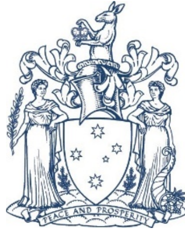

IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2016 3084

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:	D2
Date of birth:	12 July 2015
Date of death:	5 July 2016
Cause of death:	1(a) Intra-abdominal haemorrhage due to transection of the abdominal aorta and laceration of the right kidney due to severe blunt force trauma to the torso
Place of death:	Bairnsdale Hospital, Victoria
Catchwords:	family violence; filicide; Aboriginal child death

INTRODUCTION

1. D2 was 11 months old and living in Victoria with his mother, M1, his two-year-old half-sister, M2 and JN at the time of his passing.

2. M1 and JN were intermittently engaged in an intimate relationship from approximately April 2014 until the time of D2's passing.[1] Prior to the commencement of this relationship, M1 had a daughter from a previous partner, M2.

3. Between 30 March 2014 and 10 August 2014, there were three incidents of family violence reported to Victoria Police between M1 and JN.[2] M1 was identified as the Respondent in the first two of these incidents, having allegedly perpetrated controlling behaviours and verbal abuse towards JN.[3]

4. M1 and JN reportedly separated during this period and on 12 July 2015, D2 was born. Mr D1, who identified as Aboriginal, was identified as D2's biological father.[4] D2 was also Aboriginal.[5] It appears that D2 had very limited contact with his biological father prior to his passing.[6]

5. On 10 August 2014, M1 reported to police that JN had physically assaulted her in the presence of her daughter. A Family Violence Intervention Order was issued in protection of M1 and M2, and JN was charged with assault.[7]

6. JN recommenced a relationship with M1 in approximately November 2015 and moved in with the family in January 2016.[8] From this time, JN assumed a primary care role within D2 and M2's life and was responsible for daily care activities for both children.[9]

7. On 29 February 2016, a notification was made to Child Protection.[10] This was the first notification made in relation to D2 and related to concerns for the children's welfare after M2 was found alone outside of the family home. She was aged two at the time. This report remained open with Child Protection at the time of D2's passing.[11]

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[1] Coronial Brief, Statement of S Powell, 78.
[2] Victoria Police, LEAP records of Ms M1 and Mr JN.
[3] Victoria Police, LEAP records of Ms M1 and Mr JN – family violence incident report 30.03.2014; Victoria Police, LEAP records of Ms M1 and Mr JN – family violence incident report 30.07.2014.
[4] Department of Health and Human Services – Child Protection, Records of D2, 140, 142, 213, 221, 231.
[5] Department of Health and Human Services – Child Protection, Records of D2, 6, 11, 17, 76, 117, 129, 136, 140, 163.
[6] Department of Health and Human Services – Child Protection, Records of D2, 142.
[7] Victoria Police, LEAP records of Ms M1 and Mr JN – Intervention order and other criminal offences 10.08.2014
[8] Coronial Brief, Statement of S Powell, 80; Coronial Brief, Interview with the Accused JN, 188.
[9] Coronial Brief, Statement of S Powell, 80; Coronial Brief, Interview with the Accused JN, 189.
[10] Department of Health and Human Services – Child Protection, Records of D2, 204-223.
[11] Department of Health and Human Services – Child Protection, Records of D2, 204-223.

8. In approximately June 2016, M1 began an intimate relationship with another man.[12] It is unclear whether JN and M1 were in a relationship at this point as both parties have presented conflicting accounts.[13]

THE CORONIAL INVESTIGATION

9. D2's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (the Act). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

10. 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.

11. 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.

12. The Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of D2's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

13. This finding draws on the totality of the coronial investigation into the death of D2, including evidence contained in the coronial brief and further evidence obtained under my direction. 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. [14]

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[12] Coronial Brief, Statement of PS, 96-97.

[13] Sentencing Remarks, *the Director of Public Prosecutions v JN* [2018] VSC 466

[14] 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.

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

Circumstances in which the death occurred

14. On 5 July 2016, M1 had spent the early part of the day with the two children. JN got up at about 3.30pm in the afternoon. M1 had put the children down for their afternoon nap.[15]

15. D2 woke up at about 5.30 pm and would not take the milk that M1 offered to him. M1 took him into the lounge room, placed him in his walker, and gave him food to eat. M1 then went to M2's bedroom down at the back of the house to sort out some of M2's clothes.[16] M1 was in the bedroom for about an hour. The bedroom door was open and M1 could hear JN talking to D2, who was laughing.[17] M1 thought that the two of them were either in the lounge room or in D2's bedroom, which was across from the lounge room and the kitchen, and at the opposite end of the passageway where M2's bedroom was.[18]

16. M1 then heard JN use the microwave. At about that time, M2 closed the bedroom door. About five minutes later, M1 heard JN coming down the passageway.[19] She heard him call out to her, asking her to call an ambulance and to open the bedroom door. When M1 opened the door, JN appeared carrying D2 in his arms who did not appear to be breathing.[20] JN said that he did not know what had happened to D2. He said that he had been playing with D2, had changed him, and left him in his bedroom while M1 went to make a bottle of milk. He said that when he returned, D2 had stopped breathing.[21]

17. At approximately 7.29pm, M1 called 000 as JN carried D2 to the lounge room and placed him on the floor. As M1 tilted D2's head back in order to commence cardio-pulmonary resuscitation ('CPR') as instructed by the 000 operator, she saw D2 take a gasp of air, but did not see any further breathing.[22]

18. At 7.41 pm, the first two ambulance officers and paramedics arrived and took over from M1.[23] Another four emergency responders arrived over the next 20 minutes. Both M1 and JN told one of the paramedics that D2 had not suffered any trauma and that there was nothing they could

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[15] *Coronial Brief*, Statement of M1 dated 19 August 2016, 61
[16] Ibid, 61-62
[17] Ibid, 62
[18] Ibid
[19] *Coronial Brief*, Appendix D – Transcription of interview with M1 on 8 July 2016, 169-172
[20] Ibid
[21] *Coronial Brief*, Appendix E – Transcription of interview with JN 7 July 2016, 191-196
[22] *Coronial Brief*, Appendix C, 120-136
[23] *Coronial Brief*, Statement of Paramedic Ben Patrick dated 8 July 2016, 49

tell him.[24] JN said that he had been holding D2, that he was fine but had then struggled to breath, so he had put him down. JN again said that there had been no trauma or anything unusual before that.[25]

19. D2 was then transported by ambulance to the Bairnsdale Hospital, where medical professionals confirm that he had passed away.[26]

20. JN was arrested on 8 July 2016 after a post-mortem autopsy performed by Dr Heinrich Bouwer, a forensic pathologist from the Victorian Institute of Forensic Medicine (**VIFM**) revealed that the cause of D2's death was linked to blunt force trauma to the torso.[27]

21. At criminal trial in the Supreme Court of Victoria, Dr Bouwer was of the opinion that the complete transection of the aorta and damage to the spine was caused by either bending the spine with the subject on his back or by applying force to the spine from the back.[28] In either case, the injuries would be caused by hyperextension of the spine. The force had been sufficient to snap the ligaments supporting the spine.[29]

22. On 25 July 2018, in the Supreme Court of Victoria, JN was found guilty of D2's murder and was sentenced to a term of imprisonment of 30 years with a non-parole period of 26 years.[30]

Identity of the deceased

23. On 5 July 2016, Ms M1 visually identified the deceased to be her son, D2 born 12 July 2015.

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

Medical cause of death

25. Forensic Pathologist Dr Heinrich Bouwer from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an autopsy on 7 July 2016 and provided a written report of his findings dated 27 October 2016.

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[24] Ibid, 51-52; Statement of Paramedic Phillip Clark dated 9 July 2016, 56
[25] Ibid
[26] *Coronial Brief*, Statement of Senior Constable John Hooper dated 29 July 2016, 101
[27] Medical Examiners Report prepared by Dr Bouwer which confirms his autopsy was performed on 7 July 2016; *Coronial Brief,* Statement of Detective Senior Constable Matthew Garbutt dated 17 August 2016, 103-104
[28] *DPP v JN* [2018] VSC 466, 5
[29] Ibid, 5-6
[30] Ibid

26. Dr Bouwer noted the following:

(a) The abdominal aorta was completely transected in the immediate vicinity of acute fractures of the lower thoracic and lumbar spine. There was approximately 350 mL of blood within the peritoneal cavity and approximately a further 150 mL of blood in the retroperitoneal space. Evidence of previous haemorrhage in this region evidenced by macrophages which stained positive for iron with Perl's stain in the areas of fibrosis or scar tissue in this region. The only plausible cause for this scar tissue is noted as previous blunt force trauma.

(b) There was a laceration of the right kidney with associated haemorrhage.

(c) The lesser omentum adjacent to the stomach was lacerated and the proximal small bowel was bruised and the overlying serosa also lacerated. There was further evidence that the diaphragm was also bruised.

(d) There were multiple bilateral rib fractures and spinous process fractures of the lower spinal column. Many of these fractures showed evidence of healing characterised by callous formation and/or periosteal reaction.

(e) There were small bruises underneath the scalp over many different places but there was no skull fracture of intracranial haemorrhage.

27. The proposed mechanisms in this instance that have caused the transection of the abdominal aorta, kidney laceration and fractures of the lower lumbar spine are most likely due to hyperextension/hyperflexion and/or blunt impact to the abdomen.

28. Toxicological analysis indicated that there was a trace level of alcohol detected in blood cavity at a level of 0.02%. This is most likely from postmortem fermentation but consumption prior to death cannot be entirely excluded. No other common drugs or poisons were detected.

29. Dr Bouwer provided an opinion that the medical cause of death was '1(a) Intra-abdominal haemorrhage due to transection of the abdominal aorta and laceration of the right kidney due to severe blunt force trauma to the torso'.

30. I accept Dr Bouwer's opinion.

FURTHER INVESTIGATIONS AND CPU REVIEW

Family violence investigation

31. As D2's death occurred in circumstances of recent family violence, I requested that the Coroners' Prevention Unit (**CPU**) [31] examine the circumstances of D2's death as part of the Victorian Systemic Review of Family Violence Deaths (**VSRFVD**).[32]

32. The available evidence suggests that M1 and JN's relationship was tumultuous and characterised by numerous family violence incidents.

33. D2's relationship with JN met the definition of '*family member'* under the *Family Violence Protection Act 2008* (Vic) (**the FVPA**).[33] The family violence perpetrated by JN towards D2 in the fatal incident by fatally assaulting him met the definition of '*family violence'* in the FVPA.

34. An in-depth family violence investigation was conducted in this case and I requested materials from several key service providers that had contact with D2, M1 and JN prior to D2's death.

M1 and D2's engagement with Child Protection

35. M2 had been subject to three reports to Child Protection prior to the last report made on 29 February 2016. These reports surrounded concerns that M2 had been exposed to family violence between M1 and her partner, that M2 had been in contact with a registered sex offender, that M1 continued to expose M2 to males who presented as a potential risk, that the family was experiencing transience and that M2 had been exposed to parental drug use.[34]

36. In the most recent notification, it was reported that M2 was found alone with rubber bracelets around her arm that were preventing circulation to her hand. Witnesses also described the family home as '*filthy'* and Child Protection were informed that a registered sex offender was residing at the address.[35]

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[31] 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.

[32] 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.

[33] Section 8(1)(d) of the *Family Violence Protection Act 2008*

[34] Department of Health and Human Services – Child Protection, Records of D2, 208-210.

[35] Department of Health and Human Services – Child Protection, Records of D2, 204-223.

37. At intake, D2 was deemed a High Risk Infant due to his age and that he was '*highly vulnerable to risk of harm in the care of the mother and her defacto partner JN'*.[36]

38. On 2 March 2016, the matter was transferred for further investigation due to concerns that the children were being exposed to a registered sex offender and '*concerns around poor supervision and environmental neglect'*.[37] As per the policies in place at the time, this decision was communicated to the Victorian Aboriginal Child Care Association (VACCA) on the same day.[38]

39. On 3 March 2016, Child Protection undertook their first visit with the family.[39] During this visit JN and M1 signed a protective plan outlining that they would ensure that both children had no contact with the registered sex offender and would re-engage with Maternal and Child Health Services.[40] Child Protection assessed that it was '*safe for the children to remain in M1's care however support services are needing to be put in place to support M1's ongoing capacity to care for the children'*.[41] In the follow up actions for this visit, Child Protection identified the need to re-consult with VACCA, however this did not occur until 14 April 2018.[42]

40. A further visit was conducted on 6 April 2016.[43] No concerns were noted for the family during this visit, however M1 was observed to be isolated and it was agreed that Child Protection would refer the family to Child FIRST. Follow up actions for this meeting also included consulting with VACCA.[44]

41. On 14 April 2016, Child Protection emailed VACCA advising the agency of the matter, noting that D2's father identified as Aboriginal and requesting further insight into the family.[45]

42. On 15 April 2016, a referral to Child FIRST was submitted and this was accepted by the agency on 21 April 2016.[46]

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[36] Department of Health and Human Services – Child Protection, Records of D2, 174.
[37] Department of Health and Human Services – Child Protection, Records of D2, 172.
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[39] Department of Health and Human Services – Child Protection, Records of D2, 157-160.
[40] Department of Health and Human Services – Child Protection, Records of D2, 156.
[41] Department of Health and Human Services – Child Protection, Records of D2, 160.
[42] Department of Health and Human Services – Child Protection, Records of D2, 160.
[43] Department of Health and Human Services – Child Protection, Records of D2, 142.
[44] Department of Health and Human Services – Child Protection, Records of D2, 142.
[45] Department of Health and Human Services – Child Protection, Records of D2, 140.
[46] Department of Health and Human Services – Child Protection, Records of D2, 125.

43. On the same day, a High Risk Infant consultation occurred between Child Protection workers. During the meeting, M1's history of childhood trauma was noted to potentially impact on her parenting capacity and several follow up actions were identified.[47]

44. On 22 April 2016, Child Protection consulted with VACCA who advised that they were unaware of the family and would try to seek further information. During this conversation, VACCA advised that they would be '*interested in doing a joint visit*'[48] with Child Protection, however this does not appear to have occurred prior to the fatal incident.

45. On 8 June 2016, Child Protection attended the family home with Child FIRST to introduce the agency and to provide a handover. No concerns were noted during this visit, however, both M1 and JN appeared disengaged. Child Protection advised the family that they would only close when they had engaged with Child FIRST.[49]

46. On 4 July 2016, Child Protection sought an update from Child FIRST regarding a meeting held with the family on 15 June 2016. No concerns were noted and M1 had agreed to continue with the referral and work towards gaining her license.[50]

47. Child Protection had no further contact with the family prior to the fatal incident.

M1 and D2's engagement with Child FIRST

48. Child FIRST is a voluntary service that operates as a central intake point for all child and family support programs. Following receipt and acceptance of a referral, Child FIRST will contact a family and undertake an assessment with them to identify support needs and refer them to an appropriate program.

49. On 15 April 2016, Child Protection referred M1 and her children to Child FIRST.[51] Child FIRST made an unsuccessful attempt to contact M1 on 20 May 2016 and were able to successfully contact her on 1 June 2016.[52] On 8 June 2016, Child FIRST attended M1's home for an introductory visit in the company of Child Protection and arranged a date for further assessment.[53]

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[47] Department of Health and Human Services – Child Protection, Records of D2, 126.
[48] Department of Health and Human Services – Child Protection, Records of D2, 124.
[49] Department of Health and Human Services – Child Protection, Records of D2, 92.
[50] Department of Health and Human Services – Child Protection, Records of D2, 86.
[51] Department of Health and Human Services – Child Protection, Records of D2, 128-132.
[52] Gippsland Lakes Complete Health, Child First Records of D2, 12-13 & 11.
[53] Ibid, 8.

50. On 15 June 2016, Child FIRST visited M1 again to undertake an assessment. During this meeting, M1 was observed to behave appropriately with D2 and M2 and advised that she would like support to obtain her driving license and material aid.[54] During the visit, M1 also informed the worker that JN often cared for the children once they were in bed as she would leave to visit her friend. No concerns were noted during this interaction, and it was agreed that Child FIRST would complete a referral to an appropriate agency. Child FIRST had no further contact with the family prior to the fatal incident.[55]

51. The available evidence suggests that there appears to be a delay in the provision of services to M1 and her children in the circumstances of this case. Child FIRST was established to provide early intervention with families in need, in order to prevent the escalation of their risk and the involvement or further intervention of Child Protection. In this instance, Child Protection had a delay of over two months from the receipt of the referral to the time of assessment and faced a further delay in obtaining assistance for the family. In this period, M1 was not accessing support to address the concerns identified by Child Protection.

52. The 2015 *Early Intervention Services for Vulnerable Children and Families* review completed by the Victorian Auditor General's Office (**VAGO**) undertook a review of the effectiveness of Child FIRST services.[56] This review found that the establishment of Child FIRST services as a provider of early and preventative interventions to families at risk was not realised and that the Government had failed to '*forecast or respond to demand'*.[57]

53. Increased staffing of Child Protection, along with the establishment of Safety and Support Hubs (otherwise known as Orange Doors) has, in part, sought to rectify these issues. At present, there are seven Support and Safety Hubs currently in operational in Victoria, with 10 more to be introduced by 2022. The design of these Safety and Support Hubs sees family violence and family services (Child FIRST) coming together to provide collaborative support to women and families requiring assistance.

54. In May 2020, VAGO undertook a review of the established Safety and Support Hubs and found that the Hubs were not helping children affected by family violence or whose families need support to care for them '*as well as they could'*.[58] The Auditor General also identified that employees within the hubs had not been provided with a tool '*separate to family violence risk*

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[54] Ibid, 4.
[55] Ibid, 4.
[56] Victorian Auditor-General's Office, 'Early Intervention Services for Vulnerable Children and Families' (2015).
[57] Victorian Auditor-General's Office, 'Managing Support and Safety Hubs' (2020), 29.
[58] Victorian Auditor-General's Office, 'Managing Support and Safety Hubs' (2020), 14.

assessment tools'[59] in order to assess for child wellbeing risk and that the Hubs focused heavily on family violence, whilst failing to consider the welfare needs of children when family violence was not present. Data limitations within the Hubs has also meant that the effectiveness and timeliness of engagement with children by these services has not yet been established.

55. Several other significant issues with the design, implementation, staffing and operation of the Hubs have meant that they have been unable to meet the founding objectives of their design, resulting in clients receiving inconsistent service and lengthy response times.

56. The VAGO made nine recommendations to Family Safety Victoria with a view to improving service delivery and increasing the success of future Hubs. In relation to demand management, VAGO recommended that the Hubs establish '*measures and targets for service backlog and timeliness'*[60] and ensure that performance against these measures is promoted in regular service delivery reports. In addition, VAGO recommended that the Hubs update client relationship management systems so that '*it can track when clients are awaiting a response because of capacity issues at external services'*.[61] The Department of Fairness, Families and Housing (**DFFH**) accepted all nine recommendations with a plan for a staged implementation to be complete by June 2022.

57. I support the recommendations made by VAGO to Family Safety Victoria and DFFH.[62]

COMMENTS

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

Child Protection services and Aboriginal children

58. Aboriginal children are '*significantly overrepresented in the child protection and out-of-home care population'*.[63] A range of policies and practice guides have been developed with the aim of addressing this overrepresentation, to avoid Child Protective practices employed during the Stolen Generation, and to improve the outcomes of children who identify as Aboriginal. These policies and procedures are supported by the obligations set out in the Child Protection Manual

[59] Ibid.
[60] Ibid, 17.
[61] Ibid.
[62] Victorian Auditor-General's Office, 'Early Intervention Services for Vulnerable Children and Families' (2015).
[63] Department of Families, Fairness and Housing – Child Protection, *Aboriginal children policy* (1 March 2016) <https://www.cpmanual.vic.gov.au/policies-and-procedures/aboriginal-children/aboriginal-children-policy>.

and the *Protocol between the Department of Human Services Child Protection Services and the Victorian Aboriginal Child Care Agency* (**the Protocol**).[64]

59. As per the Protocol and the Child Protection Manual in place at the time of the fatal incident and currently in place, Child Protection practitioners working with children who identify as Aboriginal are required to regularly consult with an ACSASS in order to ensure that a child's cultural wellbeing is considered and that their connection to their community is not disrupted.

60. I note that Child Protection practitioners are specifically instructed to consult with an ACSASS '*prior to making significant decisions*'[65] for a family. A '*significant decision*'[66] includes a decision to involve '*other agencies and services*'[67] in the care of the family, conduct home visits and progress a matter for case investigation. Child Protection workers are also advised to share information with an ACSASS, seek their participation in the management of the family and organize for an ACSASS to '*attend client visits*'.[68]

61. Child Protection are also required to consult with an ACSASS in a timely manner to ensure the best outcome for the child.[69] This consultation is required to occur until the child is no longer engaged with Child Protection or it has been confirmed that the child does not identify as Aboriginal.

62. The available evidence indicates that Child Protection did not engage the relevant ACSASS, in this instance the Victorian Aboriginal Child Care Agency (**VACCA**), in a meaningful way during their involvement with D2 and his family from 29 February 2016 to the time of his passing. As such, the evidence suggests that Child Protection's service engagement with D2 and his immediate family did not meet the requirements of the Protocol or the standards of what is considered to be best practice in the area of child and family services.

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[64] Department of Human Services – Child Protection and the Victorian Aboriginal Child Care Association, *Protocol between the Department of Human Services and the Victorian Aboriginal Child Care Agency*, (11 April 2002).

[65] Department of Health and Human Services – Child Protection, *Additional requirements for Aboriginal children* (16 March 2016) <https://web.archive.org/web/20160701023131/http://www.cpmanual.vic.gov.au/policies-and-procedures/aboriginal-children/additional-requirements-aboriginal-children>.

[66] Department of Health and Human Services – Child Protection, *Additional requirements for Aboriginal children* (16 March 2016) <https://web.archive.org/web/20160701023131/http://www.cpmanual.vic.gov.au/policies-and-procedures/aboriginal-children/additional-requirements-aboriginal-children>.

[67] Department of Health and Human Services – Child Protection, *Additional requirements for Aboriginal children* (16 March 2016) <https://web.archive.org/web/20160701023131/http://www.cpmanual.vic.gov.au/policies-and-procedures/aboriginal-children/additional-requirements-aboriginal-children>.

[68] Department of Health and Human Services – Child Protection, *Additional requirements for Aboriginal children* (16 March 2016) <https://web.archive.org/web/20160701023131/http://www.cpmanual.vic.gov.au/policies-and-procedures/aboriginal-children/additional-requirements-aboriginal-children>.

[69] Department of Health and Human Services – Child Protection, *Program Requirements for the Aboriginal Child Specialist Advice and Support Service* (February 2019) https://www.cpmanual.vic.gov.au/sites/default/files/2019-11/2850%20ACSASS%20program%20requirements%20-%20revised%20February%202019.pdf.

63. VACCA have provided a statement to the Court in review of their engagement with Child Protection in relation to this matter and the ongoing challenges they face in collaborating with Child Protection in order to support the cultural wellbeing and safety of Aboriginal children.

64. VACCA conceded that they had did seek further information in relation to D2 as agreed with Child Protection on 22 April 2016 and cited several reforms within their service to ensure that staff proactively seek updates from Child Protection regarding children known to their service.[70]

65. VACCA also cited several challenges in working with Child Protection in relation to D2, noting that they were unable to '*provide culturally attuned input into risk assessments during consultations'*[71] with Child Protection as their service was provided with limited information regarding D2 and the circumstances of his involvement with Child Protective services.[72]

66. VACCA also confirmed that Child Protection did not consult with their service in a timely manner and did not involve them in several significant decisions as they were required to under the Protocol.[73]

67. In submissions to the Court, both VACCA and Child Protection note a range of improvements in practice and policy in response to these inadequacies and note that these changes have supported greater collaboration and coordination between their services.[74]

68. Child Protection advise that they have increased the training provided to practitioners in relation to the additional requirements of workers when engaging with Aboriginal children and families. In addition to this, program guidelines between ACSASS providers and Child Protection have been updated and strategies to improve partnerships between Child Protection and ACCOs have also been established.[75]

69. The 2016 *Always was, always will be Koori children* report by the Commission for Children and Young People (**CCYP**), which specifically considers the needs of Aboriginal children in out-of-home-care, found that '*the child protection system fails to preserve, promote and develop cultural safety and connection for Aboriginal children*.'[76] This report highlighted '*Deficient*

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[70] Victorian Aboriginal Child Care Agency, Report of Belinda Jose and Belinda Kostos dated 28 July 2021, 4 & 6-7.
[71] Ibid, 5 & 9.
[72] Ibid, 9.
[73] Ibid.
[74] Victorian Aboriginal Child Care Agency, Statement of Belinda Jose and Belinda Kostos, 9; Department of Families, Fairness and Housing, Statement of Tracy Beaton dated 12 June 2021
[75] Ibid.
[76] Ibid, 11.

*practices by [the Department of Health and Human Services] and [Community Service Organisations], including non-compliance with legislative and practice requirements for cultural planning and inadequate inclusion and engagement with Aboriginal family, programs and community in decision-mak*ing'.[77] The CCYP note that these failures '*have resulted in the dislocation from culture and family for large numbers of Aboriginal children in out-of-home care'*.[78]

70. In 2018, the Victorian Government, in partnership with Victorian Aboriginal communities and the child and family service sector released the *Wungurilwil Gapgapduir: Aboriginal Children and Families Agreement*.[79] This agreement outlined several principles including a commitment 'to address the current and historical funding inequities and barriers so Aboriginal organisations and communities are fully resourced to deliver a continuum of services'.[80] The implementation of this agreement is overseen by the Aboriginal Children's Forum who review key performance measures and other accountability criteria.[81]

71. In line with this agreement in December 2020, the Victorian Government announced funding for a pilot program that '*will see Aboriginal-led teams respond to child protection reports*.'[82] Under this pilot program '*Aboriginal-led teams will respond to child protection reports, in partnership with the Department of Health and Human Services, and help local families who may become involved in the child protection or care services system*.'[83]

72. Despite these changes, VACCA have advised the Court that there are a range of challenges that continue to inhibit their ability to work effectively with Child Protection to provide culturally informed responses to children and their families.[84] Most notably, VACCA have stated ongoing difficulties in meeting the breadth of their obligations under the Protocol given the limited resourcing received by their organization.[85] VACCA reported that in 2016 a typical ACSASS practitioner at their service was responsible for case managing approximately 100 children and families, noting that there had only been a slight decrease in these ratios since.[86] These high

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[77] Ibid.
[78] Ibid.
[79] Victorian Government, *Wungurilwil Gapgapduir: Aboriginal Children and Families Agreement,* (Melbourne, 2018) <https://www.dhhs.vic.gov.au/sites/default/files/documents/201804/Aboriginal%20Children%20and%20Families%20Agreement%202018_1.pdf>.
[80] Ibid, 7.
[81] Ibid, 21.
[82] Premier of Victoria, *Nation First Initiative for Aboriginal Child Protection* (10 December 2020) <https://www.premier.vic.gov.au/nation-first-initiative-aboriginal-child-protection>.
[83] Ibid.
[84] Victorian Aboriginal Child Care Agency, Statement of Belinda Jose and Belinda Kostos,8-9.
[85] Ibid, 9.
[86] Ibid.

caseloads and the limited resourcing available to respond to this demand were cited as having significant impacts on VACCAs capacity to support Aboriginal children engaged with Child Protection and provide the range of services they are required to under the Protocol.[87]

73. In addition to these challenges, VACCA also advised that Child Protection regularly do not meet their contractual obligations to ACSASSs by not seeking regular consultation from VACCA in a timely manner and by not including them in '*significant decisions'* pertaining to the care and welfare of Aboriginal children.[88]

RECOMMENDATIONS

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

Child Protection

Given the ongoing challenges faced by both ACSASS and Child Protection in complying with the Protocol, I recommend that the Department of Families, Fairness and Housing (**DFFH**) review the current case management systems to ensure that compliance with the *Protocol between the Department of Human Services Child Protection Services and the Victorian Aboriginal Child Care Agency* can be accurately recorded, reported and reviewed.

I also recommend that DFFH regularly audit staff compliance with the obligations of the above protocol to ensure that mandated objectives are being met and any concerns identified in specific catchments areas can be addressed in a timely manner.

Victorian Government

I recommend that the Victorian Government, in line with their commitment to the *Wungurilwil Gapgapduir: Aboriginal Children and Families Agreement and Strategic Action Plan*, review current funding provisions for Victorian ACSASS programs and ensure that adequate resourcing is provided to meet current and projected demand.

[87] Ibid.
[88] Ibid.

FINDINGS AND CONCLUSION

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

    (a) the identity of the deceased was D2, born 12 July 2015;

    (b) the death occurred on 5 July 2016 at the Bairnsdale Hospital, Victoria from 1(a) Intra-abdominal haemorrhage due to transection of the abdominal aorta and laceration of the right kidney due to severe blunt force trauma to the torso; and

    (c) the death occurred in the circumstances described above.

76. Having considered all the available evidence, I am satisfied that no further investigation is required in this case.

77. I convey my sincere condolences to D2's family for their loss.

78. 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.

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

Ms M1, Senior Next of Kin

Mr D1, Senior Next of Kin

The Honourable Gabrielle Williams, MP, Minister for Prevention of Family Violence

The Honourable Anthony Carbines, MP, Minister for Child Protection and Family Services

The Honourable Daniel Andrews, MP, Premiere of Victoria

Ms Sandy Pitcher, Secretary, Department of Fairness, Families and Housing

Ms Leng Phang, Managing Principal Solicitor, Department of Fairness, Families and Housing

Ms Muriel Bamblett, CEO, Victorian Aboriginal Child Care Agency

Ms Belinda Jose, Executive Manager, Victorian Aboriginal Child Care Agency

Ms Belinda Kostos, Senior Program Manager (Gippsland), Victorian Aboriginal Child Care Agency

Detective Leading Senior Constable Mark Berens, Coroner's Investigator

Signature:

JUDGE JOHN CAIN

STATE CORONER

Date: 15/12/2021

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.