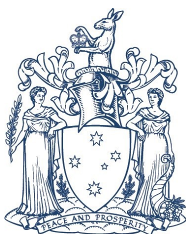

IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2016 0423

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)
Section 67 of the Coroners Act 2008

Findings of:	**JOHN CAIN, STATE CORONER**
Deceased:	**KALEB BAYLIS-CLARKE**
Date of birth:	4 October 2015
Date of death:	30 January 2016
Cause of death:	I(a) Head injury in the setting of chronic subdural haemorrhage
Place of death:	Monash Medical Centre, Clayton, Victoria
Catchwords:	Child homicide; family violence; unexpected; violent; not from natural causes; baby child death; head injury

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HIS HONOUR:

BACKGROUND

1. Kaleb Baylis-Clark (**Kaleb**) was 17 weeks old at the time of his death. Kaleb was born premature at 37 weeks gestation in Berwick on 4 October 2015. Kaleb's parents were Shannon Spackman (**Mr Spackman**) and Erin Baylis-Clarke (**Ms Baylis-Clarke**) whom met in 2013 but separated whilst Ms Baylis-Clarke was pregnant with Kaleb around April 2015.

2. Kaleb was the only child of the relationship between Ms Baylis-Clarke and Mr Spackman. Shortly after their relationship ended, Ms Baylis-Clarke formed a new relationship with Jesse Vinaccia (**Mr Vinaccia**) prior to Kaleb's birth.[1]

3. Mr Vinaccia had a one-year son from a prior relationship at the time he started a relationship with Ms Baylis-Clarke. Mr Vinaccia moved in with Ms Baylis-Clarke around January 2016 and was working intermittently as a brick layer.[2]

4. Ms Baylis-Clarke worked at a local restaurant and after Kaleb's birth, Mr Vinaccia would help look after Kaleb whilst she attended evening shifts at work.[3]

14-17 January 2016 – Monash Health treatment

5. On 14 January 2016 at around 11:00am, Ms Baylis-Clarke noticed an '*egg'* sized lump on Kaleb's head that wasn't present when she put him to sleep an hour prior in his cot. Ms Baylis-Clarke called Mr Vinaccia to drive over as she didn't have a car and transport them to Monash Health Casey Hospital Emergency Department (ED).[4]

6. Ms Baylis-Clarke reported to treating ED doctors that Kaleb had been vomiting recently and was drinking less than half of his usual intake of milk as well as the raised fontanelle[5]. A raised fontanelle alerted the ED doctors to suspect abnormal accumulation of cerebrospinal fluid.[6] The presentation and examination was discussed with the Monash Health Clayton paediatric team.[7] Kaleb underwent an urgent cranial ultrasound at Casey Hospital which showed enlargement of fluid filled spaces in the brain and probable fluid in the subdural

[1] *Coronial brief*, Statement of Erin Lee Baylis-Clarke dated 25 January 2016, 27
[2] Ibid, 28
[3] Ibid
[4] Ibid, 29
[5] Fontanelle is a reference to soft spots on a baby's head where the skull bones haven't fused together.
[6] Cerebrospinal fluid, clear, colourless liquid that fills and surrounds the brain and the spinal cord and provides a mechanical barrier against shock.
[7] Monash Health medical records provided to the Court, 55-56

spaces. Treating ED doctors noted that there were no brain haemorrhages and recommended a Magnetic Resonance Imaging (MRI) for follow up.[8]

7. Kaleb's hospital presentation and imaging results were discussed with the Monash Health, Clayton paediatric neurosurgical team.[9] Kaleb was transferred to Monash Health Clayton and admitted under the care of the general paediatric team with consults by the paediatric neurosurgical team.[10]

8. On 15 January 2016, Kaleb underwent an MRI brain scan under anaesthetic that showed mild ventricular dilatation and bilateral small and benign stable subdural hygromas.[11] No mass or acute brain bleed was identified. The paediatric neurosurgical team deliberated the need for a diagnostic fontanelle tap[12] to exclude blood in the subdural space and planned to perform a tap on 17 January 2016.[13]

9. On 17 January 2016, a paediatric neurosurgical team review concluded a fontanelle tap was not warranted at this time given Kaleb appeared well, with no vomiting and was tolerating his feeds.[14] The impression was that the MRI brain findings were likely benign. Following a final neurosurgical review of Kaleb on the same day, he was discharged home with a plan for follow up in two weeks by the paediatric neurosurgical team in outpatients.[15]

THE PURPOSE OF A CORONIAL INVESTIGATION

10. Kaleb's death constituted a '*reportable death*' under the *Coroners Act 2008* (Vic) (**the Act**), as the death occurred in Victoria and was violent, unexpected and not from natural causes.[16]

11. The jurisdiction of the Coroners Court of Victoria is inquisitorial.[17] The Act provides for a system whereby reportable deaths are independently investigated to ascertain, if possible, the

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[8] Ibid, 55
[9] Ibid, 309-310
[10] Ibid
[11] A collection of cerebrospinal fluid in the subdural space.
[12] Removal of fluid using a needle inserted through the anterior fontanelle.
[13] Monash Health medical records provided to the Court, 313
[14] Ibid, 316
[15] Ibid
[16] Section 4 Coroners Act 2008
[17] Section 89(4) Coroners Act 2008

identity of the deceased person, the cause of death and the circumstances in which the death occurred.[18]

12. It is not the role of the coroner to lay or apportion blame, but to establish the facts.[19] It is not the coroner's role to determine criminal or civil liability arising from the death under investigation,[20] or to determine disciplinary matters.

13. The expression "*cause of death*" refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

14. For coronial purposes, the phrase "*circumstances in which death occurred*,"[21] refers to the context or background and surrounding circumstances of the death. Rather than being a consideration of all circumstances which might form part of a narrative culminating in the death, it is confined to those circumstances which are sufficiently proximate and causally relevant to the death.

15. The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through the observations made in the investigation findings and by the making of recommendations by coroners. This is generally referred to as the Court's "*prevention*" role.

16. Coroners are also empowered:

    (a) to report to the Attorney-General on a death;[22]

    (b) to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice;[23] and

    (c) to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice.[24] These powers are the vehicles by which the prevention role may be advanced.

17. All coronial findings must be made based on proof of relevant facts on the balance of probabilities.[25] In determining these matters, I am guided by the principles enunciated in

[18] See Preamble and s 67, *Coroners Act 2008*
[19] *Keown v Khan* (1999) 1 VR 69
[20] Section 69 (1)
[21] Section 67(1)(c)
[22] Section 72(1)
[23] Section 67(3)
[24] Section 72(2)

Briginshaw v *Briginshaw*.[26] 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 that they caused or contributed to the death.

18. In conducting this investigation, I have made a thorough forensic examination of the evidence including reading and considering the witness statements and other documents in the coronial brief.

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

Identity of the Deceased, pursuant to section 67(1)(a) of the Act

19. On 29 January 2016, Ms Erin Baylis-Clarke visually identified the deceased to be her son, Kaleb Baylis-Clarke, born 4 October 2015.

20. Identity is not in dispute in this matter and requires no further investigation.

Medical cause of death, pursuant to section 67(1)(b) of the Act

21. On 1 February 2016, Dr Linda Iles, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an autopsy upon the Kaleb’s body. Dr Iles provided a written report, dated 3 June 2016, which concluded that Kaleb died from I(a) Head injuries in the setting of chronic subdural haemorrhage.

22. Dr Iles commented on the following:

    (a) Postmortem examination demonstrates severe brain injury. There is severe widespread hypoxic-ischaemic injury, subarachnoid haemorrhage, subdural haemorrhage and haemorrhages secondary to ischaemic injury and secondary venous thromboses;

    (b) Antemortem CT and MRI images related to Kaleb's final presentation to Monash Medical Centre have been reviewed with a paediatric radiologist and these do not demonstrate evidence of significant scalp bruising, thus it is unlikely that any of these small areas of bruising are directly referrable to trauma preceding the deceased's admission on 23 January 2016;

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[25] Re State Coroner; ex parte Minister for Health (2009) 261 ALR 152
[26] (1938) 60 CLR 336

(c) The combined antemortem and autopsy findings can be summarised as a combination of encephalopathy (global cerebral ischaemic injury), bilateral retinal haemorrhages and subdural haemorrhage. Disrupted bridging veins were demonstrated at autopsy. There is no evidence of extracranial injury. There is no evidence of underlying skeletal injury;

(d) The above "triad" of pathological change is thought to be produced through mechanical craniocervical trauma in infants. This is thought to be induced by shaking with or without a cranial impact. The precise mechanism by which this triad of injuries may be produced is not fully understood as accurate biofidelic models do not exist; and

(e) There is no evidence of an underlying coagulopathy on antemortem testing, no evidence of metabolic disease, no evidence of a central nervous system or systemic infection and no evidence of a pre-existing arachnoid cyst, aneurysm, vascular malformation or central nervous system malformation or atrophy on antemortem imaging or at post mortem examination. No history of accidental trauma has been provided that might account for Kaleb's injuries.

23. A toxicological analysis of post-mortem samples from the Kaleb’s body detected the presence of therapeutic medication that would have been administered during an inpatient stay.

24. I accept the cause of death proposed by Dr Iles.

Circumstances in which the death occurred, pursuant to section 67(1)(c) of the Act

25. On 23 January 2016 at approximately 4.30pm, Ms Baylis-Clarke was getting ready to leave for work and noted that before she left, Kaleb appeared fine and was playing on a mat on the floor with Mr Vinaccia.[27]

26. Whilst at work, Ms Baylis-Clarke received a message on her phone at around 6.45pm from Mr Vinaccia, indicating that Kaleb was not well and not breathing.[28] Mr Vinaccia called Ms Baylis-Clarke and she advised him to call an ambulance and that she would leave immediately to head home.[29]

27. Mr Vinaccia contacted emergency services and an ambulance was called out.[30] Mr Vinaccia commenced cardiopulmonary resuscitation whilst under instruction from an emergency services

[27] *Coronial brief*, Statement of Erin Lee Baylis-Clarke dated 25 January 2016, 32
[28] Ibid
[29] Ibid
[30] *Coronial brief*, Statement of Jesse Vinaccia dated 25 January 2016, 57

operator. Ambulance Victoria paramedics arrived at around 6.54pm and continued cardiopulmonary resuscitation for 20 minutes before transferring Kaleb to Monash Health (Clayton).[31] Ms Baylis-Clarke had returned home at this stage whilst Ambulance paramedics had pulled up to the residence.

28. On arrival at Monash Health (Clayton), Kaleb was treated by emergency medical practitioners and they performed several initial investigations including ordering a Computerised Tomography (CT) brain scan which identified bilateral subdural haematomas[32] and MRI imaging which was performed on 24 January 2016.[33]

29. The MRI scans from the 24 January 2016 were compared to the previous 15 January 2016 imaging and the 24 January 2016 MRI showed subdural collections were increased in size in addition to signs of an extensive hypoxic brain injury.[34] In the initial discussion between the Paediatric Intensive Care Unit (PICU) doctors with Ms Baylis-Clarke and Mr Vinaccia it was explained the subdural haemorrhages were new and not seen in the 15 January 2016 MRI.[35]

30. The occurrence of a sudden cardiorespiratory arrest and the presence of unexplained subdural haemorrhages along with a skull fracture in an infant raised concern for non-accidental injury.

31. On 25 January 2016, Kaleb was referred to Victorian Forensic Paediatric Medical Service (VFPMS)[36] for medical assessment and physical examination.[37]

32. Given Kaleb was critically ill and unstable in PICU, a limited examination was performed by a specialist from the VFPMS in the presence of PICU staff and Kaleb's family. A review by an ophthalmologist consultant on the same day identified multiple retinal haemorrhages in Kaleb's eyes.[38] The subsequent VFPMS report noted that, '*the presence of sudden unexplained collapse, intracranial haemorrhages, retinal haemorrhages and cerebral hypoxic ischaemic injury in an infant indicated head trauma that was* ***almost certainly caused by acceleration-deceleration and rotational forces***. [emphasis added]'[39]

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[31] *Coronial brief,* Statement of Andrew Paul Teese dated 2 February 2016, 172-173
[32] Bleeding inside the skull
[33] Monash Health medical records provided to the Court, 135-136
[34] Hypoxic brain injuries are brain injuries that form due to a restriction on the oxygen being supplied to the brain
[35] Monash Health medical records provided to the Court, 135-165
[36] The VFPMS has state-wide responsibilities in relation to forensic medical assessments and care for abused, assaulted and neglected children. The service is based at the Royal Children's Hospital
[37] Monash Health medical records provided to the Court, 163
[38] Monash Health medical records provided to the Court, 151
[39] Monash Health medical records provided to the Court, 160

33. Over the following days, Kaleb's condition did not improve and following extensive family meetings with medical staff at Monash Health (Clayton), a decision was made to withdraw intensive care support. Kaleb died on 30 January 2016 at 10.02am.

34. Mr Vinaccia was later charged by Victoria Police with recklessly causing serious injury to Kaleb and child homicide.[40]

COMMENTS PURSUANT TO SECTION 67(3) OF THE ACT

35. The unexpected, unnatural and violent death of a young child is a devastating event. Violence perpetrated by a family member is particularly shocking, given the family unit is expected to be a place of trust, safety and protection.

36. For the purposes of the *Family Violence Protection Act 2008*, the relationship between Kaleb and his parents was one that fell within the definition of family member[41] under that Act. Moreover, the non-accidental injuries inflicted by Mr Vinaccia that led to Kaleb's death constitutes family violence.[42]

37. In light of Kaleb's death occurring under circumstances of family violence, I requested that the Coroners' Prevention Unit (**CPU**)[43] examine the circumstances of Kaleb's death as part of the Victorian Systemic Review of Family Violence Deaths (**VSRFVD**). 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.

Family violence and filicide

38. Family violence literature on filicide defines it to be the murder of a child older than 12 months of age by a parent or step-parent, the circumstances of Kaleb's death meets this definition.[44] Available statistics indicate that filicides affect female and male children

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[40] *Coronial Brief*, Criminal Prosecution Charge-Sheet, 16
[41] *Family Violence Protection Act 2008,* section 8.
[42] *Family Violence Protection Act 2008*, section 5(1)(a)(i)
[43] The Coroners Prevention Unit is a specialist service for Coroners established to strengthen their prevention role and provide them with professional assistance on issues pertaining to public health and safety
[44] Dominique Bourget, Jennifer Grace and Laurie Whitehurst, 'A review of maternal and paternal filicide.' (2007) 35(1) *Journal-American Academy of Psychiatry and the Law* 74.

equally[45], whilst younger children were found to be at greater risk of fatal harm from their mothers and older children at greater fatal risk from their fathers.[46] In addition to this, the majority of victims of filicide are below six years of age.[47]

39. Whilst research into filicides is considerably underdeveloped, a study of 378 cases of filicide in Canada provides evidence that step-parents are more likely to cause fatal injury to a child than genetic parents. This same study also evidences that step-parents kill younger children at a higher rate than genetic parents who kill their children.[48]

40. Research also suggests that step-parents are found to use more violent ways of killing their step-children compared to genetic parents who kill their children.[49] Step-parents were more likely to kill a child by beating or bludgeoning them and in another study were found to be "*more likely to kill after maltreating the child*."[50]

41. Whilst there is limited Australian research on filicides, research surveying Canadian trends in filicide between 1961 and 2011 found that the proportion of step-fathers killing their step-children has increased from 11 per cent between 1974 and 1983, to 29 per cent from 2004 to 2011.[51] This research suggests that a rise in blended families has been a contributing factor to the increase in filicide deaths involving a step-parent.[52]

42. The Australian Institute of Criminology published a report last year on Filicide Offenders[53] which confirmed that a study of 42 filicide deaths by the Monash Filicide Research Project[54] identified nine children were killed by a step-father that filicide occurs when difference

[45] A. S. C. Ciani and L. Fontanesi, 'Mothers who kill their offspring: testing evolutionary hypothesis in a 110-case Italian sample.' (2012) 36 (6) *Child abuse & neglect*, 519-527.
[46] A. Debowska, D. Boduszek and K. Dhingra, 'Victim, perpetrator, and offense characteristics in filicide and filicide–suicide' (2015) 21 *Aggression and violent behavior*, 113-124
[47] [47] A. Debowska, D. Boduszek and K. Dhingra, 'Victim, perpetrator, and offense characteristics in filicide and filicide–suicide' (2015) 21 *Aggression and violent behavior*, 113-124
[48] G. T. Harris, N. Z. Hilton, M. E. Rice and A. W. Eke, '*Children killed by genetic parents versus stepparents'* (2007) 28 *Evolution and Human Behavior*, 85–95
[49] V. A. Weekes-Shackelford and T. K. Shackelford, '*Methods of filicide: Stepparents and genetic parents kill differently'* (2004) 19(1) *Violence and Victims*, 75–81
[50] M. Liem and F. Koenraadt, F., '*Filicide: A comparative study of maternal versus paternal child homicide'* (2008) 18 *Criminal Behaviour and Mental Health*, 166–176 in Agata Debowska, Daniel Boduszek, and Katie Dhingra, 'Victim, perpetrator, and offense characteristics in filicide and filicide–suicide' (2015) 21 *Aggression and violent behaviour,* 118
[51] M. Dawson, '*Canadian trends in filicide by gender of the accused, 1961–2011'* in Thea Brown, Danielle Tyson and Paula F. Arias (eds), *When Parents Kill Children: Understanding Filicide* (Springer International Publishing AG, 2018), 18
[52] Ibid, 18-19
[53] Brown T et al, '*Filicide offenders. Trends & issues in crime and criminal justice'* (2019) Australian Institute of Criminology, available online at: https://www.aic.gov.au/publications/tandi/tandi568
[54] Ibid, 2; The filicide study was conducted by the Monash Filicide Research Project which investigated filicide deaths that occurred in Victoria between 2000 and 2009.

factors, such as mental illness, domestic violence and family dissolution, interact and there is an absence of appropriate intervention.[55]

43. The Monash study indicated that most step-fathers had a history of domestic violence (67%; n=6) or child abuse (56%; n=5) and were known to use illicit drugs (78%; n=7).[56] The Monash study also noted that step-fathers '*behaved differently'* to fathers and mothers—they were less likely to give prior warning about possible harm to children or to attempt or commit suicide. Further, step-fathers almost exclusively killed children aged one to four years.[57]

44. Further research is required in this area as there are very few studies into filicides similar to Kaleb's death in Australia. ANROWS, the national organisation researching violence against women and children, is currently working on a project with the Australia Domestic and Family Violence Death Review Network[58] aiming to develop a national minimum filicide dataset. I confirm that the Court is an active member contributing to this valuable research with Victorian coronial data provided to ANROWS to improve data protocols and our understanding of filicides on a national scale.

Family violence investigation

45. I confirm that the CPU family violence team did not identify any missed opportunities for prevention or intervention in relation to services that had proximate contact with Kaleb and his immediate family.

Review of the medical treatment proximate to the fatal incident

46. I also directed healthcare professionals from the CPU Health and Medical Investigations Team (HMIT) to evaluate the clinical management and care provided to the deceased by reviewing the medical records, the autopsy report and any particular concerns which have been raised by the deceased's family.

47. In the proximate period prior to the fatal incident, Kaleb had contact with medical practitioners at both Monash Health Hospitals in Casey and Clayton when he was admitted between 14-17 January 2016. Kaleb's family have raised concerns with the Court and specifically requested the following issues be investigated:

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[55] Ibid, 3
[56] Ibid, 3
[57] Ibid
[58] The VSRFVD is a contributing member of this national network.

(a) During the period of Kaleb's admission between 14-17 January 2016, Ms Baylis-Clarke was informed that several tests would be performed to ascertain whether Kaleb suffered from a brain bleed. It was unclear whether all the tests that could have been done were administered prior to Kaleb's discharge on 17 January 2016; and

(b) If all the tests had been performed to diagnose the cause of any injuries that Kaleb may have sustained, were there any indications that the injuries that Kaleb suffered of a non-accidental source? If so, would this have prompted a notification to Child Protection and law enforcement regarding a potential child at risk of harm?

Monash Health treatment on 14-17 January 2016

48. A thorough review was conducted by medical specialists from the HMIT CPU team of statements provided by medical staff at both Monash Health in Casey and Clayton and medical records from both services.

49. Medical specialists from the HMIT CPU note that the test referenced was likely a fontanelle tap, an invasive procedure that is not without risk of infection. Given Kaleb's condition had improved, the neurosurgical team at Monash Health Clayton concluded a fontanelle tap was not warranted as Kaleb appeared well with no vomiting and was tolerating feeds.[59]

50. A response was requested from Monash Health who provided a statement dated 6 August 2020 and confirmed that following admission to the Casey Hospital Emergency Department on 14 January 2016, blood was taken from Kaleb for urea, electrolytes and creatinine, full blood examination, glucose and C-reactive protein. These results were within normal limits, apart from a mildly increased platelet count. A cranial ultrasound was also performed at Casey Hospital on 14 January 2016 and then Kaleb was transferred to the General Paediatric Unit at Monash Medical Centre for MRI brain which was performed on 15 January 2016.

51. Kaleb was reviewed by the neurosurgical team at Monash Medical Centre on the morning of 16 January 2016. A treatment plan was made to tap the anterior fontanelle on his skull on 17 January 2016. This procedure involves passing a needle through the anterior fontanelle (soft spot between the skull bones at top of head) into the cerebrospinal fluid (CSF) spaces. Some of the CSF would be removed with the intention of reducing any raised intracranial pressure and relieving symptoms. The procedure is performed under anaesthetic and carries risks of

[59] Monash Health medical records provided to the Court, 313

introducing infection into the CSF or causing bleeding. The purpose of the tap was to assist with symptom relief given his presenting history of vomiting and irritability.

52. Monash Health confirm that given Kaleb's clinical improvement, including cessation of vomiting and reduction in irritability the tap procedure was cancelled on the morning of 17 January 2016. No other tests had been planned during the admission 14-17 January 2016. Monash Health also confirmed that analysing the fluid collected via a tap of the anterior fontanelle cannot confirm or refute non-accidental injury. [60]

53. VFPMS provided a report dated 8 February 2016 addressed whether the enlargement of Kaleb's subarachnoid space was benign[61] in nature or the result of a traumatic injury. VFPMS considered Kaleb's small bilateral hygromas diagnosed on 14 January 2016 may have resulted from past intracranial trauma, but also may have resulted from non-traumatic causes. However, if trauma related, '*estimates of timing of traumatic events leading the formation of subdural hygromas are imprecise*.'[62] Therefore, '*if caused by previous trauma it was not possible to determine if this was a previous single episode or multiple episodes of trauma, and it is not possible to precisely determine the timing of those traumatic episodes*.'[63]

54. The VFPMS report noted that the presence of ear bruising along with subdural hygromas suggested the possibility of at least one previous episode of trauma to the head. However significantly, the VFPMS report concluded it was not possible to establish the timing of head trauma before the incident on 23 January 2016.[64]

55. Since Kaleb's death, Monash Health have conducted an internal review[65] and have since implemented the following relevant recommendations:

    (a) re-education of clinical staff regarding the need for comprehensive examinations to include a review of any previous admissions, documentation and diagnostics;

[60] Monash Health response dated 6 August 2020

[61] Benign enlargement of the subarachnoid space is a relatively common condition seen in infants and can be associated with birth.

[62] Monash Health medical records provided to the Court

[63] Ibid

[64] Ibid, 161

[65] Monash Health response dated 6 August 2020

(b) further education of staff in both the Children's and Emergency Programs, reinforcing the importance of early discussion and escalation to relevant clinicians when a diagnosis of non-accidental injury is considered;

(c) Monash Health have implemented changes to Emergency Department Orientation Handbook, Suspected Child Abuse procedure, Imaging of Non-Accidental Injury in Children procedure and Child at risk – who to call implementation tool. These changes include that:

(i) any child under 6 months of age with any bruising must be discussed with the senior doctor in the Emergency Department.

(ii) any child where the possibility of non-accidental injury exists must be discussed with the admitting consultant; and the concerns documented in the Electronic Medical Record (EMR).

(iii) any child where the possibility of non-accidental injury exists must be discussed with the VFPMS. Admission under general paediatrics for further investigation will be highly recommended.

(iv) any radiology report identifying subdural collections in an infant under the age of 12 months will include advice to discuss the case with VFPMS.

(d) Additionally Monash Health have implemented an EMR, which has assisted with improved communication across sites, departments and units.

56. In addition to the above specific recommendations, Monash Health confirm that the VFPMS is better integrated within Monash Children's Hospital (Clayton) with the VFPMS Deputy Director on site as Head of Unit for VFPMS at Monash Children's Hospital since April 2017.[66] As a reflection on the increased awareness, accessibility and integration of the VFPMS, and a possible indication of the reduced cultural reluctance to consider a diagnosis of non-accidental injury, inpatient referral numbers to the VFPMS from within Monash Children's Hospital have gradually increased.

57. The VFPMS clinical guidelines now includes a brief guideline regarding Abusive Head Trauma as and on the Royal Children's Hospital's Clinical Practice Guideline for infant head trauma**.** Education has also been enhanced, and "The Child at Risk" Learning module from

[66] Ibid

Department of Health and Human Services is available to all Monash Emergency Program and Monash Children's Program staff. [67]

58. The VFPMS continues to regularly provide education to nursing and medical staff in the emergency department, wards, diagnostic imaging and Paediatric Intensive Care Unit (ICU) across Monash Health; as well as medical students, Child protection unit staff, regional paediatricians and community-based nurses and midwives. Additionally, a Vulnerable Children Committee has been established within the Children's Program of Monash Health and the Victorian Child Safe Standards have been implemented across Monash Health.[68]

59. On 14 October 2019, in the Supreme Court of Victoria, Mr Vinaccia was found guilty of child homicide in relation to Kaleb's death. Mr Vinaccia was sentenced to eight years and six months' imprisonment with a non-parole period of five years and six months.[69] On 7 June 2022, Mr Vinaccia's conviction was upheld on appeal.[70]

60. I am satisfied that the available evidence does not identify any obvious missed opportunities that could have prevented Kaleb's death and no further investigation is required.

FINDINGS AND CONCLUSION

61. Having investigated the death, without holding an inquest, I make the following findings pursuant to section 67(1) of the Act:

    a) the identity of the deceased was Kaleb Baylis-Clarke, born 4 October 2015;

    b) the death occurred on 30 January 2016 at the Monash Medical Centre, Clayton, Victoria, from head injuries in the setting of chronic subdural haemorrhage; and

    c) the death occurred in the circumstances described above.

62. I convey my sincerest sympathy to Kaleb's family.

63. Pursuant to section 73(1) of the *Coroners Act 2008*, I order that this finding be published on the internet.

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[67] Ibid
[68] Ibid
[69] *R v Vinaccia* [2019] VSC 683
[70] *Jesse Vinaccia v The Queen* [2022] VSCA 107

64. I direct that a copy of this finding be provided to the following for their information:

a) Ms Erin Baylis-Clarke, Senior Next of Kin;

b) Mr Shannon Spackman, Senior Next of Kin;

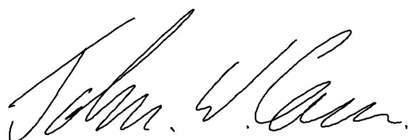
c) Ms Liana Buchanan, Principal Commissioner, Commission for Children and Young Persons;

d) Dr Lilian Johnstone, Deputy Program Director – Children's Program, Monash Medical Centre;

e) Dr Joanna Tully, Deputy Director, Victorian Forensic Paediatric Medical Services; and

f) Detective Senior Constable Rachael Kennedy, Victoria Police, Coroner's Investigator.

Signature:



Judge John Cain
STATE CORONER
Date: 29 May 2023

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.