of the new Practice Induction program in May 2024, further training programs will be developed for

[896] Liana Buchanan, Commission for Children and Young People Expert Report dated 18 September 2023, paragraph 135.
[897] Oral evidence of Ms Buchanan, Inquest transcript of evidence for 5 October 2023, page 43-44.
[898] Department of Families Fairness and Housing, supplementary material filed 24 November 2023, paragraph 34.

foundation, advanced and expert level Child Protection practitioners in key areas of practice, which will include work with infants, at each stage of intervention.

4.86 In relation to recommendation (b), the Digital Opportunities Project is a set of ten Initiatives specified by the Department's Service Enhancement Branch of the Community Operations and Practice Leadership Division to address concerns raised in the Victorian Auditor General's Office (**VAGO**) report into '*Quality of Child Protection Data (2022)*'. The Digital Opportunities Project is running across two financial years and will be completed in early 2025. The initiatives are aimed at enhancing systems including data entry check capability, client summary overviews, and voice to text to meet business needs for a more efficient and user-friendly Integrated Client Case Management system with improved data quality. The initiatives will create greater alignment with what is required for completion under the policies set out in the Manual. The two initiatives described below form part of the program of works.

(a) Client Case Overview relates to how DFFH can improve CRIS to support the consolidation of the key client case information for Child Protection into a single view within the client's current case. It will also support practitioners in the identification of any data compliance issues within the case related to policy and practice requirements.

(b) Client Practice Compliance Dashboard project will deliver a real time digital solution that identifies data integrity issues, where Child Protection practitioners have not entered or updated information about the client or the case and these fields, based on policy requirements should be completed prior to closure of the case to ensure compliance with policy, practice, and data quality guidelines.

Assessment of parental mental health

4.87 The evidence of NWMH in relation to the episodes of treatment provided to Ms DA was appropriate in light of her presentation and the legislation under which they operate. In her evidence, Ms Buchanan questioned whether the risk to Child 4 was assessed comprehensively as at September 2016 (noted as '*nil risk*') in light of all the information

known to NWMH, particularly given the 2013 episode and the number of episodes of inpatient treatment.[899]

4.88 As to the final report in relation to Child 4, Counsel Assisting submitted that further information should have been sought including assessments in relation to the impact of her mother's mental health on parenting capacity. In their supplementary material, DFFH advised that Intake practitioners have recently received specific training on this issue as part of the targeted and unique practice support for these practitioners.[900]

4.89 Counsel Assisting have identified that discharge planning for Ms DA, in light of the risk of relapse, might have deserved closer scrutiny. It is noted that a discharge plan was provided to her GP only on the final occasion, when NWMH were to work with the clinic to ensure she was attending for her injectable medication.

4.90 Ms Buchanan also identified that she has made recommendations arising out of Child 4's case that guidance should be provided to hospitals regarding comprehensive discharge planning such that the safety and risk guidelines consider the impact of mental health on parenting capacity.[901] There have been some recent updates as noted by Ms Buchanan but she identified some shortfalls in relation to safety planning where dependent children are at risk, as in this case.[902]

4.91 Ms Buchanan identified that the Guidance provided by the Office of the Chief Psychiatrist's '*Transfer of care and shared care*' would be improved if further information were included regarding the circumstances where a child may be at risk in terms of managing that risk. I support this recommendation.

Responding to children absconding from care

4.92 In the final years leading up to Child 3's passing, there were many occasions when Child 3 would leave placement without prior notification to her carers. This occurred irrespective

[899] Oral evidence of Ms Buchanan, Inquest transcript of evidence for 5 October 2023, page 66.
[900] Department of Families Fairness and Housing, supplementary material filed 24 November 2023, paragraph 37(b).
[901] Liana Buchanan, Commission for Children and Young People Expert Report dated 18 September 2023, paragraph 144 and following.
[902] Liana Buchanan, Commission for Children and Young People Expert Report dated 18 September 2023, paragraph 150.

of the care arrangement that Child 3 was in, and her reason for absconding particularly in the 12 months prior to her passing was to maintain contact with her mother.

4.93 It has been noted in previous inquiries conducted by the CCYP that returning to family is a common reason for children and young people being absent from their placement.[903] Related to this, is the necessity of ensuring that contact between young people and their families occurs as safely as possible.

4.94 I readily accept that implementing a safe framework for young people, particularly teenagers, on how they have contact with their family, is limited by the reality that they may (and do) continue to have contact in spite of any restrictions. Indeed, the safety plan for Child 3 was created following Child 3's repeated absconding from placement in order to spend time with her mother.

4.95 However, it is submitted by Counsel Assisting, and I agree, that responding to children absconding from care should prompt a proactive approach and should not be a reactive response. The response should include regularly updated risk assessments, regularly reviewed case plans, transparent sharing of information between relevant agencies and Child Protection, and utilisation of the high-risk youth panel as appropriate. This could also include consideration of brokerage or funding to support older children in out-of-home care to spend time with their families in safe and appropriate environments.

4.96 It was noted by Ms Buchanan that decisions regarding reporting of a child missing was often not based on consistent grounds.[904] In Child 3's case, the carer determined when a report was made, which in Ms Buchanan's view placed an unfair level of responsibility on a carer.[905] She also noted concerns in carers not being provided adequate information[906] in order to best support the placement.

[903] Liana Buchanan, Commission for Children and Young People Expert Report dated 18 September 2023 [160]
[904] Oral evidence of Ms Buchanan, Inquest transcript of evidence for 5 October 2023, page 48
[905] Oral evidence of Ms Buchanan, Inquest transcript of evidence for 5 October 2023, page 49
[906] Oral evidence of Ms Buchanan, Inquest transcript of evidence for 5 October 2023, page 54

4.97 It was Ms Buchanan's view that more needs to be done about risk assessments for young people missing from placement.[907] I agree with Ms Buchanan's assessment. One particular mechanism that could have assisted in this way was utilising the High Risk Youth Panel.

4.98 Whilst there had been a referral made for Child 3 to be presented to the High Risk Youth Panel, it was conceded by Ms Lomas in her evidence that it was not clear the referral was followed through. Had this occurred, possible outcomes included a collaborative interagency approach, the oversight of a director[908] and looking at the causes of the absconding[909]. Furthermore, the Panel would determine what follow-up was required in each case[910] which could include that information seeking should be conducted whether contact with a parent (and others/partners) was authorised or unauthorised[911]

4.99 Despite the existence of the High Risk Youth Panel, there have been concerns raised about its effective utilisation. In particular, the CCYP recommended that Child Protection evaluate the current use of the High Risk Youth Schedule and Panel in order to assess whether:

a) High-risk cases are being identified in a timely way.

b) the current approach is enabling a sufficiently differentiated response to a young person's specific, complex circumstances.

c) there is adequate senior governance oversight and input[912]

It is understood that this is a work in progress for Child Protection.

4.100 Counsel Assisting suggested the following recommendation:

a) Where children in care are noted as regularly absconding from placement, Child Protection regularly update risk assessments and case plans, ensure frequent and

[907] Oral evidence of Ms Buchanan, Inquest transcript of evidence for 5 October 2023, page 49.
[908] Oral evidence of Ms Lomas, Inquest transcript of evidence for 20 April 2023, page 223-224.
[909] Oral evidence of Ms Lomas, Inquest transcript of evidence for 20 April 2023, page 225.
[910] Oral evidence of Ms Lomas, Inquest transcript of evidence for 20 April 2023, page 228-229.
[911] Oral evidence of Ms Lomas, Inquest transcript of evidence for 20 April 2023, page 244-245.
[912] *Liana Buchanan, Commission for Children and Young People Expert Report dated 18 September 2023 [154].*

transparent sharing of information between relevant agencies and Child Protection, and utilisation of the high-risk youth panel as appropriate.

4.101 In response to Counsel Assisting's proposed recommendation, in their submissions, DFFH made the following observations:

- DFFH accepts the importance of regular updates of risk assessments and case plans, information sharing between agencies, and the utilisation of the high-risk youth panel. Each of these matters is already addressed and provided for in the Child Protection Manual.

- Provided the Manual is properly followed, each of the matters raised would be satisfied.

4.102 In relation to Counsel Assisting's proposed recommendation, the '*Missing children and young people*' policy advice and procedure documents in the Child Protection Manual provide guidance to Child Protection practitioners to formulate a risk assessment of the child's missing episode and undertake a review of the risk assessment.[913] This includes updating the case plan, behaviour support plan, care and placement plan and safety planning. Additionally, guidance is provided to ensure goals and tasks of the case plan focus on responding to a child's missing behaviours and include strategies to prevent them from going missing.

4.103 For each missing episode, Child Protection is required to regularly review the '*repeat missing template*' which includes a review of the risk assessment. Further, a weekly missing update is completed for the Area review process.

4.104 DFFH is also currently undertaking substantial work to implement the 18 recommendations from the Commission for Children and Young People's '*Out of Sight*' Inquiry report, tabled in the Victorian Parliament on 24 June 2021, which examined children and young people who are absent or missing from residential care. The Out of

[913] See SW-140, "Missing children and young people" advice, document ID number 2359, Version 3, effective 14 August 2019, CB-2, 5674; SW-142, "Missing children and young people" procedure, document ID number 1515, effective 17 July 2020, CB-2, 5682. The current version of the procedure is accessible here: <https://www.cpmanual.vic.gov.au/policies-and-procedures/critical-incidents/missing-children-and-young-people>.

Sight Inquiry recommendations seek to support children and young people to remain in care, to safeguard them when they are absent or missing and to support them when they return. DFFH's progress in addressing the 18 Out of Sight Inquiry recommendations is publicly available via the Commission's website.[914]

4.105 In the context of missing children, the Care Team is the primary and most effective means of information sharing.[915] As part of the Care Team, information is requested and shared with the relevant professionals in order to formulate a risk assessment of the child's missing episode. Also, as part of the Care Team, information is gathered and shared which may help decrease the likelihood of future missing episodes.

4.106 Further, for shared clients with Youth Justice, the young person's Youth Justice worker is involved, via the Care Team or directly, in completing the risk assessment. It is important to engage Youth Justice in this process, to enable Youth Justice to exercise its own responsibilities in relation to the young person and noting Youth Justice may hold additional information about the young person's circumstances and contacts.

Workforce issues

4.100 In 2015, the VAGO published the Early Intervention Services for Vulnerable Children and Families report, in review of the child and family service system. The findings of that report found that Child Protection services were under resourced and ill-equipped to meet the demand placed on their service. In addition, the Protecting Victoria's Vulnerable Children Inquiry highlighted the skill deficit of Child Protection practitioners and highlighted these factors as among the leading causes responsible for the malformation of Child Protection services.

[914] See < https://ccyp.vic.gov.au/assets/Publications-inquiries/Inquiry-Progress-Tables-202223/CCYP- Progress-table-OOS.pdf>

[915] See SW-108, "Care Teams" procedure, document ID number 1103, CB 2, 5512; SW-112, "Care Teams" advice, document ID number 2110, CB 2, 5531; and see updated versions of those documents here: <https://www.cpmanual.vic.gov.au/advice-and-protocols/advice/out-home-care/care-teams>; <https://www.cpmanual.vic.gov.au/policies-and-procedures/out-home-care/care-teams>.

4.101 The Safe and Wanted inquiry in 2017[916] found that Child Protection's ability to undertake critical case work was undermined by factors including:

a) increased demand for child protection and out-of-home care services;

b) resourcing that had not kept pace with demand;

c) significant numbers of cases (children) without an allocated worker;

d) staff shortages and high caseloads ranging from 15 to 20 cases; and,

e) a workforce that continued to struggle to meet that demand and inadequate levels of expenditure to support the system.

4.102 In 2018 the Victorian Government planned to expand the Child Protection workforce by funding an extra 452.6 Child Protection workers to respond to increasing workload demands. However, at this time Child Protection were already struggling to fill current vacancies arising from their relatively high attrition rates.

4.103 In 2019, the '*In our own words*' inquiry found that although notifications, investigations and substantiations had tripled between 2008–2009 and 2017–2018, there had only been a 73 percent increase in funding for Child Protection. Further, whilst there had been substantially increased investment in child protection services since 2015– 2016, there had been no corresponding increase in recruitment, meaning that funded recruitment targets had not been met.[917]

4.104 There continues to be a shortage of qualified candidates available to cover the range of child protection services needed. Child Protection have acknowledged their difficulty in recruiting and retaining adequate staffing.

[916] CCYP, '…safe and wanted.': Inquiry into the implementation of the Children, Youth and Families Amendment (Permanent Care and Other Matters) Act 2014, June 2017.

[917] CCYP, In our own words: Systemic inquiry into the lived experiences of children and young people in the Victorian out-of-home care system, November 2019.

4.105 An inquiry currently in progress by the CCYP suggests that '*systemic issues impacting Child Protection workers' capacity to fulfil role requirements have not improved.*'[918] In particular, between the '*In our words*' inquiry and 2022, data received by the CCYP indicates:

a) the rate of staff attrition in Child Protection increased from 14.4 percent in 2018 to 21.4 percent in 2022.[919]

b) the number of staff employed in Child Protection has increased from 2107.1 full time equivalent (**FTE**) in 2018-19 to 2255 FTE in 2021-22 as a result of government investment; however, many of the funded positions are unfilled and there were 231.1 FTE vacancies in 2021-22.

c) the median case load for Child Protection staff has remained at a similar level (14 in 2022) but the number of Child Protection staff with more than 25 cases increased; and,

d) the proportion of children without an allocated worker has increased from 13.5 percent in 2019 to 18.5 per cent in 2022.[920]

4.106 In addition, it is noted that the vacancy rate is particularly high at the frontline practitioner level, being at 28% in 2022.[921] Furthermore, Child Protection Practitioners only received 56% of their supervision as mandated in 2021[922] which undermines the ability for the early-stage workforce to benefit from the practice experience of their superiors.

4.107 Counsel Assisting suggested that it is very likely that underlying some of the missed opportunities in Child Protection's responses to the families the subject of this inquest is linked to the above deficits in resourcing. Given Child Protection policies and procedures rely heavily on the professional judgement of the practitioner and their supervisors to assess risk and determine intervention steps, the continued shortage of qualified Child

[918] *Liana Buchanan, Commission for Children and Young People Expert Report dated 18 September 2023 para-169.*
[919] Ibid.
[920] Ibid.
[921] https://www.audit.vic.gov.au/report/follow-maintaining-mental-health-child-protection-practitioners.
[922] https://www.audit.vic.gov.au/report/follow-maintaining-mental-health-child-protection-practitioners.

Protection practitioners to meet demand surely factors into the capacity of practitioners to continually seek all relevant information and update risk assessments accordingly.

4.108 In answer to the issue of an ideal caseload for child protection practitioners, Ms Lomas stated that '*It is not possible to recommend or identify an ideal workload for each Child Protection practitioner.*'[923] When Ms Buchanan was asked to comment on the same issue, her evidence was that the Commissioner had never undertaken a '*blank slate review*' of what would be an appropriate case load, however she did note the finding from the '*Protecting Victoria's Vulnerable Children Inquiry*' that a caseload of 16 was excessive.[924]

4.109 Several reforms have been proposed since 2017 in an effort to improve the capabilities of the Child Protection system. The Child Protection workforce strategy for 2017-2020 (**the Strategy**) outlines priorities regarding Child Protection staff including the recruitment of the best people, and the development and retention of staff. The Strategy includes an updated Child Protection capability framework (**the Capability Framework**), which details the capabilities required of Child Protection staff according to their classification. The Capability Framework appears to lack any formalised accountability measures for ensuring that staff are meeting the expected capabilities of their role classification.

4.110 The Child Protection Workforce Strategy for 2021-2024 was released in August 2021 and like its previous iteration communicates a commitment to the recruitment of the best people and the development and retention of staff.

4.111 Throughout the course of the inquest, it became apparent that in addition to the high caseloads of Child Protection practitioners, they are also required to be familiar with and apply a voluminous amount of policy advice and practice guidance. Whilst the SAFER framework is intended to guide and inform professional judgement, it does not seem to consolidate the copious amounts of resource material that practitioners are expected to be aware of. Ms Buchanan made recommendations for revision and streamlining of guidance to practitioners, and additional investment and activity devoted to structured, ongoing

[923] Kirstie Lee Lomas Statement 28 June 2022 at [90].
[924] Oral evidence of Ms Buchanan, Inquest transcript of evidence for 5 October 2023, page 26.

professional development and refresher opportunities.[925] I agree with and endorse these recommendations. In order to ensure policy guidance is easily accessed by staff, where practicable it could be integrated into data input software, including for intake staff to support compliance with the extant policy.

4.112 As referred to previously in this finding, DFFH indicated in their supplementary material that as of June 2023, they are undertaking a review of the structure of the Manual utilising a '*human centred design approach*.'[926] The Manual is to be redesigned over four phases in order to improve the resource and its ease of use by protective workers who are often invariably balancing caseload pressures. I commend DFFH for this work as I think once complete, it will be beneficial to practitioners.

4.113 DFFH also pointed to the $2.4 million budgetary allocation that allowed for Child Protection to provide wellbeing services and to strengthen continuous professional development for all practitioners, which was then designated for the development of six senior learning consultant positions and the delivery of outputs to support career pathways that appear likely to promote the retention of practitioners. Counsel Assisting submitted that such strategies can only be effective so long as efforts are also directed to recruiting entry-level staff in order to reduce caseload pressure. Career pathways for the most senior staff are unlikely to reduce turnover if those pressures remain. The 2021-2024 Workforce Strategy refers to consultation being undertaken with the workforce at two points throughout its implementation. Such consultation is essential such that those staff can then inform efforts at recruitment and retention.

4.114 It is apparent from the evidence in this inquest that recruitment and retention of staff in the sector is a significant issue that will continue to plague the sector unless addressed. The Child Protection Workforce Strategy 2021-24 whilst addressing some of the recruitment issues has not resolved the issue and more needs to be done. An adequate workforce, properly trained, supervised, and managed is vital to overcoming the ongoing

[925] *Liana Buchanan, Commission for Children and Young People Expert Report dated 18 September 2023* para-173.
[926] Department of Families Fairness and Housing, supplementary material filed 24 November 2023, paragraphs 1 to 7.

issues in the sector and the recommendations below may go some way to addressing these issues.

4.115 DFFH are currently undertaking a review of the Child Protection operating model '*with the aim of developing a contemporary child protection program which supports recruitment, retention and service delivery to children and their families*'. Further details are provided by DFFH in their supplementary material.[927] Ms Buchanan suggested that "*it will be vital that this review also identifies barriers to the recruitment and retention of Child Protection practitioners and sets clear limits in relation to caseloads and unallocated lists*".

Recommendation 7

a) The Victorian Government develop a further workforce (beyond 2024) plan to address the workforce challenges currently facing the whole of the community and social service sectors in Victoria, including appropriate caseloads, for and attrition rates of Child Protection practitioners.

b) In consultation with the sector, the Victorian Government review the relevant Enterprise Agreement governing Child Protection Practitioners with the view of assessing the adequacy of current wage and leave entitlements, ensuring they are competitive within the industry and that conditions and wage progression is attractive to staff.

c) The Victorian Government explore new or consider expanding current opportunities to increase the pipeline of workers entering the social service industry, consideration should be given to traineeship models, expanding the Shift to Social Work or like programs, paid study and free tuition.

d) The Victorian Government expand the Shift to Social Work program to increase intake and encourage the recruitment of social workers in Victoria. This program should also be extended to include the Bachelor of Social Work.

[927] Department of Families Fairness and Housing, supplementary material filed 24 November 2023, paragraphs 14 to 21.

e) The Department of Families, Fairness and Housing publicly report on the progress of the *Child Protection Workforce Strategy 2021–2024* and upon its completion, undertake an evaluation of the effectiveness of this strategy, and make the findings of this evaluation public.

Audits and other mechanisms for oversight

4.116 Recommendations for systemic change that arise from inquiries into the circumstances of deaths of children in care must be appropriately implemented to maximise prevention opportunities and minimise adverse outcomes. As such, implementation of recommendations must be followed by a process to understand and assess whether any real changes have been affected.

4.117 Audits have been identified as one of the mechanisms to assess how effectively recommendations have been followed up by service providers, both in terms of their implementation and outcome. Indeed, audits in themselves have been the subject of coronial recommendations.

4.118 One such example in recent times included a recommendation in the Baby S coronial inquest that asked the DFFH to conduct a '*review and audit of the updated Child Protection policies and procedures listed, to determine whether these changes have effectively improved Child Protection's response to and management of high-risk infants. In addition, [it was] recommended that the Secretary to the Department conduct a compliance audit to ensure that staff are complying with the policies and procedures listed*.'

4.119 The audit involved reviewing 20 cases relating to high-risk infants and the specifics relating to the relevant policies in that regard have been discussed above.

4.120 Whilst the sample size was quite limited, and the focus of the audit related to a specific cohort of children within Child Protection, there were some general comments made that continue to mirror the systemic concerns evident in this cluster inquest. These included observations from participants that '*it was difficult to fully comply with all of the*

requirements all of the time given high workloads, staff vacancies, staff turnover and insufficient experienced practitioners.' Furthermore, and perhaps of greater concern, was the observation that '*classification decisions are subjective and decisions (about whether infants are classified IR or IIR) vary depending on the decision maker, even across teams in the same area.*'

4.121 Counsel Assisting submitted that these observations reflect the continuing prevalence of workforce issues impacting the ability of Child Protection to discharge their roles and the inherently subjective nature of their role. It is suggested that these observations be borne in mind when assessing the efficacy of responses to recommendations, whether this be in the form of audits or another accountability mechanism.

4.122 Counsel Assisting are unaware of any regular and/or systemised use of audits regarding Child Protection policy. Ms Buchanan noted '*in the context of a highly pressured system in which practitioners are expected to manage high caseloads and perform a wide range of critical tasks, regular audits specifically testing adherence to Child Protection policy and procedure would:*

a) provide Child Protection leadership with information about gaps in compliance and areas of practice creating significant risk.

b) enable the department to address any gaps with practical, well-directed measures.

c) make amendments to policy or procedure when audit results indicate that amendment is needed.

d) *enable the department to proactively assess and strengthen practice, rather than relying on adverse events to draw attention to areas of high risk.*'[928]

4.123 Ms Buchanan provided her opinion, to which Counsel Assisting agreed, that 'the use of regular audits would be a valuable component of a strengthened continuous improvement framework for Child Protection. Ideally, a program of audit would target known areas of

[928] *Liana Buchanan, Commission for Children and Young People Expert Report dated 18 September 2023* para-181.

risk, such as family violence risk assessment and responses to infants, as well as having flexibility to assess emerging areas of concern.[929]

4.124 DFFH accepts that the use of audits and reviews is an essential element of the work of Child Protection. In this respect, DFFH refers to and repeats paragraph [38] of the Annexure to its correspondence to the Court dated 24 November 2023, where detail was provided as to DFFH's use of and approach to audits within Child Protection.

4.125 DFFH acknowledge, and I agree, that there is a need to standardise a process and methodology for case reviews, which provide qualitative data to supplement the quantitative data extracted from CRIS.[930] This appears in line with Ms Buchanan's recommendation.

PART FIVE - FINDINGS

4.1 My role as the investigating coroner in all four child deaths is to make formal findings as to the identity, cause of death and the circumstances of each child's death pursuant to section 67(1) of the Act.

Child 1

4.2 In relation to Child 1, I find:

a) the identity of the deceased was Child 1, born 4 February 2013;

b) Child 1 died on 25 August 2015 at Mildura, Victoria from blunt force trauma to the chest and abdomen; and

c) Child 1 died in circumstances as described in Part Two of this finding.

Child 2

4.3 In relation to Child 2, I find:

[929] *Liana Buchanan, Commission for Children and Young People Expert Report dated 18 September 2023* para-180.
[930] Department of Families Fairness and Housing, supplementary material filed 24 November 2023, paragraph 38.

a) the identity of the deceased was Child 2, born 21 December 2015;

b) Child 2 died on 27 June 2016 at Glenroy, Victoria from head injury; and

c) Child 2 died in circumstances as described in Part Two of this finding.

Child 3

4.4 In relation to Child 3, I find:

a) the identity of the deceased was Child 3, born 24 April 2001;

b) Child 3 died on 2 March 2017 at Footscray, Victoria from effects of fire; and

c) Child 3 died in circumstances as described in Part Two of this finding.

Child 4

4.5 In relation to Child 4, I find:

a) the identity of the deceased was Child 4, born 5 May 2016;

b) Child 4 died on 5 June 2017 at Reservoir, Victoria from incised injury to the neck; and

c) Child 4 died in circumstances as described in Part Two of this finding.

PART SIX – RECOMMENDATIONS

Recommendation 1

a) Compliance with Child Protection's obligations to consult with ACSASS, and to produce cultural plans, and be sufficiently monitored that non-compliance trigger oversight and enforcement of such obligations (whether through SAFER or other oversight mechanisms).[931]

[931] As has been addressed in the Yoorrook report at Recommendation 16, 22 and 26.

b) DFFH and VACCA to publish an update about the outcome of the Aboriginal-led State-wide Cultural Planning Forum, and any outcomes relevant to these findings.

c) The Court endorses Recommendation one of the Yoorrook report[932] and that Aboriginal-controlled organisations be funded sufficiently to be able to meet the demand to undertake these roles.

Recommendation 2

That Child Protection, as part of the work they are doing to reform and improve Child Protection Manual, incorporate easy access to a singular policy and simple tool relevant to cumulative harm assessment being undertaken.

Recommendation 3

a) That DFFH engage a suitably qualified consultant or an internal person to conduct a review of the operation and effectiveness of the SAFER Framework with particular reference to its identification and assessment of risk associated with a parent entering a relationship with a new partner or any other person who is regularly in the house.

b) That DFFH publicly report on the implementation and evaluation of the SAFER framework.

c) That DFFH ensure mandatory training for protective workers and supervisors incorporate a positive obligation on staff to be assessing the risk of any new partner that may potentially have any contact with the subject children, whether they are residing in the home or not, and incorporate assertive engagement such that the risk assessment is always prioritised, even when it may impinge upon the parent and partner's privacy.

[932] Retrieved from Yoorrook-for-justice-report.pdf (yoorrookforjustice.org.au).

Recommendation 4

a) That Child Protection undertake an impact evaluation of SAFER broadly, and to include the terms as set out in recommendation 13 of the Yoorrook Report, noting my earlier recommendation at 3(a).

b) Professional development reinforcing the importance of entering data into the CRIS system, and systems for oversight to ensure mandatory tasks are completed in a timely fashion and the system can be easily audited for compliance be expedited.

Recommendation 5

Child Protection update current policy regarding consequences of non-engagement with voluntary services including consideration of re-report or not closing until engagement has been confirmed with Child Protection. In the event of non-engagement, focus on risk assessment and mitigation should be prioritised.

Recommendation 6

That the '*Unborn Child Reports – advice*' clarify the circumstances that will mandate that a case conference be convened and include advice that Child Protection seek to identify and address any material or practical needs of the parents prior to birth.

Recommendation 7

a) The Victorian Government develop a further workforce (beyond 2024) plan to address the workforce challenges currently facing the whole of the community and social service sectors in Victoria, including appropriate caseloads, for and attrition rates of Child Protection practitioners.

b) In consultation with the sector, the Victorian Government review the relevant Enterprise Agreement governing Child Protection Practitioners with the view of assessing the adequacy of current wage and leave entitlements, ensuring they are competitive within the industry and that conditions and wage progression is attractive to staff.

c) The Victorian Government explore new or consider expanding current opportunities to increase the pipeline of workers entering the social service industry, consideration should be given to traineeship models, expanding the Shift to Social Work or like programs, paid study and free tuition.

d) The Victorian Government expand the Shift to Social Work program to increase intake and encourage the recruitment of social workers in Victoria. This program should also be extended to include the Bachelor of Social Work.

e) The Department of Families, Fairness and Housing publicly report on the progress of the *Child Protection Workforce Strategy 2021–2024* and upon its completion, undertake an evaluation of the effectiveness of this strategy, and make the findings of this evaluation public.

PUBLICATION OF FINDING

To enable compliance with section 73(1) of the *Coroners Act 2008* (Vic), I direct that this finding be published on the internet.

DISTRIBUTION OF FINDING

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

Mr AB, Senior next of kin to Child 1

Ms BA, Senior next of kin to Child 2

Mr CB, Senior next of kin to Child 3

Mr DB, Senior next of kin to Child 4

Assistant Commissioner Lauren Callaway, Family Violence Command, Victoria Police

Chief Commissioner of Police (C/- Victorian Government Solicitor's Office)

Darebin City Council, (C/- Maddocks Lawyers)

Mallee Family Care, (C/- HWL Ebsworth Lawyers)

Melanie Heenan, Deputy Secretary, Family Safety Victoria

North West Mental Health (C/- DTCH Lawyers)

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

Peta McCammon, Secretary, Department of Families, Fairness & Housing

Uniting (Victoria and Tasmania) (C/- HWL Ebsworth Lawyers)

Victorian Aboriginal Child Care Agency

Victorian Government

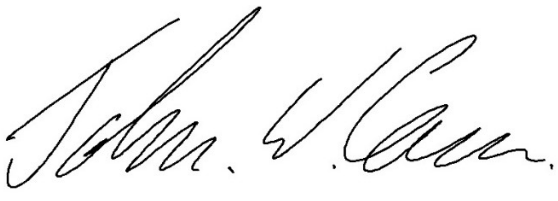
Sergeant Anthony Wilson, Coroner's Investigator (Child 1), Victoria Police

Sergeant Kevin Burke, Coroner's Investigator (Child 2), Victoria Police

Detective Senior Constable Dimitrios Gogorossis, Coroner's Investigator (Child 3), Victoria Police

Detective Senior Sergeant Jennifer Booth, Coroner's Investigator (Child 4), Victoria Police

Signature:



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JUDGE JOHN CAIN
STATE CORONER
Date:14 February 2025

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.