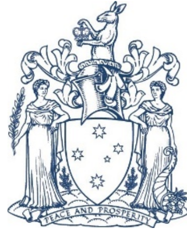

IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2020 001984

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Judge John Cain, State Coroner
Deceased:	Child A
Date of birth:	[redacted]
Date of death:	11 April 2020
Cause of death:	1(a) Unascertained in the setting of a remote head injury
Place of death:	[redacted]
Keywords:	Family violence; child protection; child homicide

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

INTRODUCTION

1. On 11 April 2020, Child A was six months old when he passed away at a regional Victorian Hospital. Child A was born to parents CFT and NBV and was their second child. Child A's older sister, Child B, was born in

2. CFT and NBV met in 2018, when they were about 16 and 18 years old, respectively. NBV first perpetrated family violence about one month after their relationship commenced. Following Child B's birth in , professionals involved with the family began to suspect that NBV was perpetrating family violence towards her. Following Child A's passing, CFT disclosed that NBV perpetrated family violence against her including physical assaults, verbal abuse, controlling behaviour and threats to harm or kill her.

3. Child A was born prematurely at 27.5 weeks gestation. He had to be intubated due to his prematurity and was transported to a hospital in Melbourne for treatment. Child A remained at the Melbourne hospital until 4 January 2020, before being transferred to a regional Victorian Hospital. He remained there until 13 January 2020 and was then discharged home with his family.

4. NBV is a proud man who was born in as one of five children. Sadly, two of his siblings passed away during his childhood. His father was reportedly violent towards the family and experienced periods of incarceration. His mother reportedly struggled with mental illness, drug and alcohol addiction. NBV commenced using cannabis at the age of nine, began drinking alcohol at 10, and started using methamphetamine at the age of 15. He was heavily abusing methamphetamine at the time of Child A's passing. NBV's criminal history dated back to the age of 13, and he had convictions for violent offences, property offences and for possession of a weapon.

THE CORONIAL INVESTIGATION

5. Child A's passing 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.

6. 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.

7. 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.

8. Victoria Police assigned Sergeant Hannah Thompson to be the Coroner's Investigator for the investigation of Child A's passing. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, support workers, child protection practitioners, and investigating officers – and submitted a coronial brief of evidence.

9. This finding draws on the totality of the coronial investigation into the passing of Child A including evidence contained in the coronial brief. Whilst I have reviewed all the material, I 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.[1]

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

Identity of the deceased

10. On 12 April 2020, Child A, born [redacted], was visually identified by his mother, CFT.

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

Medical cause of death

12. Forensic Pathologist Dr Paul Bedford, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an autopsy on 14 April 2020, and provided a written report of his findings dated 10 September 2020.

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[1] 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.

13. The post-mortem examination revealed a right parietal fracture with scalp bruising and underlying subarachnoid haemorrhage with subdural membranes and haemorrhage involving the eyes.

14. Internal pathology included mesenteric adenitis. Parechovirus was identified in the bowel and rhinovirus in the naso-pharyngeal aspirate. These infections would not lead to death. mixed growth was found in the blood culture, while the infection marker procalcitonin was not elevated.

15. Neuropathological examination showed intradural and subdural haemorrhages, haemorrhages around both retrobulbar nerves, almost confluent retinal haemorrhages of the right globe as well as haemorrhages of the cervical spine in soft tissues and associated with nerves. These injuries were not explained by the cardiac arrest.

16. Dr Bedford summarised that whilst it was clear that there had been blunt force trauma to the head with significant changes involving the scalp, skull, brain and eyes, the actual pathway to death was less clear. He explained that the bleeding around the brain appeared to have occurred in a time period of days to maybe weeks before death. The brain was not swollen.

17. Dr Bedford stated that the timing of the skull fracture was difficult to determine. There was no radiological evidence of healing, which meant that the fracture occurred recently. The scalp bruising also appeared to be recent.

18. Toxicological analysis of post-mortem samples did not identify the presence of alcohol or any other commonly encountered drugs or poisons.

19. Dr Bedford provided an opinion that the medical cause of death was *unascertained in the setting of a remote head injury.*

20. I accept Dr Bedford's opinion as to the medical cause of death.

Circumstances in which the death occurred

21. On Saturday 11 April 2020, CFT, NBV, and their two children spent the day at their home located in a regional Victorian town. Child A had a cold and was reportedly a little unsettled, however otherwise appeared happy. NBV spent the afternoon playing games on his Xbox, whilst CFT cared for the children.

22. At 7.35pm, CFT placed an online order for pizza, garlic bread, and a drink from a local pizza shop. A delivery driver arrived at their home at about 8.25pm with only the pizza and the garlic bread. NBV asked about the drink; however, the driver did not have it with him. NBV was upset and told CFT to call the pizza shop, which she did using his phone. The shop employee could hear NBV yelling in the background of the phone call, "*where is my fucking drink*", whilst CFT tried to placate him. CFT was also attempting to nurse Child A during the call.

23. Once NBV ended the phone call, she was still nursing Child A when NBV became angry at her again. He punched CFT in the face, who begged him to stop, then hit her in the back with a photo frame. CFT placed Child A down as she was afraid that he might get hurt during the assault. NBV pushed CFT onto the ground, dragged her by her hair and punched her several times to the ribs and stomach.

24. Child A started crying during this incident, so NBV picked him up and placed him on the couch, next to him. CFT asked NBV to pass Child A over to her, so that she could comfort him, however he ignored her. He picked up Child A, held him under the arms and sat him on his lap. He shook Child A, bounced his legs up and down and did not support Child A's head, causing it to flop around. Child A continued to cry as NBV bounced him up and down. At one point, CFT witnessed Child A's head hit NBV's knee. NBV then placed Child A in a car seat that was in their living room.

25. CFT prepared a bottle for Child A, but he did not want it, so she tried to give him his dummy, which he later spat out. Child A continued crying, before falling silent and closing his eyes. CFT thought he was asleep, however when NBV tried talking to him, he did not respond. NBV picked him up again and noted he was floppy. When CFT tried to rouse Child A, she realised he was unresponsive, so she called 000. The call-taker instructed the couple to remove Child A's clothes and sit him upright, then commence cardiopulmonary resuscitation. Paramedics arrived quickly and continued resuscitation efforts. Child A was rushed to a regional Victorian hospital, however passed away about 45 minutes after arrival.

Subsequent investigation and criminal proceedings

26. Initially, Child A's passing was considered 'unexplained'. CFT and NBV were questioned by police five days after his passing. NBV gave a 'no comment' interview, whilst CFT did not disclose how NBV handled Child A. A few weeks later, she disclosed what actually occurred, leading to NBV's arrest on 5 June 2020. NBV was originally charged with murder, however

at the committal hearing on 14 July 2021, he pleaded guilty to child homicide. On 23 November 2021, NBV was sentenced to eight years and six months' imprisonment, with a non-parole period of five years and six months.

CPU REVIEW

27. The relationship between Child A and NBV met the definition of a 'family member' as defined in the *Family Violence Protection Act 2008* (Vic) (**FVPA**). As Child A's passing occurred in circumstances where there was a reported history of family violence, I requested that the Coroner's Prevention Unit (**CPU**)[2] examine the circumstances of his passing as part of the Victorian Systemic Review of Family Violence Deaths (**VSRFVD**).[3]

28. At the time of Child A's passing, the family were engaged with multiple services including a regional Victorian Aboriginal Service, Child Protection, and housing services. NBV was also engaged with a regional Victorian Aboriginal Service men's behaviour change program, drug and alcohol services, and Corrections Victoria. In those circumstances, I requested the CPU consider the family's engagement with those services and whether there were any prevention opportunities arising from that engagement.

29. I make observations concerning service engagement with the family as they arise from the coronial investigation into his death and are thus connected thereto. However, the available evidence does not support a finding that there is any <u>direct causal</u> connection between the circumstances highlighted in the observations made below and Child A's passing.

30. I further note that a coronial inquiry is by its very nature a wholly retrospective endeavour and this carries with it an implicit danger in prospectively evaluating events through the "*the potentially distorting prism of hindsight*".[4] I make observations about services that had contact with Child A's family to assist in identifying any areas of practice improvement and to ensure that any future prevention opportunities are appropriately identified and addressed.

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[2] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

[3] 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

[4] *Adamczak v Alsco Pty Ltd (No 4)* [2019] FCCA 7, [80].

Victoria Police

18 July 2019

31. On 18 July 2019, emergency services were contacted following a verbal argument between CFT and NBV, with NBV allegedly assaulting CFT. CFT was holding Child B and was about 15 weeks pregnant with Child A at the time of the incident. Upon police arrival, both CFT and NBV minimised the incident, and CFT explained that the argument occurred because she was stressed and Child B was sick. Police observed NBV displaying controlling behaviours, "*telling her she wasn't allowed to go with her family and if she went with them she had to leave the baby with him as he was paranoid she would leave…and not come back*". Police also observed NBV yell at CFT, stating it was her fault if he got arrested.

32. Child Protection arrived at the address during the incident and directed CFT to leave with Child B. Police applied for a family violence intervention order (**FVIO**) in full conditions, to protect CFT and Child B. This was later finalised in limited conditions for 12 months on 2 September 2019. The FVIO was varied to permit NBV to be present at the family home, provided he did not use drugs or alcohol. No criminal charges were laid on this occasion. Police followed up with NBV on two occasions after the incident and noted that he reported being engaged with a regional Victorian Aboriginal Service men's behaviour change program and was planning on attending rehabilitation for his substance misuse issues.

24 February 2020

33. On 24 February 2020, a witness called 000 and reported a woman in distress being dragged down a driveway. CFT's father, OKM, also called police and advised that NBV had threatened CFT and she called OKM to ask him to pick up the children. When police attended, they spoke with CFT alone and she denied that any assault had occurred. She was observed to have a graze on her knee but explained that it had occurred whilst she was caring for her daughter. NBV similarly denied any violence had occurred and explained that the couple had merely had a minor argument regarding Child B's teething.

34. The Family Violence Investigation Unit (**FVIU**) determined that this was a high-risk incident and contacted CFT on 27 March 2020. CFT stated that no further incidents had occurred and that her relationship with NBV was going well. No further action was taken. It does not appear that police made an application to vary the limited FVIO in place to increase the level of protection.

Victoria Police Family Violence Death Assessment

35. Following Child A's passing, Victoria Police conducted a Family Violence Death Assessment (**FDA**) in relation to the July 2019 and February 2020 contacts and concluded that attending police were compliant with relevant policies and procedures.

36. I note that in relation to the February 2020 incident, police did not further investigate the witness who reported seeing CFT being dragged by NBV. Under Victoria Police's *Code of Practice for the Investigation of Family Violence* (**Code of Practice**) in place at the time, members were (and are) required to "*investigate all family violence incidents coming to their notice by gathering background information and physical evidence, including photographs, clothing and statements from direct or indirect witnesses*". From the records provided to the Court, it does not appear this witness was spoken to by police.

37. In their submissions to the Court, Victoria Police noted that the witness who made the 000-call wished to remain anonymous. Therefore, police were unable to call them back to find out more details. I accept this explanation and therefore that police were unable to pursue this line of enquiry any further.

38. I also note that the Code of Practice requires members to provide First Nations affected family members with access to an Aboriginal Community Liaison Officer (**ACLO**) if available in the local area. The regional Victorian town has had an ACLO available since 2019. It does not appear that CFT was offered contact with the ACLO.

39. In their submissions to the Court, Victoria Police noted that following the 24 February 2020 incident, they provided formal referrals for both parties. Additionally, during a visit by police on 27 March 2020, CFT noted that she "*did not want more referrals*" as she was engaged with a regional Victorian Aboriginal Service and was content with same.

40. Victoria Police also noted that the most recent version of the Code of Practice does not specify a requirement for police to offer parties support from an ACLO if available in the local area. Rather, it states:

    a) When responding to family violence impacting an Aboriginal person, Victoria Police will offer the choice of referral to Aboriginal support services or mainstream support services according to their preferences; and

    b) Responding police officers may also refer to or consult with an ACLO.

41. Regardless of whether CFT spoke to an ACLO or if it was possible for police to speak to the 000 caller, there is no evidence to suggest that different actions taken by Victoria Police on either occasion would have prevented Child A's tragic passing. Victoria Police acknowledged that there may have been missed opportunities for police to attempt to hold NBV to account for his behaviour and/or potentially reduce his offending towards CFT and the children.

42. It is also clear that CFT was not forthcoming with police regarding NBV's behaviour, possibly due to her fear of him and/or possibly due to a mistrust of police. As an alternative, a co-responder model is one option that can provide victims of family violence with another pathway to raise family violence concerns as an alternative to police. These models usually consist of providing victims of family violence with a dual response from a specialist family violence worker and a police member. This can help improve police responses to family violence and can provide a non-criminal avenue for victims to access support and safety.

43. Co-responder models have recently received support at both the state and federal levels of government. An expert panel appointed by the federal government to undertake a rapid review of evidence-based approaches to prevent gender-based violence recommended:

> *The Commonwealth and state and territory governments to work together to strengthen multi-agency approaches and better manage risk, with a lens on harm and safety, for victim-survivors of [domestic, family and sexual violence], including risk of homicide and suicide…*
>
> > *a. the introduction and expansion of multi-agency responses, including fit for purpose police co-responder models – with an immediate focus on collaborative responses that increase access to forensic examinations (states and territories).*[5]

44. I see great merit in expanding such services. Whilst some victims of family violence are comfortable engaging with police, many are not. A culturally informed co-responder model may be more successful in engaging victims who are not comfortable speaking to police and would provide them with a safe alternative. I support and endorse the expert panel's recommendation above.

[5] Rapid Review Expert Panel, *Report of the Rapid Review of Prevention Approaches: Unlocking the Prevention Potential*, 22.

Corrections Victoria

45. NBV was subject to two community corrections orders (**CCOs**) in the lead up to the fatal incident. A six-month CCO expired on 27 December 2019 which was imposed for dishonestly receiving stolen goods. A 15-month CCO was active at the time of Child A's passing, and was imposed in relation to burglary, theft, committing an indictable offence whilst on bail and contravening bail.

46. As part of the conditions of the order, NBV was subject to judicial monitoring and was required to engage with supervision by Corrections Victoria, drug treatment, mental health treatment, the regional Victorian Aboriginal Service, an employment support service and other programs designed to reduce reoffending. Upon commencement of the orders, NBV was allocated an Aboriginal case manager, with whom he met between three and five occasions from July 2019 to April 2020.

47. Corrections Victoria undertook a review of its case management of NBV, and noted that it:

    a) Did not adequately consider, assess or address NBV's known use of family violence and the risk it posed to CFT and the children.

    b) Did not adequately share information and engage with other services involved with NBV and the family.

    c) Did not use opportunities to explore NBV's use of violence and hold him accountable for same.

    d) Did not adequately address his support needs and had limited oversight of his engagement with the regional Victorian Aboriginal Service men's behaviour change program on, mental health services, and drug and alcohol services.

48. Corrections Victoria made a series of recommendations in response to the above findings. As of July 2022, two of those recommendations were completed, with the remainder due throughout the second half of 2022. The remainder were completed in 2022 and 2023. I am satisfied that Corrections Victoria has appropriately reviewed and addressed the deficiencies that it identified and therefore no further recommendations are required.

Men's Behaviour Change Programs

49. NBV was referred to a men's behaviour change program run by a regional Victorian Aboriginal Service on two occasions, due to concerns about his risk of perpetrating family violence. Upon review of the records held by the regional Victorian Aboriginal Service, it appears that whilst NBV attended several sessions, he had limited individualised engagement with practitioners that was focused on addressing his use of violence.

50. A recent study of perpetrator attrition and engagement with men's behaviour change programs underscored the importance of individualised supports for perpetrators of violence and the importance of these supports in responding to trauma and its intersection with their use of violence.[6] The study found that one-on-one counselling and case management, in combination with a men's behaviour change program is the preferred model of support for men who use violence. It can assist them to address their trauma and other factors that may be contributing to their use of violence, can assist in developing readiness for change and can decrease attrition.

51. Dardi Munwurro is one organisation that provides intensive and residential interventions to First Nations men who have used family violence. As discussed during NBV's sentencing, NBV was subject to extensive trauma as a child and adolescent, which likely impacted his decision to use violence against his partner and children. It is likely that programs offered by organisations such as Dardi Munwurro may have been beneficial in addressing this behaviour.

52. Unfortunately, whilst Corrections Victoria records prior to the fatal incident discussed the possibility of a referral to Dardi Munwurro, the referral was not actually made until after Child A's passing. Dardi Munwurro is only funded to operate in Melbourne, and it is possible that the referral was not made as NBV lived in a regional Victorian town. In a submission to the Yoorrook Justice Commission, the Victorian Aboriginal Legal Service (**VALS**) recommended that the Victorian Government expand the Dardi Munwurro program across Victoria to support First Nations men to address their use of violence, regardless of their location.

53. Whilst it cannot be determined now that NBV's engagement in a program such as the one run by Dardi Munwurro would have prevented his offending against CFT and the children or

[6] Fitz-Gibbon, K., McGowan, J., Helps, N. & Ralph, B. (2024) Engaging in Change: A Victorian study of perpetrator program attrition and participant engagement in men's behaviour change programs. Monash University, Victoria, Australia, 66, 64.

Child A's passing, I am of the view that it would have been nevertheless beneficial to NBV and other men like him. In those circumstances, I intend to support and endorse VALS' recommendation to Yoorrook.

Child Protection

54. Child Protection received two reports in relation to Child B and Child A. An unborn report for Child B was received on 25 July 2018 due to concerns about NBV's aggressive and controlling behaviours towards CFT and a housing worker. This report was closed on 14 August 2018, following consultation with CFT and NBV and the agencies involved with the couple. Child Protection noted there were no concerns for family violence and that CFT was capable of advocating for herself, despite being only 16 years old at the time.

55. A second report was made on 30 May 2019 regarding CFT, Child B and her unborn child (Child A). The report noted concerns regarding NBV's controlling behaviours, aggression, perpetration of family violence and possible substance misuse. The report noted physical damage was observed around the house, injuries were observed to CFT's face several times and that CFT was not permitted to attend appointments without NBV's permission. This report remained open with Child A and Child B at the time of the fatal incident.

56. The Commissioner for Children and Young People (**CCYP**) undertook a Child Death Inquiry (**CDI**) into Child A's passing, and made the following findings:

    a) Child Protection appropriately identified risks posed to Child A but failed to clearly define how these risks would be addressed and did not coordinate professionals to address protective concerns.

    b) Child Protection did not undertake ongoing monitoring and risk assessments.

    c) Child Protection did not adequately manage the family's risk level during COVID-19.

    d) the regional Victorian Aboriginal Service withdrew services and over-relied on phone communication with NBV and CFT during COVID-19.

57. In response to these findings, the CCYP recommended:

a) That Child Protection work in collaboration with the regional Victorian Aboriginal Service to identify and overcome barriers that might prevent Aboriginal families from accessing culturally appropriate and safe parental capacity assessment services in the regional area.

b) That the regional Victorian Aboriginal Service develop a public health emergency response targeted to the needs of their clients and community.

c) That the Department of Families, Fairness and Housing (**DFFH**) use this matter to inform its response to future COVID-19 lockdowns.

58. I agree with the findings of the CDI, however, note the relevance of recommendations pertaining to a COVID-19 lockdown may have waned somewhat in the time that has elapsed. There were some additional concerns in relation to Child Protection's response to the family, namely:

a) Whilst Child Protection acknowledged the impacts of NBV's engagement with Child Protection during his childhood and his history of trauma, there was no evidence that practitioners took steps to address those factors and their consequences on NBV's parenting or use of violence. Instead, these factors were considered as risk factors contributing to a likelihood of harm.

b) Child Protection were aware of and had witnessed NBV's perpetration of violence towards CFT. Despite repeated incidents of violence, Child Protection did not undertake any assessments of risk posed by NBV to CFT and the children. It also did not appear that Child Protection took appropriate steps to support CFT to disclose her experience of violence. After Child A's passing, CFT noted that she "*lied about the cause of this injury to Child Protection as [NBV] was present in the home and she was fearful of the repercussions*".

c) Child Protection took limited action to address concerns about NBV and CFT's parenting capacity, despite the original report to Child Protection noting same. Child Protection arranged a limited assessment of CFT's caring capabilities prior to Child A's discharge from hospital, however NBV was not assessed and attended the hospital potentially under the influence of drugs. CFT's parenting capacity was noted to be good, however her capacity was not considered in the context of caring for two children under the age of one, family violence and drug use. It also did not appear that

Child Protection used the period of time that Child A was in hospital to develop CFT and NBV's parenting skills despite multiple concerns being raised by hospital staff. These concerns included NBV handling Child A in an unsafe manner, NBV's drug use, and NBV's perceived failure to prioritise Child A and Child B.

d) Child Protection appeared to have placed an over-reliance on CFT to be the 'protective parent', advocate for herself, and ensure the safety of herself and her children, despite her young age and documented evidence of NBV's controlling and violent behaviour.

e) Despite a recommendation from the Infant Risk Management Team and supervisors, Child Protection practitioners did not consult with a specialist family violence advisor in relation to the risk that NBV posed to CFT or the children.

f) Child Protection did not consider the impact of the stressors faced by the family or the risk posed to CFT and the children's welfare. This is particularly concerning noting that CFT contacted services in April 2020 to advise that she was not coping and needed a break from NBV. Services overheard NBV "*heightened*" and yelling abuse in the background whilst Child A was heard crying. In response to these concerns, Child Protection and the other services involved, agreed that CFT and NBV would be encouraged to go for a walk around the block "*to have a break*" and liaise with other services as required. In my view, this was an inadequate method of managing the risk posed by NBV.

Child protection response to observations about service engagement

59. At my direction, the Court wrote to Child Protection regarding the concerns identified above and provided them with an opportunity to respond. I have summarised their responses below.

<u>Reliance on the CCYP CDI</u>

60. Child Protection submitted that my proposed adverse comments were too heavily influenced by CCYP's report and that the CCYP has a different role and remit to that of the coroner. I accept that is true, however I also note the significant overlap between our investigative powers and remit. My reliance upon the CDI to inform my investigation does not equate to findings of fact against Child Protection; rather it merely assisted me with reviewing the most pertinent parts of Child A's involvement with Child Protection and determining the appropriateness of same. I therefore support and endorse the findings of the CDI.

Child Protection's consideration of NBV's trauma

61. Child Protection submitted that they did take steps to address NBV's history of trauma and the consequences on his parenting skills and use of violence. For example, on 25 October 2019, there was a care team meeting where counselling options were discussed. Furthermore, a Child Protection report submitted to the Children's Court recommended that NBV engage with a psychologist, which was not accepted. When a Family Preservation Order (**FPO**) was made in February 2020, it included a condition for NBV to attend counselling. Child Protection referred him to a regional Victorian Aboriginal Service for culturally safe counselling.

NBV's perpetration of violence towards CFT

62. Child Protection disagreed with this concern and submitted that it did identify family violence as a predominant risk issue. It noted that on 26 November 2019, an assessment documented:

> *Child protection have assessed there is a likelihood of harm due to history with Child B, ongoing exposure to family violence and NBV's drug use…Child protection are substantiating concerns on ground 162 (c) child not protected from physical harm by parent due to exposure to family violence whilst in utero and 162 (e) child not protected from emotional or psychological harm b parents.*

63. Child Protection also submitted that on 14 October 2019, the likelihood of physical harm was assessed as "*current*", on 11 March 2020 an assessment referred to the risk of family violence several times, and Child A's case plan referred to protective concerns including his exposure to family violence.

64. In relation to my concern that CFT was not adequately supported to disclose her experience of violence, Child Protection submitted that there were occasions in which Child Protection attempted to speak to CFT away from NBV and did speak to her without him present, however accepted that CFT may have still been understandably fearful to disclose her experience of violence. Child Protection also noted that they referred CFT to The Orange Door and to the regional Victorian Aboriginal Service's Family Preservation Program.

Concerns about CFT and NBV's parenting capacity

65. Child Protection disagreed with this proposition and noted that it was aware of the parents' capacity to care for two young children. Child Protection noted that it had referred CFT and

NBV to the regional Victorian Aboriginal Service, Early Years Cradle to Kinder program, a support worker attended the family at least once per week (prior to COVID-19) and the Enhanced Maternal Health Nurse visited twice per week (prior to COVID-19).

66. Child Protection noted that there were several positive notes in the file about CFT's parenting but nevertheless took steps to refer the parents to parenting services. On 20 November 2019, Child Protection discussed options for a Queen Elizabeth Centre or Tweddle parenting assessment for the family. There were concerns about these services not being culturally appropriate for the family and suggested other options. Child Protection further noted Maternal Child Health also visited three times per week and discussed safe sleeping, appropriate feeding and dressing.

Reliance upon CFT as the 'protective parent'

67. Child Protection noted there were records suggesting that they acted against CFT's wishes in order to protect the children, for example, not supporting CFT's desire to withdraw the FVIO in place against NBV. Child Protection further noted there was an extensive culturally safe support network around the parents and children including the Department of Justice and Community Safety, several regional Victorian Aboriginal Service programs, a local general practitioner, a counsellor, Family Services Men's Behaviour and the Melbourne hospital.

68. Child Protection submitted that it made decisions that went against CFT's wishes and therefore was not overly reliant upon CFT to ensure the children's safety.

Consultation with a specialist family violence advisor

69. Child Protection conceded that it did not consult with a specialist family violence advisor and noted that there were limitations to access this role during 2019 and 2020 due to recruitment issues. Since August 2023, this has improved, and the role has been filled.

Impact of stressors on the family

70. Child Protection submitted that their records indicate that the stressors impacting CFT were indeed considered. It explained that the infants were classified as 'required an Intensive Infant Response' due to the stressors and risk. When the first COVID-19 lockdown occurred in Victoria in March 2020, NBV and CFT were flagged as 'red category cases', i.e., that they were high-risk clients.

71. Child Protection disputed that NBV was "*yelling abuse in the background*" during a phone call in April 2020, however accepted that he was heard yelling abuse in the background on other occasions.

72. Child Protection conceded that with the benefit of hindsight, that the advice provided to NBV (to go for a walk) by the regional Victorian Aboriginal Service was not commensurate with the level of risk posed to the children. However, it submitted that this advice was provided by the regional Victorian Aboriginal Service, and not Child Protection and furthermore, it occurred during the first week of the COVID-19 lockdown which was widely accepted to be an unprecedented and challenging time for the Victorian community.

Conclusion about Child Protection's involvement

73. Child Protection requested that I remove the above comments from the finding or make a comment that Child Protection disagrees and that I do not endorse or support the comments.

74. However, I am satisfied these observations should not be removed from the finding. These observations are not considered findings of fact, they are only observations. Furthermore, I am not satisfied that strict and total compliance with all Child Protection policies and procedures would have prevented the final outcome. There is no evidence before me to suggest that a particular action on Child Protection's behalf would have prevented Child A's passing.

75. I am also satisfied that it is relevant and appropriate to include the above commentary as it is not a finding against Child Protection, and it provides relevant context to the significant changes and work undertaken by the Department in the five years since Child A's passing. These changes are discussed further below.

Improvements implemented by Child Protection

76. DFFH and Child Protection noted that they have closely considered Child A's case and have implemented multiple improvements in its practice since his passing, for example:

    a) Changes were implemented to improve Child Protection practice to better respond to family violence, including implementation of the recommendations in the 2015 Royal Commission into Family Violence and the implementation of the Multi-Agency Risk Assessment and Management Framework (**MARAM**) with training for all staff.

    b) An increase in funding to the regional Victorian Aboriginal Service to support local culturally safe services. Since 2020, there has been a 23.4% increase in funding to the

regional Victorian Aboriginal Service from the department. Funding to the regional Victorian Aboriginal Service Family Violence Services has more than doubled since 2020.

c) Increased funding for Aboriginal Identified positions within Child Protection, including the appointment of Aboriginal Children in Aboriginal Care (**ACAC**) positions to support the transition of Aboriginal children to the care of Aboriginal Community Controlled. There has also been recruitment to the new position of Navigator – Aboriginal Response, to support coordination of Aboriginal children and families to the Family Preservation/Reunification Response.

d) There is now a funded in-home Parenting Assessment and Skills Development Service (**PASDS**) for children aged two and under. The regional Victorian Aboriginal Service are funded to provide nine in-home PASDS interventions for child protection clients annually. Further, the regional town's Family Services sector can refer to PASDS Plus, which is an early intervention skills development program for families who are not involved with Child Protection.

77. Since Child A's passing, DFFH noted that there have been many updates to relevant policies and procedures, including the infant risk assessment and response decision, assessing and managing family violence, and responding to Aboriginal children. For example:

a) In November and December 2021, updates were made in relation to the implementation of the SAFER Child Framework.

b) In June 2024, Client Relationship Information System (**CRIS**) document updates were made to reflect changes to infant intensive response policies, panels, and templates.

c) In July 2024, updates were made to the implementation of the *Statement of Recognition Act 2023*.

78. DFFH has also developed several CRIS upgrades to improve the visibility of infants assessed as being high-risk infants. The CRIS upgrades include a new compliance dashboard providing practitioners and managers a summary view of clients that identify outstanding or incomplete compliance measures and activities. Lack of action by a practitioner against a compliance activity (such as a weekly home visit) will result in a non-compliance record visible to the allocated practitioner and their line manager.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Child A, born [redacted];

    b) the passing occurred on 11 April 2020 at [redacted] [redacted], from *unascertained in the setting of a remote head injury*; and

    c) the passing occurred in the circumstances described above.

RECOMMENDATIONS

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

(i) That the **Victorian Government** expand funding for the Dardi Munwurro program across Victoria to support First Nations men to address their use of violence regardless of their location.

(ii) I recommend the **Victorian Government** continue to work with the **Commonwealth Government** to strengthen multi-agency responses to family violence in Victoria.

COMMENTS

Pursuant to section 67(3) of the Act, I make the following comments.

(i) I support and endorse the recommendation by the federal government's expert panel which recently undertook a rapid review of evidence-based approaches to prevent gender-based violence, namely:

> *The Commonwealth and state and territory governments to work together to strengthen multi-agency approaches and better manage risk, with a lens on harm and safety, for victim-survivors of [domestic, family and sexual violence], including risk of homicide and suicide…*
>
> a. *the introduction and expansion of multi-agency responses, including fit for purpose police co-responder models – with an immediate focus on collaborative responses that increase access to forensic examinations (states and territories).*

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

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

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

CFT, Senior Next of Kin

Chief Commissioner of Police

Commission for Children and Young People

Commonwealth Government

Department of Families, Fairness and Housing

Department of Justice and Community Safety (C/- Russell Kennedy Lawyers)

Hospital

Sergeant Hannah Thompson, Coroner's Investigator

Victorian Government

Signature:

Judge John Cain
State Coroner
Date: 7 April 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 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.