IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2019 003733

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Ingrid Giles
Deceased:	Baby LT[1]
Date of birth:	20 May 2019
Date of death:	17 July 2019
Cause of death:	1(a) Pneumonia
Place of death:	Portland District Health / Hospital, 141-151 Bentinck Street, Portland, Victoria, 3305

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

[1] This Finding has been de-identified by order of Coroner Ingrid Giles which includes an order to replace the name of the deceased, and the names of other persons related to or associated with the deceased, with a pseudonym of a randomly generated letter sequence for the purposes of publication.

INTRODUCTION

Background

1. Baby LT was 2 months old when he passed away on 17 July 2019. Baby LT was the third child to Ms MT. His father was Mr QS. Mr QS never met Baby LT. Baby LT lived with his mother and two older half-sisters, aged 2 and 4 years. Baby LT was described by Ms MT as a bright, happy, and bubbly baby.

2. Baby LT was born on 20 May 2019 by caesarean section at the Warrnambool Hospital. There were no complications or medical issues arising from his birth.

Peripartum Care

3. Ms MT presented to Portland District Hospital (**PDH**) on 19 May 2019 in early stages of labour and was transferred to Warrnambool Base Hospital (**WBH**) of Southwest Healthcare (**SWH**) for ongoing management. Ms MT was not known to the team at SWH. She had previously been referred to the Women's Health Clinic at SWH by her GP but did not attend a scheduled appointment on 8 April 2019 and did not respond to follow-up (in the form of a letter, SMS text message, and through her GP). As such, there was limited antenatal care. In light of this, following Ms MT's admission to the ward at SWH, the nurse in charge contacted Child Protection[2] to enquire if Ms MT had any Child Protection involvement with her pregnancy. Child Protection reported that there was no record of an open case at that time.

4. Baby LT was born at term gestation on 20 May 2019 by emergency caesarean birth due to a delay in labour progress. Baby LT was delivered in good condition, with Apgar scores of nine at one minute, and nine at five minutes.[3] SWH assessed the major risk factor for the pregnancy being insufficient antenatal care and/or investigations. This was based on the history provided by Ms MT and the information provided by PDH.

5. SWH was aware during Ms MT's inpatient stay that she was Aboriginal, as this was on her clinical record, both paper and electronic based. Baby LT's medical record from SWH also

[2] The Department of Families, Fairness and Housing (**DFFH**) is the department responsible for child protection matters. DFFH was previously known as the Department of Health and Human Services (**DHHS**). Any reference to the 'Child Protection' is referable to DFFH from February 2021 onwards, and DHHS prior to February 2021.

[3] The Apgar score is used to evaluate the health of newborns at one and five minutes after birth. It is scored out of 10 based on the baby's skin colour, pulse rate, grimace, activity, and respiratory effort.

indicates his Aboriginal status. Ms MT was not offered an Aboriginal Health Liaison Officer (**AHLO**) or other social services during her inpatient stay.

6. On 21 May 2019, Ms MT was considered to be recovering well. She was interacting well with Baby LT. Ms MT expressed a desire to go home or transfer to PDH. Ms MT's understanding was that she had been "*cleared to go home".* Transfer to PDH was arranged by private car.

7. When Ms MT had not arrived at PDH three hours following her SWH discharge, the midwife who was expecting her arrival called Ms MT. Ms MT reported that she had chosen to go directly home, rather than be admitted at PDH. During the phone call, Ms MT reported she did not have any pain and therefore did not require admission to PDH for pain relief. Shortly after this phone call, Ms MT called the same midwife to report distressing pain.

8. Ms MT was offered admission at PDH for ongoing management however declined as she had to care for her other children. She was advised to find someone to care for the children and then present to hospital. The PDH midwife subsequently called SWH to advise that Ms MT did not arrive for admission. SWH informed PDH that there were no concerns noted regarding her mothering skills whilst in hospital.

9. A home visit was organised for the next day, 22 May 2019. Ms MT was not at home for the visit and remained uncontactable for the rest of that day.

10. Another home visit was organised for 23 May 2019. At this visit, the attending midwives were concerned regarding Baby LT's weight loss[4] and the home environment being very untidy, with a broken window, an offensive smell, and evidence of mice.

11. The on-call Paediatrician for PDH, Dr Britta Baade (**Dr Baade**), was consulted and she provided advice on a feeding plan. She recommended Baby LT be weighed the next day and that he should be reviewed by a paediatrician. Dr Baade offered to review him at PDH at 2pm the following day. The midwife informed Dr Baade of her concerns about the home environment and limited engagement with health professionals. Dr Baade advised the midwife they should contact Child Protection if concerned about the home environment.

12. On 24 May 2019, Ms MT did not attend for the scheduled paediatric review, and was not able to be contacted by midwives at PDH. This prompted a referral to Child Protection. Clinical

[4] Normal weight loss is up to 10% of birth weight in the days after birth. Any loss of more than 10% should prompt medical review.

notes were made regarding social concerns and the Child Protection notification, but no formal alert was placed in Baby LT's medical records.

13. On Child Protection's direction, Baby LT and his siblings were moved to his grandparents' house on 25 May 2019, where two further home visits on 25 and 26 May 2019 occurred. Baby LT was noted to have gained weight on these visits. Baby LT was discharged from domiciliary midwife care on 26 May 2019, and his care was handed over to the local maternal and child health nurse (**MCHN**).

MCHN Service Engagement

14. On 4 June 2019, Baby LT had the first of his Key Ages and Stages[5] (**KAS**) Maternal Child Health Nurse visit with Ms Jenny Trenorden (**Ms Trenorden**). Ms Trenorden noted the MCHN team had difficulties locating Ms MT and the family did not appear happy with the MCHN visit. However, Ms Trenorden noted Baby LT was alert and watchful, with good weight gain.

15. Baby LT had two subsequent appointments on 11 June and 18 June 2019 by MCHN Ms Georgie Sweeney (**Ms Sweeney**). On 18 June 2019, Ms Sweeney was concerned regarding crusting around Baby LT's eyes and discharge under the arms, and noted Baby LT had not gained weight as expected. She advised Ms MT to increase the amount of formula top-ups given to Baby LT and made an appointment for Ms MT and Baby LT at Winda-Mara Aboriginal Corporation GP clinic that afternoon. Ms Sweeney called Ms MT to follow up on the scheduled the appointment but was informed that Ms MT had been unable to attend due to bad weather.

16. Ms Sweeney rescheduled an appointment for 20 June 2019 and provided an interim management plan. That same day, Ms Sweeney called Ms MT to follow up on the appointment, but Ms MT was uncontactable. Ms Sweeney called the allocated Child Protection Practitioner to update her about the concerns from her review, and Ms MT's lack of attendance at two scheduled GP appointments.

17. On 9 July 2019, Ms Sweeney attempted to contact Ms MT after she did not attend for the planned eight-week KAS visit. She was unable to make contact and called the Child Protection Practitioner with this information. Ms Sweeney was informed that Baby LT was on the

[5] Key ages and stages visits are universal visits provided by MCHN to children in Victoria. They include ten visits across the preschool age: 2 weeks, 4 weeks, 8 weeks, 4 months, 8 months, 12 months, 18 months, 2 years, 3.5 years.

Intensive Infant Response register, which involved regular team meetings, the first being on 15 July 2019. Ms Sweeney stated it would be difficult for the MCHN to attend this meeting due to their workload.

18. On 15 July 2019, Ms MT took Baby LT to attend the Portland Child and Family Complex for his routine vaccinations. Baby LT was seen by MCHN, Simone Taylor (**Ms Taylor**). She recorded a temperature of 38 degrees Celsius, congested nose, noisy breathing, and an elevated respiratory rate of 80-100 breaths per minute. Ms Taylor called Dhauwurd-Wurrung Elderly and Community Health Service (**DWECH**) to attempt to get Baby LT seen by a GP, but none were available. She also attempted to call the paediatrician at the Portland Specialist clinic but was advised that they had left for the day. She then called PDH Urgent Care Centre (**UCC**) to inform them of her clinical concerns and that she had advised Ms MT to present there with Baby LT for review.

19. Ms Taylor was aware of the Child Protection involvement, and that Baby LT was on the Intensive Infant Response register, but this information does not appear to have been communicated to the PDH UCC in the phone referral.

Portland District Health Urgent Care Centre

20. On 15 July 2019 at 16.00 hours, Ms MT took Baby LT to PDH UCC. The triage note stated "*referred by MCHN with increased respiratory rate and fever, noted to have temperature of 38 degrees and rash*". Baby LT was initially seen by locum doctor Dr Mohammad Abody (**Dr Abody**), who then requested review by on-call paediatrician Dr Baade. Dr Baade was unaware that Baby LT was the same child she was consulted on by a midwife on 23 May 2019, nor was she informed or aware that Child Protection was actively involved with Baby LT, or of his Aboriginal status. Dr Abody provided a summary to Dr Baade of Baby LT's presentation. Dr Baade also confirmed the history from Ms MT, who did not disclose that Child Protection was involved.

21. Baby LT was eating and drinking and had a normal number of wet nappies. There was no vomiting or diarrhoea. It was reported that his siblings had a cold-like illness. Ms MT informed Dr Baade that Baby LT's temperature may have been high as he had been in front of a heater. One set of vital signs were initially done by a nurse, which demonstrated that Baby LT had normal temperature, respiratory rate, and heart rate. On examination by Dr Abody and Dr Baade, Baby LT looked well with no signs of respiratory difficulty reported. He had no

neck stiffness. He had a mildly inflamed pharynx.[6] A blanching rash was seen on his trunk and limbs. Dr Baade stated that when she and Dr Abody examined Baby LT, his vital signs were again normal, although the exact parameters were not documented in the medical notes.

22. The impression was that Baby LT was a well-looking child who was afebrile with respirations in the normal range. Dr Baade's differential diagnoses were either a viral infection or an environmental response. Ms MT reported Baby LT had spent time in front of the heater and was noted to be over-dressed when he arrived at the PDH UCC with a heat rash.

23. Dr Baade did not request further investigations or tests and advised Ms MT to take Baby LT for review by his GP the following day if the rash persisted or if Baby LT had a fever. Dr Baade advised Ms MT to return to the UCC if she had concerns, including increased rate or work of breathing, fever, decreased oral intake, lethargy, or irritability.

24. Baby LT was discharged home from the PDH UCC with instruction to follow up with the GP the following day and return to the ED if Ms MT was concerned. The outcome of this presentation and discharge plan were not communicated to the MCHN or Child Protection. Baby LT and his family left the PDH UCC at 5:00pm.

Child Protection involvement

25. Child Protection had previously received a report in November 2017 in relation to Baby LT's siblings. This report proceeded to the Protective Intervention phase. Child Protection closed the case in November 2018. At the time of closure, Child Protection noted in its file that Ms MT was pregnant. An unborn child report was not made.

26. On 19 May 2019, nursing staff from SWH contacted Child Protection to inquire if they had had previous involvement with Ms MT during the pregnancy and were informed there were no current open cases in the family.

27. On 24 May 2019, when he was four days old, Child Protection received a referral for Baby LT. The team noted that the older siblings were the subject of previous Child Protection reports with concerns regarding exposure to family violence and parental substance use, and a history of non-engagement with services. All of these cases were closed at the time of the May 2019 report.

[6] Medical term for the throat. An inflamed pharynx is often seen in viral illnesses of the upper respiratory tract.

28. After a home visit on 24 May 2019, an interim accommodation order (**IAO**) was made in relation to Ms MT and Mr DM (the father of the two elder children) on the proviso the children stayed with the maternal grandparents in Heywood. On 27 May 2019, the Court made an order that Baby LT and his siblings continue to live with Ms MT and Mr DM, and the children's maternal grandmother in Heywood. Following the IAO hearing, Child Protection made an Intensive Infant Response Decision regarding Baby LT. The rationale for this included concerns "*...held regarding the health and wellbeing of the child following concerns re no medical intervention pre or post birth and that the baby is reported to have lost 10% of the birth weight*".

29. On 7 June 2019, the case was allocated to a Child Protection Practitioner. On 11 June 2019, the Child Protection Practitioner completed a home visit at the maternal grandparents' house in Heywood and Ms MT agreed to engage with the Cradle to Kinder Program[7] for intensive family services. On 17 June 2019, the Child Protection Practitioner completed a home assessment and made an application to vary the above IAO given Ms MT's compliance with attending MCH appointments, willingness to engage with support services, Baby LT's weight gain, and the improvements made to the family home.

30. On two occasions, Child Protection accompanied staff from Aboriginal organisations to meet the family. On one of these visits with the Victorian Aboriginal Child Care Agency (**VACCA**), they were made aware of the reasons for Ms MT's disengagement with Winda-Mara Aboriginal Corporation and at Dhauwurd-Wurrung Elderly and Community Health Service. This was due to the family connections to her former partner, Mr QS. As a result, Child Protection prioritised Ms MT's engagement with Gunditjmara Aboriginal Cooperative and the MCHN service.

31. VACCA engaged with Ms MT and Baby LT through the Lakidjeka program. A VACCA worker met with Ms MT and Baby LT on one occasion when they attended a home visit with Child Protection. On this visit, Ms MT was asked about Aboriginal services she would be happy to engage with and was given information about the Aboriginal Family-Led Decision-Making process. VACCA continued to consult with Child Protection following this visit.

[7] An intensive whole of family support intervention available until the child reaches four years of age. Baby LT was referred to the Gunditjmara Intensive Health Services, the local Aboriginal Collective based in Warrnambool. The family were also referred to the Gunditjmara Family Violence Service, provided through the Gunditjmara Aboriginal Cooperative.

32. On 18 June 2019, a referral was made to Cradle to Kinder which was subsequently accepted by Gunditjmara Aboriginal Cooperative. On 27 June 2019, the Child Protection Practitioner completed a further joint home visit with a worker from Gunditjmara Intensive Family Services and a referral was made to the family violence service.

33. On 5 July 2019, the Child Protection Practitioner consulted with her practice leader and placed Baby LT on the Intensive Infant Response register.[8] On 9 July 2019, the Child Protection Practitioner made an appointment for Baby LT with the MCHN as the family had not attended an appointment in three weeks. During this time, the Child Protection Practitioner attempted to organise a case meeting on 15 July but was unsuccessful. On 12 July 2019, she became aware that Gunditjmara Intensive Family Services and Family Violence Service also had not been able to contact Ms MT since 27 June 2019.

34. On 15 July 2019, the Child Protection Practitioner had a further consultation with her team leader and established a plan for fortnightly care team meetings (and to encourage engagement from other services), a joint home visit on 19 July, and discussion at an intensive infant response meeting. On 16 July 2019, a six-month family preservation order was made.[9] On 17 July, the intensive infant response panel met, and plans were made to organise MCHN appointments, follow-up with Cradle to Kinder regarding non-engagement and to review IAO conditions with respect to GP appointments.

35. At the time of Baby LT's passing, Child Protection had visited the family on five occasions. The Child Protection case was open at the protection order stage, and Baby LT was assessed as a child requiring an Intensive Infant Response.

THE CORONIAL INVESTIGATION

36. Baby LT's passing[10] was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

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[8] All children under the age of two have a risk assessment performed by child protection. This determines if children require an 'infant response' or an 'intensive infant response'. An intensive infant response requires weekly home visits, practice leader involvement, a case conference or care team approach, and discussion at the next infant intensive response meeting.

[9] A family preservation order is made if the child is in need of protection and the child can safely stay in their parents' care whilst the protective concerns are being addressed.

[10] The term 'passing' is generally more accepted and sensitive terminology to use when discussing the death of Aboriginal and Torres Strait Islander people due to the spiritual belief around the life cycle (*see* 'Sad News, Sorry Business: Guidelines for caring for Aboriginal and Torres Strait Islander people through death and dying', Queensland

37. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

38. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

39. Victoria Police assigned Detective Sergeant Jason von Tunk to be the Coroner's Investigator for the investigation of Baby LT's passing. The Coroner's Investigator conducted inquiries on the Court's behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

40. Upon review of the coronial brief, the Coroners Prevention Unit was requested to review the medical management of Baby LT, along with Child Protection's involvement, to determine whether Baby LT's engagement occurred in accordance with the expected standards of culturally competent care. The CPU was established in 2008 to strengthen the coroners' prevention role and assist in formulating recommendations following a death. The CPU is comprised of health professionals and personnel with experience in a range of areas including medicine, nursing, mental health, public health, family violence and other generalist non-clinical matters. The CPU may review the medical care and treatment in cases referred by the coroner, as well as assist with research related to public health and safety.

41. Coroner Simon McGregor initially held carriage of the investigation into Baby LT's passing. I assumed carriage in July 2023 for the purposes of conducting additional investigative steps, finalising the case, and making findings.

42. This finding draws on the totality of the coronial investigation into the passing of Baby LT including evidence contained in the coronial brief. Whilst I have reviewed all the material, I

Government, December 2015, available here). On the advice of the Coroners Aboriginal Engagement Unit, the term 'passing' will be used instead of 'death' in this Finding, save where required by the words of relevant statutes.

will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[11]

CIRCUMSTANCES IN WHICH THE PASSING OCCURRED

43. On the morning of 17 July 2019, Baby LT was reportedly well. Ms MT fed him sometime between 1:00pm and 2:00pm, and then put him to sleep in his pram. Baby LT was laid down in the pram in a slightly elevated position with a thin, soft blanket over the top of him which was not tucked in. The heater was on.

44. Ms MT stated she recalled hearing normal baby sounds and checked on Baby LT every five minutes or so. She went to check on him after 2:30pm and felt he didn't look right. Baby LT was breathing faintly, and Ms MT attempted CPR. She then went next door and sought assistance from her neighbours.

45. The neighbours contacted emergency services and Ambulance Victoria paramedics arrived at 2:48pm. Baby LT was taken to Portland Hospital and arrived at 3:06pm.

46. Baby LT received ongoing CPR and was intubated at 3:11pm. He received two doses of adrenaline via an intraosseous needle. Baby LT could not be revived and was confirmed to have passed at 3:18pm.

IDENTITY OF THE DECEASED

47. On 17 July 2019, Baby LT, born 20 May 2019, was visually identified by his mother, Ms MT, who signed a formal statement of identification to this effect.

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

MEDICAL CAUSE OF DEATH

49. On 19 July 2019, Forensic Pathologist Dr Victoria Francis (**Dr Francis**) from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an autopsy. Dr Francis reviewed the Victoria Police Report of Death Form 83, post-mortem computed tomography (**CT**), medical

[11] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

deposition from Portland Hospital, and SUDI checklist, and provided a written report of her findings.

50. The post-mortem examination revealed pneumonia in both lungs.

51. Post-mortem microbiology showed *staphylococcus hominis* in the enrichment media of the cerebrospinal fluid and *staphylococcus epidermidis* in the blood culture enrichment culture.

52. Two intussusceptions were identified in the small bowel. An intussusception occurs when a segment of bowel telescopes inside an adjacent section. The cause of this is uncertain but is thought to be related to mesenteric adenitis (inflammation of the mesenteric lymph nodes). An intussusception can cause significant abdominal pain and can cause distress, vomiting, and unexplained lethargy.

53. There were no histological changes surrounding Baby LT's intussusceptions. Sometimes they can be a terminal event in an unwell child. This is considered the most likely cause in this case.

54. Anterior rib fractures were identified on the post-mortem imaging, as reported by Dr Rao, consultant paediatric radiologist from the Royal Children's Hospital. These are likely due to cardiopulmonary resuscitation.

55. No underlying congenital abnormality was identified during the post-mortem examination.

56. Toxicological analysis of antemortem and post-mortem blood and urine specimens showed no alcohol, common drugs, or poisons.

57. Amphetamines and cannabis were detected in Baby LT's hair. This may represent previous exposure to these drugs but may also be due to environmental exposure.

58. Post-mortem biochemistry showed elevated sodium and chloride which may be due to decompositional changes. The other electrolytes showed no significant abnormality within the limits of interpreting post-mortem specimens. There was insufficient specimen for procalcitonin testing.

59. There was a vitreous glucose level of 0.5mmol/L. Glucose levels normally decreased in the post-mortem period.

60. Metabolic testing was non-contributory. There was no evidence of violence or injury causing or contributing to death.

61. On the basis of the information available, Dr Francis is of the opinion that the death was due to natural causes. She noted the report was subject to a technical review process and was reviewed in its entirety by another pathologist.

62. Dr Francis provided an opinion that the medical cause of death was 1 (a) pneumonia.

63. I accept Dr Francis's opinion.

CPU REVIEW

64. The CPU reviewed the medical care provided and Child Protection involvement and provided a report for my consideration. The CPU found that the health care coordination, especially for a socially vulnerable child, was suboptimal and likely impacted on the health care received. The CPU acknowledged that although care during the perinatal and birth period did not directly contribute to Baby LT's passing, a break in health care coordination and communication of family vulnerabilities likely impacted on the quality of health care received.

65. It was further identified that on presenting to the Portland District Health Urgent Care Centre, key social and cultural information for Baby LT was not considered. This lack of knowledge may have impacted Baby LT's subsequent medical care.

Review of medical management

Portland District Health Urgent Care Centre

66. Baby LT was referred for medical review on 15 July 2019 at PDH by the MCHN due to a fever and a high respiratory rate. The duration of observation at PDH for one hour was relatively brief, and this length of monitoring appears limited given documented abnormal observations by the MCHN. In the medical records, there is one set of documented observations, although in her statement Dr Baade states that when she examined Baby LT, observations were repeated and normal (with the exact parameters not provided in the statement). As Baby LT had normal vital signs documented in the Urgent Care Centre and examined well, Dr Baade stated that, while appreciating that a one-hour period of observation

appears brief, based on her clinical assessment, further investigations were not indicated and a longer period of observation was not required

67. The clinical assessment of Baby LT by Dr Baade concluded that Baby LT was well, with a viral or a heat rash, and appropriate for discharge home. It was described that Baby LT had been positioned close to a heater as a potential explanation for his reported fever and rash. While the CPU advised that for a two-month-old with fever, overheating should be a diagnosis of exclusion after infection is ruled out, particularly in the context of associated elevated respiratory rate and rash, Dr Baade clarified that Baby LT's temperature was 37 degrees at this presentation (and therefore was not at that stage indicative of fever).

68. Given his symptoms and clinical presentation on 15 July 2019, the CPU considered it possible that Baby LT had a viral illness at that time. An initial viral infection may have predisposed Baby LT to developing a secondary bacterial pneumonia,[12] which was ultimately the cause of his passing.

69. In her statement, Dr Baade states that she took the time to explain to Ms MT her clinical findings and discussed the potential risk of viral infections. Dr Baade states that she avoided using medical terminology and discussed the discharge plan with Ms MT. She asked if she had any concerns about Baby LT, which Ms MT did not. Dr Baade explained that Ms MT should look out for Baby LT being lethargic, more tired than usual, not waking up for feeding, crying more than usual, developing a temperature and fever, if the rash was non-blanching (demonstrating to Ms MT how the rash would blanch if pressure was applied), irritability and decreased oral intake. She asked if Ms MT had any questions or comments, which she did not. When Dr Baade asked Ms MT if she felt comfortable to take Baby LT home, she said she was keen to take him home. Dr Baade suggested Ms MT follow up with a GP the following day if the rash was persisting or if he had a fever, or to return to PDH UCC if concerned. However, no formal medical follow up was booked, and the discharge plan was not relayed to the MCHN or Child Protection.

70. Dr Baade advised the Court, and I accept, that it is not standard practice for Emergency Departments or Urgent Care Centres to schedule General Practice appointments for patients. She noted this responsibility lies with the patient or their caregiver. Dr Baade further noted that the MCHN was not on duty at the time of Baby LT's discharge.

[12] Viral illnesses can predispose to secondary bacterial infections, but the occurrence of this cannot be predicted with certainty.

71. The CPU advises that a fever in a child less than three months should prompt careful review as per statewide Febrile Child Clinical Practice Guidelines (**CPG**), developed by the Royal Children's Hospital.[13] In a two-month-old without any unwell features and with no clear focus for infection, the RCH CPG suggests a urinary sample, and consideration of blood tests as well as admission for observation. If the infant remains well and investigations are normal, the infant can be discharged with a plan for follow up within 12-24 hours. The RCH CPG also suggests a lower threshold for investigations for children in high-risk groups, which includes the Aboriginal and Torres Strait Islander population. For a two-year old Aboriginal baby with a fever with no clear source the guidelines suggest a longer period of observation and consideration of further investigations.

72. Dr Baade advised that PDH is not credentialled to admit paediatric patients, so admission was not an available option. The nearest hospital with the ability to provide inpatient paediatric care was approximately 100km away. Dr Baade advised she did not feel Baby LT presented in a manner that would justify transferring him to another facility for admission. Further, Ms MT had advised she was keen to take him home.

73. In her statement, Dr Baade said that she was not aware of Baby LT's social vulnerabilities or cultural background when assessing Baby LT that day as they had not been communicated to her or documented on his PDH medical records, despite being well known to the MCHN network.

74. Dr Baade was not aware that Child Protection was involved with Baby LT, as there was no record of this on his PDH file. She stated that she was also not aware there was a history of missed health appointments. Additionally, Dr Baade also stated that she was unaware that Baby LT was the same infant who had been discussed with her on 23 May 2019. The CPU could not speculate on whether awareness of these issues would have changed the medical management or outcome, however it may have prompted a longer period of observation, further investigations, and more robust follow up. Dr Baade subsequently confirmed with the Court that, had she been aware of Child Protection's involvement with Baby LT, she would have kept him in the UCC for longer.

75. The CPU noted that medical care of children does not occur in isolation and should consider the social and cultural context of the child and their family. It concluded that although Baby LT did have normal vital signs and examined well, it would have been reasonable and

[13] Royal Children's Hospital Clinical Practice Guidelines, Febrile Child. Clinical Practice Guidelines: Febrile child (rch.org.au)

considered good practice to admit and observe a 2-month-old Aboriginal infant who had previously reported fever, and to consider further investigations. CPU opined that, upon discharge, timely medical follow-up should have been arranged.

Warrnambool Base Hospital coordination of care

76. Baby LT was born at WBH to a young Aboriginal mother who had limited antenatal care and engagement with health services. It appears the opportunities for provision of culturally appropriate care and safe discharge planning were missed, including links with an Aboriginal Health Liaison Officer (**AHLO**) and intensive community supports.

77. An intended transfer to PDH was planned by private car. Ms MT and Baby LT did not transfer to PDH as arranged, and instead went directly home. This resulted in a discharge within a short time frame of a caesarean section and absent robust support network. This missed opportunity resulted in the unplanned discharge of a vulnerable young baby to a family with social complexities.

78. A statement was provided to the Court by Dr Grace Sousa (**Dr Sousa**), Interim Executive Director Medical Services at South West Healthcare.

79. According to SWH Child Safety Policy, Baby LT was considered a vulnerable child.[14] The PDH Child Safety Policy states "*any health professionals who believes that a child, young person (0-17) or unborn child is vulnerable to harm or neglect should refer the child and family to Child First who will refer to a Child Protection officer if required*."

80. When the nurse in charge at SWH maternity ward contacted Child Protection to enquire if there had been any Child Protection involvement in the pregnancy, she was told that there was no record of an open case. The nurse was not notified of previous Child Protection involvement for Baby LT's siblings. Although the threshold for Child Protection notification was not met at that time, the CPU considers that concerns raised considering Baby LT was an Aboriginal child and limited antenatal care may have prompted consideration of a social work and AHLO referral.

81. In relation to hospital transfer from WBH to PDH via private vehicle, Dr Sousa provided the SWH Post-natal Client Transfer Policy and Patient Transfer Policy.

82. The Post Natal Client Transfer Policy states that that "*all uncomplicated postnatal patients can be transferred after 6 hours following vaginal birth and 24 hours following Caesarean*

[14] Young, isolated and/or unsupported family, and significant social or economic disadvantage.

unless a valid medical indication warrants additional time at Southwest Healthcare Warrnambool."

83. Ms MT fulfilled these criteria, as she was over 24 hours since her caesarean section and was reported to be recovering well. Therefore, the decision for transfer was reasonable. However, communication with Ms MT, communication with PDH, and decision on the mode of transport appears to be sub-optimal. The SWH Patient Transfer Policy states that transport to another service via private vehicle is suitable if: no clinical supervision is required, the patient is clinically stable, not on oxygen, and able to sit up for the duration. The SWH Patient Transfer Policy also states that documentation of senior doctor approval for the form of transport should be documented in the medical records. In the medical records, there is no clear documentation that Ms MT's transfer was discussed with a consultant doctor at SWH.

84. PDH is approximately 80 minutes' drive from SWH. The SWH policy also states that for private transfer, instructions to the family should be documented in the medical records. There is no documentation in the SWH medical records. The CPU further noted the lack of documentation is not addressed in Dr Sousa's statement. Nor is there clear documentation in the medical records, or from Dr Sousa's statement, of how the transfer plan was communicated with Ms MT, only that Ms MT had indicated her preference for transfer. It was Ms MT's understanding she was "*cleared to go home*".

85. With regards to handover of care, the Patient Transfer Policy states that a transfer letter should be provided to the receiving health service. There does not appear to be a transfer letter, but there is a brief discharge summary. This mentioned that there was insufficient antenatal care but does not mention Ms MT's Aboriginal status. The discharge summary states that the reason for transfer was Ms MT's preference, with no specification on medical reasons for transfer.

86. Arrangement of a non-urgent ambulance rather than private car transport on day one after a caesarean section would have been a reasonable consideration to ensure Ms MT's safe arrival at PDH. The CPU acknowledges however, even with ambulance transfer, Ms MT may have still chosen not to be admitted to PDH.

87. Dr Sousa confirmed that SWH did not have a plan for follow-up or to take any action when notified that Ms MT had chosen not to attend PDH. There is no mention on the SWH Patient Transfer Policy of the actions to take if a patient does not arrive at the intended transfer location. However, PDH did follow up, in the form of phone calls and offering of domiciliary midwife services the following day. From the medical records, it does not appear that a senior

doctor from either SWH or PDH was notified of Ms MT and Baby LT's non-admission at PDH.

88. SWH advised the patient transfer and post-natal client transfer procedures were reviewed in April 2022.

89. CPU concluded that there is no evidence to suggest the circumstances around birth and newborn care directly contributed to Baby LT's passing. There were, however, several missed opportunities to engage the family in more intensive health and social supports, provide culturally appropriate health care, and a clear plan documented on his PDH medical records.

90. On 23 May 2019, Baby LT's first home visit review by a midwife demonstrated excessive weight loss. Dr Baade advised for regular feeding with formula top ups, based on the PDH Infant Complementary Feeding Policy. However, a plan for medical review on 24 May 2019 did not occur. It appears there may have been a miscommunication between Dr Baade and the PDH midwife who consulted on the plan to address the weight loss. Dr Baade confirmed she did not receive a formal referral, and as such he was not booked into the outpatient clinic.

91. In Dr Baade's statement, she advised Baby LT was to be reviewed by a paediatrician and that she offered to see him at 2pm the next day. Dr Baade was not contacted the next day to review Baby LT and did not have any further contact from midwifery staff for follow up. Dr Baade did not receive a subsequent referral to review Baby LT and so did not follow up on Baby LT's non-attendance. It appears that midwifery staff assumed that Dr Baade's offer was confirmation of an appointment, and that no further action was required for referral to a paediatrician.

92. Despite this miscommunication, Dr Baade was informed by the midwife of her concerns with Baby LT's vulnerabilities. In hindsight, when Baby LT was not brought to the offered review on 24 May 2019, Dr Baade might have considered contacting the family and/or midwifery team to enquire whether he had been seen elsewhere by a paediatrician. When Baby LT did not attend the paediatrician appointment, the PDH midwives appropriately notified Child Protection.

Portland District Health identification of a child at risk

93. There was a lack of clear identification by PDH that Baby LT was a child at risk. A statement was provided by Dr Kaushik Banerjea (**Dr Banerjea**), Executive Director of Medical Services at PDH. Dr Banerjea outlined PDH's processes for identifying children at risk. These include:

a) Complying with the *Children Youth and Families Act 2005* (Vic); and *Commission for Children and Young People Act 2012* (Vic);

b) All staff are required to have a valid Working with Children Certificate;

c) All staff are mandated to do online learning "Children at Risk";

d) PDH Policy on "Mandatory Reporting – Children at Risk";

e) PDH policy on "Child Safe"; and

f) Management of allergies and alert on TRAK.[15]

94. The clinicians Dr Abody and Dr Baade who assessed Baby LT in the PDH UCC, were unaware of Child Protection's involvement. In his statement, Dr Banerjea outlined that in Baby LT's PDH medical records and regular clinic notes there was reference to the social concerns and Child Protection notifications. However, in her statement, Dr Baade stated that she was unable to access the MCHN records to see if there was any record of Child Protection concerns.

95. The PDH Policy, "Management of Allergies and Alerts on TRAK" outlines reasons for an alert to be placed on a patient's electronic medical record (**EMR**). These include "child vulnerable", "DHS to be notified of attendance", "Home Visit – High/Moderate Risk", all of which would have been applicable to Baby LT. However, Dr Banerjea confirmed in his statement that no formal alert was put into place on TRAK. Additionally, there is no alert option to indicate Aboriginal and/or Torres Strait Islander status.

96. The CPU considered that the presence of an alert on Baby LT's PDH medical record may have prompted the clinicians who reviewed him on 15 July 2019 to take his social vulnerabilities and cultural factors into context when determining his medical management.

97. Dr Baade reiterated that she tried to provide the best possible care to Baby LT. Dr Baade stated she tried to balance the presenting issues against the context of his socio-economic and cultural background, based on the information available to her. Dr Baade conceded she feels let down by the system and will endeavour to avoid such a situation in the future, as much as it is in her power to do so. As noted, she stated that had she known Baby LT was involved with Child Protection she would have kept him in the Urgent Care Centre for longer.

Communication between Child Protection and health services

98. Baby LT was identified as an infant requiring intensive support. Appropriate strategies were being put in place including weekly visits, care team meetings, and Child Protection team

[15] TRAK is the name of the electronic medical record program at Portland District Health.

leader support. However, as there are no data linkages between Child Protection and health service records, this information was not readily available on his medical records or to his health providers.

99. The 'Healthcare that Counts' Report, which provides a framework for improving care for vulnerable children in Victorian Health Services, includes two key action areas that address working together and effective communications.[16] The Victorian Child Death Review Committee states that "*sharing information is a two-way process; information about the child's psychosocial needs and parental functioning can beneficially inform any ongoing health response and vice versa. Information sharing…should be viewed broadly in the context of what is in the child's best interest*".[17]

100. A statement from Adam Reilly, Executive Director for the Department of Families, Fairness and Housing, Wimmera South West Area (**Mr Reilly**), outlined that:

> The infant risk assessment and response decision advice requires a case conferencing or care team approach as the key method for communication of child and family assessments and identified risks with other groups of professionals. The purpose of this is to ensure a multi-disciplinary approach for consistent, collaborative practice with clear roles and responsibilities in considering the immediate and future risks to the infant's safety and development. This is further strengthened by case reviews and Intensive Infant Response panels.
>
> Child Protection communicated with and conducted joint home visits with Aboriginal Child Specialist Advice and Support Services (ACSASS – Lakidjeka), Gunditjmara Intensive Family Services and Portland Maternal Child Health Nurse (MCHN) during the protective intervention phase for Baby LT and siblings. Communications and home visits to [Ms MT] ([Baby LT]'s mother) discussed missed General Practitioner and MCHN appointments between 19 June and 12 July 2019. A care team meeting was scheduled for 15 July 2019 with health providers regarding assessments and risks related to [Baby LT].
>
> On 17 July 2019, an Intensive Infant Response panel determined directions for [Ms MT]'s compliance with health service attendance that included regular care team meetings be held, and that drug screens be carried out for [Ms MT].

101. Despite these regular care team meetings, Baby LT was not referred to the Enhanced MCHN (**EMCHN**) service, despite meeting the criteria for eligibility. A referral to EMCHN is mentioned specifically in the 'Child Protection manual – Infant risk assessment and response

[16] Action Area 4: Working together; and Action Area 5: Effective communication and information sharing.
[17] Victorian Child Death Review Committee 2013, Annual report of inquiries into the deaths of children known to Child Protection, Melbourne.

action advice'[18] as an initiative which improves the quality of services delivered to infants at risk of significant harm.

102. According to the PDH website, the PDH-based MCHN service offers EMCHN. However, it is not clear what capacity this EMCHN service was operating at during Baby LT's involvement with the service. The EMCHN service in theory would have included more active engagement with the family, possibly including case coordination. This may have improved interagency communication, and ensured the allocated practitioner was able to attend care team meetings with Child Protection (noting that the MCHN for Baby LT expressed they were unable to attend the proposed meeting on 15 July 2019 due to workload).

103. Provision of an update by EMCHN to Child Protection on 15 July 2019 either by email or attendance at a care team meeting may have had a preventative impact by prompting Child Protection to follow up with the hospital and/or Baby LT's mother after he was noted to be unwell that day.

104. The CPU further noted that a medical practitioner was not included as part of Baby LT's care team. Although the involvement of a medical practitioner is not mandated as part of the infant risk assessment and response, given Baby LT's age, vulnerabilities, previous medical issues, and knowledge of multiple missed previous medical appointments, further support to engage him with a regular medical practitioner (GP and/or paediatrician) may have also strengthened communication between health and social services.

Communication between health providers

105. The MCHN and Child Protection were aware of Ms MT's history of limited engagement with services as demonstrated by missed MCHN and GP appointments and challenges for support services to contact the family. This does not appear to have been verbally communicated with the PDH UCC team by the MCHN when referring Baby LT to the service.

106. Conversely, as PDH UCC was not aware that Baby LT was known to Child Protection, upon discharge on 15 July 2019, there was no communication advising of his presentation and the follow up recommendations.

107. Under the Victorian Government's Child Information Sharing Scheme, professionals at authorised organisations, known as Information Sharing Entities, can request and disclose

[18] Accessible at www.cpmanual.vic.gov.au 'Service Responses'.

confidential information about any person with each other for the purpose of promoting the wellbeing or safety of a child.

108. Phase one of the scheme commenced on 3 September 2018 with entities including MCHN services. Phase 2 commenced on 19 April 2021, with regulations to authorise additional organisations and services to participate in the scheme, such as health and support services, public hospitals, community health centres, and primary health care. At the time of Baby LT's passing, phase 2 was yet to be implemented.

109. The disclosing information sharing entity must reasonably believe that sharing the information may assist the receiving information sharing entity to carry out one or more of the following activities:

    a) Making a decision, an assessment or a plan relating to a child or group of children;
    b) Initiating or conducting an investigation relating to a child or group of children;
    c) Providing a service relating to a child or group of children; and
    d) Managing any risk to a child or group of children

110. If the threshold of the scheme is met, an information sharing entity:

    a) Can proactively share information with defined entities;
    b) Can request information from another information sharing entity; and
    c) Must respond to requests for information from another information sharing entity and provide relevant information.

Cultural awareness and competency

111. The National Standards Quality Health Safety Standards (**NSQHS**) user guide on Aboriginal and Torres Strait Islander health defines cultural awareness as "*a basic understanding that there is diversity in cultures across the population. Cultural competency extends beyond individual skill or knowledge to influence the way that that a system or services operate across cultures*."[19]

112. These standards suggest a number of strategies to improve an organisation's cultural competency including partnering with local organisations to guide strategies for improving

[19] The Wardliparingga Aboriginal Research Unit of the South Australian Health and Medical Research Institute, *National Safety and Quality Health Service Standards User Guide for Aboriginal and Torres Strait Islander Health*, Sydney: Australian Commission on Safety and Quality in Health Care 2017, p22.

cultural competency, developing and implementing a cultural competency strategy and training program, developing an employment strategy, and supporting the workforce.

113. In her statement, Dr Sousa provided copies of SWH policies regarding the Reconciliation Action Plan and Aboriginal Health Liaison Services Policy.

114. In her statement, Dr Sousa outlined SWH strategies for provision of culturally safe and responsive health services to Aboriginal and Torres Strait Islander patients. Dr Sousa stated that SWH launched its first Reconciliation Action Plan (**RAP**) in March 2020. The plan allows SWH to formalise its approach and develop a deeper understanding and respect for Aboriginal and Torres Strait Islander cultures and the make its health service inclusive for those who identify as part of those communities. Cultural awareness training is mandatory for all SWH staff.

115. In his statement, Dr Banerjea provided a copy of PDH's Aboriginal and Torres Strait Islander Cultural Policy and outlined PDH's strategies for provision of culturally safe and responsive health services to patients, which include:

    a) Mandatory training for all staff in First Nations cultural competence;

    b) PDH Policy on Aboriginal Heritage Compliance;

    c) PDH Policy on First Nations Cultural Safety;

    d) Joint Committee of local Aboriginal and Torres Strait Islander Community, PDH and regional health partners to provide guidance on key priorities;

    e) Memorandum of Understanding with local Aboriginal Community Controlled Health Organisations;

    f) Regular interaction with Dhauward-Wurrung Elderly and Community Health Service (**DWECH**), with nursing staff attending there for immersive training; and

    g) A doctor from DWECH also working at PDH.

116. The CPU stated that despite SWH and PDH having policies, procedures, and training in place with regards to cultural competence and provision of culturally appropriate healthcare, these did not appear to translate into culturally responsive care for Baby LT.

Identifying and recording Aboriginal and Torres Strait Islander Status

117. The recording of Aboriginal and Torres Strait Islander status in health records was mandated in the 1990s to ensure health services captured accurate Indigenous health information.

118. Despite this, there is known under-identification of Aboriginal or Torres Strait Islander patients. A 2015 guide published by the Victorian Government noted that although Victorian health services generally ask pregnant women their Aboriginal or Torres Strait Islander status, there was under-identification of newborns as Aboriginal or Torres Strait Islander at a rate of 30-40 percent.[20] Asking and identifying Aboriginal and/or Torres Strait Islander status acknowledges a family's cultural identity and its relevance to their clinical needs and care planning. It also provides an opportunity to link Aboriginal and Torres Strait Islander families with appropriate services and supports them to partner with healthcare providers to achieve positive health outcomes.[21]

119. In his statement, Dr Banerjea noted Aboriginal or Torres Strait Islander status is asked at presentation to PDH, with the answer recorded in the electronic medical records. Dr Banerjea provided a copy of PDH's Aboriginal and Torres Strait Islander Cultural Policy, which states:

> All staff at points of admission and health care assessment are to undertake specific training on self-identification.
>
> …patients/clients receiving services will have the opportunity to: Identify as Aboriginal and Torres Strait Islander patients/clients and then plan with the individual and family and/or support person to ensure their health and wellbeing and cultural needs.
>
> Staff at PDH encourage and record self-identification of the cultural background of our clients by ensuring at each point of admission to the organisation patients are asked 'Are you of Aboriginal and/or Torres Strait Islander origin?'

120. Ms MT and Baby LT's SWH and PDH patient registration forms identify their Aboriginal status, as "*Indigenous: Aboriginal but not Torres Strait Islander Origin*". Dr Baade stated she was not aware of Baby LT's social risks or cultural factors when assessing Baby LT that day, as they had not been communicated to her nor documented on his PDH medical records.

[20] The Victorian Government Aboriginal Newborn Identification Project, 2015 'A Resource Guide' p. 5.
[21] *Ibid*, p7.

121. It is unclear whether Dr Baade had reviewed Baby LT's patient registration form, but based on her lack of awareness of his Aboriginal status, it seems likely that she did not. The CPU advised that in practice, patient registration forms are often not routinely reviewed by medical clinicians, as they are not embedded into their standard workflow. Additionally, patient registration forms may be difficult to access as they may be located on a different system to the EMR. Hence it is plausible and somewhat understandable that the patient registration form was not reviewed by Dr Abody and Dr Baade.

122. To avoid this issue, many EMR systems have the ability to provide clinician alerts, such as in the case of a vulnerable child, or to indicate Aboriginal and Torres Strait Islander status.[22] This provides a clear visual prompt to clinicians, in comparison to the aforementioned patient registration form which can be difficult to access. However, in the statement provided by Dr Banerjea, the PDH system did not have an alert present to notify clinicians of a patient's status.

Culturally safe and appropriate health care

123. Provision of culturally safe health care goes beyond cultural awareness and competence, and includes respecting cultural values, strengths, and differences, as well as addressing inequity and racism. Cultural safety involves the development of an Indigenous-led model of care. It requires health services and professionals to be culturally responsive and actively address racism and power imbalances in the health system. Improving the cultural safety and cultural responsiveness of the health system can both improve access to, and the quality of, health care provided to First Nations people.

124. One step towards the provision of culturally safe health care includes offering AHLOs to provide support to all patients and families of Aboriginal or Torres Strait Islander background.

125. In her statement, Dr Sousa provided copies of SWH policies regarding Aboriginal Health Liaison services. She stated that SWH does employ an AHLO who gives support to Aboriginal individuals throughout the hospital, liaises with other healthcare workers and acts as the patient's advocate offering support, education, and other information specific to patient need. The program also links Aboriginal patients to appropriate community support services on discharge as the need arises. The Aboriginal Health Liaison Services Policy states that the need for AHLO referral should be assessed on admission to SWH. However, there is no evidence on the SWH medical records that an AHLO (nor any other social or support service)

[22] For example, the Royal Children's Hospital's system has separate alerts on a patient's file which highlights either 'Vulnerable Child' or 'Aboriginal or Torres Strait Islander' status. These alerts are highlighted on every page of a patient's medical record, so are easily visible and can be accessed by any clinician who views a medical record.

was offered to Ms MT. This was a missed opportunity to provide culturally safe and appropriate healthcare, and ongoing support upon transfer to PDH.

126. SWH advised the Court that there have been several changes to standard maternity care since 2019, including:

    a) Regardless of discharge destination or pathway, on admission to the Maternity Unit, all women who identify as Aboriginal or Torres Strait Islander are offered a referral to AHLOs;

    b) A specific perinatal Social Worker role has been introduced. The role is intended to provide psychosocial and mental health screening, counselling, and emotional support during the perinatal period in the form of structured clinic appointments as well as postnatal ward visits and support. The role is designed to promote and support early intervention and prevention, including for expectant mothers of an unborn child. The role also provides oversight of inpatient and outpatient referrals, and provides support and advice to staff undertaking psychosocial screening;

    c) Midwives from the local Aboriginal Community Controlled Health Organisation (**ACCHO**) attend regular multidisciplinary antenatal meetings to ensure support during birth and postnatally, and improved collaboration; and

    d) If a patient does not arrive at their transport destination, a review is now completed under SWH's Incident Management Framework.

127. SWH further advised that there has been an increase in the skill base in the Social Work department, specifically with workers with experience in the Child Protection system. This has reportedly assisted SWH's work with the 'Healthy Mums Healthy Babies' program, Aboriginal Health programs, and the knowledge within the midwifery workforce in relation to vulnerable children and mothers. In his statement, Dr Banerjea stated that PDH does not currently employ an AHLO however the service is available and contracted on a fee-for-service basis with DWECH in a memorandum of understanding. However, it does not appear that an AHLO was offered by PDH at any stage to Baby LT's family.

128. Whilst it cannot be stated that the lack of provision of culturally-responsive health care directly contributed to Baby LT's passing, had this been provided, Ms MT and Baby LT may have been more engaged with health services, resulting in more regular reviews and perhaps empowering Ms MT to proactively seek medical care when required. Although it cannot be

stated with certainty, this may have impacted the subsequent presentation and management at PDH ED on 15 July 2019.

Child Protection response to Baby LT's passing

Guidelines for working with pregnant Aboriginal women

129. In a statement provided to the court, Child Protection identified several actions taken following Baby LT's passing.

130. These included the ongoing development of new guidelines for working with pregnant Aboriginal women who have been reported to Child Protection or referred to the Orange Door or Child FIRST (**the Guidelines**).[23] The Guidelines were intended for use by ACCOs, given the planned transition of all unborn child reports from Child Protection to ACCO management.

131. The Guidelines were to be developed by the Aboriginal Unborn Child Report Working Group (**The Unborn Working Group**), which was established in November 2019 and consists of key staff from DFFH and Aboriginal Community Controlled Organisations (**ACCO**s). The Unborn Working Group reports to the Wungurilwil Gapgapduir[24] Objective One Working Group and through that group to the Aboriginal Children's Forum (**ACF**). The ACF brings together representatives from ACCOs, Community Service Organisations and the Victorian Government to promote the safety, health and resilience of vulnerable Aboriginal children and young people.[25]

132. Child Protection initially advised the court that the Guidelines would be released in June 2023, and would draw upon experience and learnings from Baby Baby LT's case. However, they have since advised that the Unborn Working Group was suspended on 12 October 2022 to allow DFFH to consider the findings and recommendations of *Yoorrook for Justice: Report into Victoria's Child Protection and Criminal Justice Systems*. This report was published in August 2023, and outlines several concerns with respect to Child Protection's work with

[23] The Orange Door is a service hub providing a single area-based entry point into local specialist Family Violence Services and Integrated Family Services.

[24] Wungurilwil Gapgapduir, which means 'strong families' in Latji Latji, is a tripartite agreement between the Aboriginal community, Victorian Government and community service organisations. It outlines a strategic direction to reduce the number of Aboriginal children in out of home care by building their connection to culture, Country and community. Department of Families Fairness and Housing Victoria | Wungurilwil Gapgapduir Aboriginal Children and Families Agreement (dffh.vic.gov.au)

[25] DFFH, Aboriginal Children's Forum <Department of Families Fairness and Housing Victoria | Aboriginal Children's Forum (dffh.vic.gov.au)>.

pregnant Aboriginal women. Given these concerns, I am of the view that ACCOs would still benefit from the development and implementation of the Guidelines.

133. In its statement to the Court, DFFH also advised that there were two trials underway relevant to unborn reports and Aboriginal families. The Aboriginal Children and Families Innovation and Learning fund provides a capacity building opportunity for ACCOs to trial, test, and innovate different ways of diverting Aboriginal children away from involvement with the Child Protection system. The reported intention is to take an early risk management approach to addressing the high numbers of Aboriginal children in care and engaged with Child Protection.

134. Trials which relate specifically to unborn and infant Aboriginal children are:

    a) The Garinga Bupup trial run by the Bendigo and District Aboriginal Cooperative; and

    b) The Bringing up Babies at Home program run by the Victorian Aboriginal Child Care Agency.

135. These trials refer unborn reports received by Child Protection to ACCOs at the point of notification. The trials are intended to be ACCO designed and led and focus on building relationships with families whilst maintaining a focus on child safety. DFFH advised that the trials aim to provide wraparound early intervention support for unborn children and their mothers, to achieve agreed changes to support mothers and their children to remain together, and to prevent the need for further Child Protection involvement.

Other policy and practice changes

136. Child Protection's statement detailed a number of other actions it has taken since Baby LT's passing. These actions include:

    a) In-person training sessions held for all staff in the Wimmera South West Area. These sessions were facilitated by the Aboriginal Engagement Unit and included cultural safety and working with ACCOs. The Aboriginal engagement Unit also facilitated several 'cultural immersion days';

    b) Ensuring all staff have completed Aboriginal Cultural Framework online learning. This is a mandatory course for all Child Protection Practitioners;

    c) To improve Aboriginal cultural safety and self-determination in the area, the Aboriginal Engagement Unit and senior leaders engaged in the Aboriginal Self Determination Governance Project. The purpose was to advance Aboriginal self-

determination and to develop leadership practice that was culturally safe and informed, both within DFFH and externally with ACCOs and the wider community services sector. Further, in June 2023, the Child Protection leadership team undertook an in-person learning session on the cultural safety framework, facilitated by the Aboriginal Engagement Unit;

d) Directing Child Protection Practitioners to involve their Principal Practitioner or their Area Operations Manager in discussions about legal intervention or the removal of Aboriginal children from parental care, to ensure appropriate information gathering has taken place, particularly from ACCOs where they have been involved with families;

e) Aboriginal Corporations in the Wimmera South West area and Lakidjeka have been invited to attend the internal infant intensive response meeting. This meeting is held once per month to consider whether there is a requirement for the infant intensive response status to remain in place and to promote targeted implementation of care plans. The agencies involved work alongside Child Protection by sharing information, formulating a plan and supporting the enactment of the plan. The engagement with Lakidjeka is continuing, and Lakidjeka regularly attend the internal and external Intensive Infant Response meetings; and

f) Two new practice tools have been developed to support risk assessment and the integration of SAFER into practice since October 2022.

Yoorrook Justice Commission

137. The Yoorrook Justice Commission (**the Commission**) noted strong evidence that 'great results can be achieved where culturally appropriate services are available to pregnant Aboriginal women subject to a pre-birth report',[26] and specifically remarked on the excellent outcomes achieved by Garinga Bupup. The Commission commented on the lack of availability of such early intervention services, particularly early parenting services,[27] and pointed to inadequate and short-term funding of ACCOs as barriers to their implementation.[28]

138. As a result, Recommendation 8 of the Commission's report provides that the Victorian Government must 'enshrine prevention and early help/intervention as a guiding principle in

[26] Yoorrook Justice Commission, *Yoorrook for Justice: Report into Victoria's Child Protection and Criminal Justice Systems* (August 2023) 136.
[27] Ibid 136-7.
[28] Ibid 137.

the *Children, Youth and Families Act 2005* (Vic)', and 'as an immediate action, substantially increase investment in Aboriginal Community Controlled Organisation prevention and early help/intervention services to keep First Peoples children out of the child protection system and to prevent their involvement from escalating when it does occur'.[29] The Victorian Government has placed this recommendation under consideration.[30]

139. Further, Recommendation 9 provides that the Victorian Government must publicly report annually on the amount and proportion:

    a) of total child protection and family services funding allocated to early intervention (family and parenting services) compared to secondary and tertiary services (community delivered child protection services, care services, transition from care services and other activities); and

    b) of funding allocated to Aboriginal Community Controlled Organisations compared to mainstream services for early intervention (family and parenting services), secondary and tertiary services.[31]

140. The Victorian Government has supported Recommendation 9.[32]

141. DFFH noted that the Commission made two recommendations relating to unborn reports to Child Protection. Recommendation 11 relates to a requirement that Aboriginal unborn protective concern reports made to Child Protection are referred to an ACCO. This is to ensure that an ACCO can:

    a) Provide input into that decision;

    b) Ensure people with appropriate training and expertise are involved; and

    c) Offer culturally safe supports to the mother, father, and/or significant others in the family network.

142. Pregnant Aboriginal women are to be informed of the report by a person with the appropriate expertise to hold such a sensitive discussion, and who have the skills to respond appropriately and offer a range of culturally safe support options.

[29] Ibid 139.
[30] State of Victoria Department of Premier and Cabinet, 'Victorian Government Response to the Yoorrook for Justice Report' (April 2024) 17-8.
[31] Yoorrook Justice Commission, *Yoorrook for Justice: Report into Victoria's Child Protection and Criminal Justice Systems* (August 2023) 139.
[32] State of Victoria Department of Premier and Cabinet, 'Victorian Government Response to the Yoorrook for Justice Report' (April 2024) 18.

143. Recommendation 12 provides that Aboriginal unborn reports made to Child Protection and reports about Aboriginal children substantiated by Child Protection should, with consent, be referred to an Aboriginal Legal Service.

144. DFFH, in partnership with the Department of Justice and Community Safety and relevant ACCOs, is considering a consent-based Child Protection notification scheme for unborn reports. Further, the Victorian Government has committed to supporting Recommendations 11 and 12 in principle. DFFH stated that in combination these recommendations are directed at providing wraparound social services and legal supports to expectant Aboriginal mothers.

145. Finally, while not referred to in the most recent statement from DFFH, I note that Recommendation 10 of the Yoorrook Justice Commission Report also has resonance in the case of Baby Baby LT, namely that 'the Victorian Government should immediately give a direction to health services (including perinatal, maternal and child health services) that: a) clinical and allied health staff working with pregnant women must undertake appropriate training to address bias and build expertise in working safely and effectively with First Peoples women and families to address their social and emotional needs, and b) this training must be designed and delivered by a Victorian First Peoples business or consultants on a paid basis, and completion rates of this training must be publicly reported'. The Victorian Government has accepted this Recommendation in principle.[33]

146. While I note that the health services involved in Ms MT and Baby LT's care have reflected on the cultural responsiveness of their services, and have strengthened approaches in this regard, and I have noted the thoughtful comments of Dr Baade in relation to avoiding preconceptions about patients based on their Indigenous status that may be construed as disadvantageous to the patient and family, I consider that Recommendation 10 from Yoorrook is worth highlighting in this context.

147. I endorse these recommendations and have made a comment below in this regard.

[33] State of Victoria Department of Premier and Cabinet, 'Victorian Government Response to the Yoorrook for Justice Report' (April 2024) 18.

FINDINGS AND CONCLUSION

148. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

    a) the identity of the deceased was Baby LT, born 20 May 2019;

    b) the death occurred on 17 July 2019 at Portland District Hospital, 141-151 Bentinck Street, Portland, Victoria, 3305, from pneumonia; and

    c) the death occurred in the circumstances described above.

149. Having considered all of the circumstances, I find that Baby LT's passing was due to natural causes, and there is no evidence to suggest the circumstances around birth and newborn care directly contributed to Baby LT's passing. Despite this, I consider that there were missed opportunities in health care coordination and communication of family vulnerabilities which likely impacted the quality of health care received.

150. There was a dominant theme of communication issues in the investigation surrounding Baby LT's passing as between the primary and acute health care, community, and Child Protection sectors. The lack of provision of culturally-responsive healthcare services was also a concern.

151. Clear communication pathways are required between parents/guardians, Child Protection, health professionals, and community organisations when providing services and care to Aboriginal families. Aboriginal and Torres Strait Islander children are overrepresented in the Child Protection system. The provision of culturally appropriate coordinated care is particularly important, with the need for multidisciplinary communication and cross-agency linkages.

152. I commend South West Healthcare, Portland District Health, and the Department of Families, Fairness, and Housing, on their cooperation and proactive engagement in the coronial investigation. I acknowledge the submissions and statements provided regarding the lessons learnt from Baby LT's passing, and the changes which have been implemented to improve services for future children. The changes made since Baby LT's passing by these services, coupled with the deep and targeted body of work completed by the Yoorrook Justice Commission, have obviated the need for extensive coronial recommendations to be made in connection with Baby LT's passing.

COMMENTS

Pursuant to section 67(3) of the Act, I make the following comment connected with the death.

1. I endorse Recommendations 8, 9, 10, 11 and 12 of the Yoorrook Justice Commission Report on Child Protection and Criminal Justice Systems, and encourage health services and Child Protection to continue to work towards providing a genuinely culturally-responsive service to Aboriginal parents and children.

RECOMMENDATIONS

Pursuant to section 72(2) of the Act, I make the following recommendation.

To the Department of Families, Fairness and Housing:

1. I recommend that Child Protection, through the Aboriginal Unborn Child Report Working Group, develop and implement guidelines for working with pregnant Aboriginal women who are reported to Child Protection or are referred to the Orange Door or Child FIRST. These guidelines should be informed by the relevant findings of the Yoorrook Justice Commission.

I convey my sincere condolences to Baby LT's family for their loss and I acknowledge that the coronial investigation into his passing has been a lengthy one, which can exacerbate the grief and uncertainty that can attend upon proceedings of this nature. I also acknowledge that the coronial process is a poor vehicle for closure for Baby LT's family and those who cared for him, and cannot bring back their child who was so dearly loved. I am hopeful, however, that this finding may advance the prevention function of the Court and that Baby LT's family may find some solace in the numerous systems changes that have been made since his tragic passing.

DIRECTIONS

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

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

Ms MT, Senior Next of Kin

Emily Hart, Maurice Blackburn

Jennifer Dorney, South West Healthcare

Portland District Health

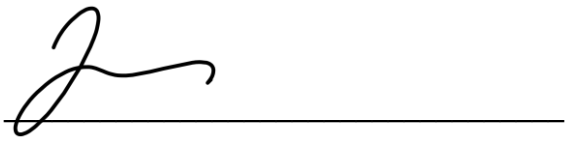
Secretary, Department of Families, Fairness and Housing

Liana Buchanan, Commission for Children and Young People

Chair, Yoorrook Justice Commission

Detective Sergeant Jason Von Tunk, Coroner's Investigator

Signature:



Ingrid Giles

Coroner

Date: 21 November 2024

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. 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.