STATE CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of BLGN [redacted] Inquest into the death of DG [redacted]
Hearing dates:	12-16 February 2018, 24 April 2018
Date of findings:	8 June 2018
Place of findings:	NSW State Coroner's Court, Glebe
Findings of:	Magistrate Harriet Grahame, Deputy State Coroner
Catchwords:	CORONIAL LAW – death of child, Sudden Death in Infancy (SUDI), death after Family and Community Services (FACS) notification of risk of significant harm to child, case closure policies
File numbers:	2014/110204 2015/192508
Representation:	(1) Counsel Assisting Ms Kate Richardson SC and Ms Tracey Stevens, instructed by Ms C Berry of the Crown Solicitor's Office (2) Department of Family and Community Services Ms A Horvath, instructed by Ms E Hourigan, Maddocks Lawyers (3) Mission Australia Ms A Chryssochoides

Findings:

BLGN [redacted]

Identity of deceased:

The deceased person was BLGN [redacted].

Date of death:

BLGN [redacted] died between 11am and 2:30pm on 10 April 2014.

Place of death:

BLGN [redacted] died in her cot at her home in [redacted], Sydney.

Cause of death:

BLGN [redacted]'s cause of death is Sudden Unexpected Death in Infancy but otherwise undetermined.

Manner of death:

BLGN [redacted] died in her cot. Her sleeping environment contained known risk factors. Her death was sudden and unexpected.

DG [redacted]

Identity of deceased:

The deceased person was DG [redacted].

Date of death:

DG [redacted] died between 3am and 7:30am on 30 June 2015.

Place of death:

DG [redacted] died in her bassinet at her home in [redacted], Sydney.

Cause of death:

DG [redacted]'s cause of death is Sudden Unexpected Death in Infancy but otherwise undetermined.

Manner of death:

DG [redacted] died in her bassinet. Her death was sudden and unexpected.

Recommendations:

To the Minister for Family and Community Services and the Secretary of the Department of Family and Community Services ("FACS"): I recommend,

1. That FACS undertake a review of the types of risk of significant harm ("ROSH") reports currently being allocated, referred to services or "closed for competing priorities" at triage (including during weekly allocation meetings), so that the FACS

Executive team (comprising of senior officers at monthly executive meetings in districts) can better monitor, consider and review resource allocation and address the need for any procedural changes.

2. That FACS require all Managers Client Services to use the Resource Management Dashboard to monitor and report to the Director Community Services (using existing monthly executive meetings) on:
    a) children reported at ROSH who have an open plan at a CSC, with no triage activity and an allocation decision pending for over 28 days, and
    b) children reported at ROSH where the report was closed after 28 days.
3. That the FACS Quarterly Business Review between the Deputy Secretary Northern Cluster and Deputy Secretary Southern and Western Cluster, which examines the performance of each district and allows for discussion of any business risks, is to include:
    a) monitoring of adherence to, and progress of, the Office of the Senior Practitioner's serious case review and practice review recommendations,
    b) monitoring of adherence to weekly group supervision requirements in line with the group supervision framework,
    c) a measure capturing the volume and geographic data of reports reported at ROSH but then closed in each CSC to be implemented (both on a monthly and quarterly basis).
4. That on every occasion that a FACS Serious Case Review Panel is convened for a child death review, it undertakes critical assessment of any applicable FACS policy and comments on any deficiencies in the drafting, implementation and compliance with such policy in the Serious Case Review Report prepared in relation to that death.
5. That FACS consider urgently amending its current policies that deal with allocation of a ROSH report that has been assessed by a triager as requiring allocation to a caseworker (herein referred to as an "unallocated ROSH report") to provide as follows:

a) An unallocated ROSH report cannot be closed prior to assessment of that report at a WAM or such other meeting at which the allocation of such reports at the CSC is considered (herein, collectively referred to as a "WAM").

b) If an unallocated ROSH report cannot be allocated (and an increase in capacity is not expected by the next WAM), the CSC is to record this information in the Resource Management Dashboard and ensure that the Director Community Services is notified. The Director Community Services must then consider the lack of capacity at the CSC and decide whether to allocate additional resources to that CSC to enable the report to be responded to.

c) The closure of an unallocated ROSH report may only occur:

    i. after a triage assessment of the level of risk in the report;

    ii. after consideration has been given to allocation at a WAM;

    iii. after notification to the Director Community Services in accordance with b) above has occurred;

    iv. after consideration of an appropriate checklist of other options available (to ensure that a report is only closed as a last resort).

d) The closure of an unallocated ROSH report may not occur for "competing priorities" (or equivalent concept) prior to assessment of that report at a WAM.

Non-publication Orders:

1. Pursuant to s. 74 of the *Coroners Act 2009*, the name and identity of the following persons, and any information that may identify the following persons, may not be published:

a. BLGN [redacted];
b. DG [redacted];
c. AA [redacted];
d. AB [redacted];
e. AD [redacted];
f. AC [redacted];
g. AE [redacted];
h. AF [redacted];
i. AG [redacted];
j. AH [redacted];
k. AI [redacted];
l. AJ [redacted];
m. AK [redacted];
n. AL [redacted];
o. AM [redacted];
p. AN [redacted];
q. AO [redacted];
r. AP [redacted];
s. AQ [redacted];
t. AR [redacted];
u. AS [redacted];
v. AT [redacted];
w. The address of [redacted] Sydney;
x. The address of [redacted] Sydney.

Notation The Court notes that any picture, material or other information which identifies or is likely to lead to the identification of the persons in the above order must not be published or broadcast in any form that may be accessible by a person in New South Wales.

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Introduction

1. This inquest[1] concerns the death of two female children. Both girls were born to AD [redacted] ("AD [redacted]"). BLGN [redacted] ("BLGN [redacted]") died on 10 April 2014, aged three months, while in the care of her mother. DG [redacted] ("DG [redacted]") died on 30 June 2015, aged 19 days, while in temporary care, under the control of the Minister for Family and Community Services ("the Minister").

2. Their tragic and unexpected deaths have brought enormous grief to their parents and extended families.

3. The inquest has been a harrowing process for all those involved. As it progressed, family members have had to grapple with understanding the complex medical evidence presented to the Court. Unfortunately it was also necessary to examine the possibility that one of the deaths may have been suspicious. Some media reporting of the inquest has been sensational rather than sensitive or constructive and this has also caused considerable distress to those already grieving the tragic loss of two loved children.

4. It is hoped that some positive changes to government policy may emerge as a result of the evidence that has been presented to this Court. Close examination of the particular circumstances surrounding these deaths has somewhat inadvertently shone a light on systemic failings in the child protection system in this State. As AD [redacted] struggled to parent with a serious ice addiction, the Department of Family and Community Services ("FACS") failed to offer her useful support or appropriate intervention. While the cause of death for each of her children was ultimately undetermined, what emerged was a picture of bureaucratic failure and an ongoing inadequate response to a family in genuine need.

The role of the coroner

5. The role of the coroner is to make findings as to the identity of a nominated person and in relation to the place and date of death. The coroner is also to address issues concerning the manner and cause of the person's death.[2] Given that DG [redacted] was in

[1] While I have considered my task pursuant to each inquest separately, for convenience I intend to refer to the proceedings jointly as an inquest in these written findings.
[2] Section 81 *Coroners Act* (2009) NSW.

care at the time of her death,[3] the law requires that her inquest be conducted by a senior coroner.[4]

6. A coroner may also make recommendations in relation to matters that have the capacity to improve public health and safety in the future.[5] Coronial recommendations are constrained by the factual circumstances arising from the death under investigation. Final submissions focussed on the involvement of FACS in relation to these children.

The evidence

7. The Court heard oral evidence over five days and received extensive documentary material in seven volumes. The material included witness statements, expert medical reports, medical records, photographs, recordings and policy documents. At the conclusion of the evidence, detailed written and oral submissions were prepared by the parties.

8. A detailed factual summary was prepared by those assisting me and formed part of the written submissions presented to the Court[6]. There were no contentions raised in relation to the factual issues set out in that document and I rely heavily upon counsel assisting's summary in outlining a chronology of events.

Background in relation to BLGN

9. BLGN was born on [redacted] to AD and AE ("AE"). [7] AD and AE were both 22 years old. They had a brief relationship and separated before BLGN 's birth.

10. BLGN 's maternal and paternal family had a fractured relationship. AD had a history of drug addiction. At the time of BLGN 's birth, she was a single parent to two young boys, AA and AB Both AD and her mother, AC ("AC"), were known to police in the years preceding BLGN 's birth. [8]

11. Although AD and AE had separated, AD retained a close and supportive

[3] Section 24(3)(b) *Coroners Act 2009*.
[4] Section 24 *Coroners Act 2009*.
[5] Section 82 *Coroners Act 2009*.
[6] I thank counsel assisting, Ms Richardson SC and Ms Stevens and their instructing solicitor Ms Berry for their extensive work in summarising the material contained in seven volumes. I thank Ms Skinner for her assistance in the final preparation of these Findings.
[7] P79A, tab 1, p. 3 and birth certificate, tab 40, p. 547.
[8] See COPS records tab 43-49.

relationship with AE's mother AF ("AF"). AF provided significant help to AD during her pregnancy and after BLGN's birth. AF attended BLGN's birth and was deeply attached to her granddaughter. It is evident that AF made real and repeated attempts in the difficult circumstances to keep BLGN safe.

12. AD moved to [redacted] Sydney, in late 2013 in an attempt to have a new beginning without drugs.[9] AC moved into the house with AD and the children.

13. On 20 February 2014 BLGN was admitted into hospital and was diagnosed with the parainfluenza virus. She had nasal congestion, cough, diarrhoea and some vomiting. She was given intravenous antibiotics. An admitting doctor made a note of a small bruise on her right upper eyelid but this was not noted by any other treating doctors.[10] On 21 February 2014 BLGN was discharged on oral antibiotics.

14. From 21 to 24 February 2014, AF had the care of BLGN at her house and did not return her because she was concerned about AD's parenting capacity and the unclean state of AD's unit. In evidence, AD agreed that AF expressed concern about the state of the house, the use of drugs, and AD's ability to look after the children. AD also said that no matter how much she and AF had disagreed, AF had always tried to help her and the children and she had been a role model to her.[11] AD told the Court, "When I look back now, if I could go [back] many things would change."[12]

15. On 5 March 2014 the Federal Circuit Court made a recovery order that BLGN be returned to her mother.[13] AF returned BLGN to AD's care. Despite the Federal Circuit Court proceedings, AF and AD remained close.

16. On 14 March 2014 BLGN was taken to her general practitioner and provided routine immunisations (Infanrix Hexa, Prevenar 13 and Rotarix). The general practitioner found no evidence of abuse or neglect and found her weight to be in the

[9] AF, ERISP, tab 23, p. 325.
[10] Dr Yew Chua, tab 6, p. 488 and Westmead Hospital notes, tab 40, p. 502-503.
[11] Transcript AD, 12/02/18, page 65, line 25 onwards.
[12] Transcript AD, 12/02/18, page 66, line 19 onwards.
[13] Federal Circuit Court order, annexure to tab 23, p. 380.

75th percentile.[14] The Court saw photographs of BLGN from this period and she looked beautiful and healthy.

17. In early 2014 two separate neighbours in the unit complex were asked for food by either AB or AA.[15] The son of one of these neighbours who lived in unit 4 of the complex told police that he heard the baby (likely BLGN) screaming on a number of (unspecified) occasions and "it would just be crying and crying the whole night."[16] One neighbour was told by AA: "I didn't have any breakfast" and "haven't got any food in the house ... my mum not cook." This neighbour also commented that a number of cars would frequent the house during an evening.[17]

Exposure to drug use and lack of supervision

18. AD told the Court that she had struggled with addiction to the drug ice since the age of thirteen.[18] She explained that her tolerance was such that she could go straight to sleep, even after having ice.[19] She was not alone with this problem. AD's mother AC, ex-partner AE and AE's mother AF had all struggled with addiction to ice either before or around the time of BLGN's death. In early 2014 the [redacted] family was beset with addiction issues. This is consistent with, and perhaps explained in part by, AD's own child protection history. At the inquest AD demonstrated some insight into her drug use. She explained to the Court that she "never really actually got high off smoking. I didn't smoke to get high...Just to numb me, I guess, from other events that happened in my life."[20] AD was both candid and insightful about her limitations to care for BLGN. It is abundantly clear that she loved her daughter greatly and regretted not having been able to care for her more consistently during that period.

19. It is necessary to comment on the role of AC in the house. AC was BLGN's grandmother and yet she was entirely incapable of providing any appropriate or protective care for BLGN, AA or AB. Even with the benefit of hindsight she did not impress the Court in her oral evidence and she continued to minimise her role in the neglect of the children. She provided no useful

[14] Dr Linh Phan, tab 37, p. 492.
[15] Eliana Cabrera, tab 28, p. 401 and Sahar Muhammad, tab 34, p. 424.
[16] Sahar Muhammad, tab 34, p. 429.
[17] Eliana Cabrera, tab 28, p.401.
[18] Transcript AD, 12/02/18, page 36, line 28 onwards.
[19] Transcript AD, 12/02/18, page 37, line 10 onwards.
[20] Transcript AD, 12/02/18, page 37, line 19 onwards.

parenting support to AD and it is likely that she further enabled AD's own addiction. She told the Court, "At the beginning I thought everything was fine and then in the end, as much as I don't like saying it, it took the death of BLGN was the realisation [sic]."[21]

20. Between February and April 2014, a neighbour, AU ("AU"), often saw AD and AC smoking ice in the house, with all three children either present or in the vicinity. AU estimates that AD was using ice regularly in the period leading up to BLGN's death.[22] During this time AU regularly cared for AB (including overnight) and AD often asked AU for money to buy drugs or nappies.[23]

21. AU gave evidence that, in the early hours of the morning of Tuesday 8 April 2014, AU saw AD and AC standing at their front door arguing over their car and the car keys. AD attempted to throw punches at AC, and then AD ran back into her house and AC ran into AU's house. Following the altercation, AC left in the car and AD went over to AU's house, leaving BLGN and AA unattended at their home (as AB was already staying at AU's house).[24]

22. During the evening of 8 April 2014, AE says that he and two friends (Ricky and Mitchell) went to AD's house. He visited the house to spend time with BLGN.[25] He had used ice himself that night before he arrived.[26] He saw AD smoke ice from an ice pipe during the night.[27] They stayed at the house in the evening, then left and returned at approximately midnight. AE went upstairs and spent time with BLGN in AD's bedroom. AE took photographs of BLGN on his mobile phone.[28] Investigating police have been unable to locate this mobile phone.[29] AE stayed the rest of the night with BLGN and left the house between 6am and 7am the following morning (9 April 2014).

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[21] Transcript AC, 13/02/18, page 50, line 42.
[22] AU, tab 27, p. 396.
[23] AU, tab 27, p. 396.
[24] AU, tab 27, p. 397.
[25] AE, ERISP, tab 21, p. 276.
[26] AE, ERISP, tab 21, p. 296.
[27] AE, ERISP, tab 21, p. 296.
[28] AE, ERISP, tab 21, p. 299.
[29] AE, ERISP, tab 21, p. 300.

23. AD and AC regularly used drugs in the vicinity of the children.[30] AD agreed that AC also regularly used ice and said that they "did it together." AE had observed occasions where "They'll get up, they'll stay on drugs for days and days and then they'll sleep for days and days, and leave the kids unattended."[31] He also said "Like I said, she'd get on drugs and then she, you just couldn't get hold of her for days 'cause she'd be asleep. There was no one to watch after, look after BLGN, there was no one to watch the other two kids around BLGN."[32] AE was candid about his own use of drugs and the more general drug use at AD's house. AE expressed frustration and anger with AD and her mother at their inability to look after BLGN. However, it should be noted that AE took very limited responsibility for BLGN in the three months of her life. He was in regular contact with AD in the month leading up to BLGN's death. He knew her drug habits. He saw BLGN's cot and knew AD often propped up BLGN with a blanket to feed. He did not know her daily routine and could not recall whether he had ever changed BLGN's nappy. AF said that he "wasn't around much" for BLGN. Moreover, he used drugs himself and participated in the use of drugs while all the children were present in the house. Although he attributes responsibility for the tragedy to AD, AE has his own part in the inadequate care of BLGN [redacted].

24. AU said in evidence that AD lacked parenting capacity when she was "coming down" off drugs or was trying to get drugs. When she was coming down, she would sleep and was not social. During this period she was not able to parent properly and the children "generally looked after themselves." She said that AD was more alert and better able to look after the children while using ice.

25. AU was also present at AD's house with AC, AE and AE's two friends at around 10.30pm on 8 April 2014. This was the last time AU saw AD use drugs prior to BLGN's death. She confirmed the date of this event in her oral evidence. She says BLGN was being "handed around from person to person", AA was walking around the house and AB was with her in the lounge. She says she saw AC, AE and AE's two friends smoking ice from a pipe in the garage. AU presented as a generally reliable witness, although it is likely that

[30] AE, ERISP, tab 21, p. 281. See also AD's admissions at Transcript 12/02/18, page 64, line 23
[31] AE, ERISP, tab 21, p. 289.
[32] AE, ERISP, tab 21, p. 304.

she may have tried to minimise her own drug use. Certainly it was AD 's evidence that AU usually contacted her when she wanted to "get on" (smoke ice).[33]

26. AD provided two accounts to investigating police as to the timing of the visit by AE and his friends. In the first account made on 11 October 2015 (some 18 months after BLGN 's death), she said that AE , Ricky and Mitchell were at the house on the night preceding BLGN 's death. She recalls all of them using ice together during the evening and AE returning to the house later by himself, in the early hours of the morning, to spend time with AD and BLGN .[34] The timing of this incident was revisited by investigating police in a further record of interview on 23 February 2016. Here AD clarifies that this incident occurred on the evening of 8 April 2014 and not the evening of 9 April 2014 (i.e. not the night immediately preceding BLGN 's death).[35] This is consistent with AU 's clear evidence of the timing and is likely accurate.

27. AD accepts that ice pipes were found in her unit and admits to using ice in the house when AE and his friends visited.[36] AD agreed in evidence that she used ice on this occasion and went to sleep the following day. She did not have a precise recollection about the incident and it was apparent that such events were not unusual and were, in fact, routine in the household.

28. AD also accepted that the children had been unsupervised on occasions prior to BLGN 's death. AA was difficult to control and very difficult to supervise. AD tried to explain that most of the reports made about the other children occurred when she was not present. She was asked about AE 's claim that she neglected her children and she answered, "it depends what he means by neglect, like I wasn't a top mum, I had a lot of things to learn and yeah I can see that now, I would change many...things."[37] When it was put to her that she was lazy with parenting when "coming down" from ice, she responded that she was lazy "not just parenting... with everything."[38] However, AD insisted that whatever else was going on, her children were always fed. She told the Court, "whether it was Maccas, whether it was whatever, they were always fed, they never starved, if I didn't have

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[33] Transcript AD 12/02/18, page 44, line 10
[34] AD , tab 19, p. 245 – 246.
[35] AD , third ERISP, tab 20, p. 253.
[36] AD , third ERISP, tab 20, p. 245.
[37] Transcript AD , 12/02/18, page 70, line 28 onwards.
[38] Transcript AD , 12/02/18, page 68, line 50 onwards.

any money I would steal it if I had to."[39]

AD and AC 's mobile phone records

29. On 6, 7 and 8 April 2014 AD made and received numerous telephone calls throughout all hours of the day and the night. These calls were all either very short telephone conversations (usually less than one minute long); attempts by AD to make calls; or attempts by others to call AD.[40]

30. At 4.50am on 8 April 2014 AD attempted to call a mobile phone number.[41]

31. At 11.42am on 8 April 2014 AD sent a text message.[42] There is no record of AD answering a call or sending a text message after this time until after BLGN 's death.

32. AC 's mobile phone records are incomplete.[43] However, on 10 April 2014 there is no record of any calls made or received until 3.26pm, which was after BLGN 's death.[44]

33. In oral evidence AD did not dispute that there was a pattern of mobile phone use that demonstrated she was very active in the days leading up to 8 April 2014, including consistently through those nights. She appeared to accept in her evidence that she did not make any calls and could not be contacted on her mobile on the day before and day of BLGN 's death. She proffered the reason that it may have been out of credit and that she "usually had it on silent anyway."

34. The inference is available that AD switched her mobile phone off at around midday on 8 April 2014 and did not turn it on again until the late afternoon or evening of 10 April 2014. This is consistent with the evidence of AU and AF in regard to unsuccessful attempts that they made to contact AD on her mobile phone during that period. The inference is also available that AD used her mobile phone very frequently while using ice, and then either did not use it or turned it off on the days when she was "coming down" and not using drugs.

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[39] Transcript AD , 12/02/18, page 69, line 19 onwards.
[40] Optus call charge records, tab 54, p. 657-659.
[41] Optus call charge records, tab 54, p. 659.
[42] Vodafone call charge records, tab 55, p. 666.
[43] Vodafone, Telstra and Optus call charge records, tabs 57 – 60 and p. 670 – 679.
[44] Telstra call charge records, tab 59, p.676.

The chaotic state of the house

35. The house was a two storey unit in a townhouse complex. Following BLGN 's death, investigating police examined and photographed inside the house and created a floor plan of the unit.[45] The downstairs contained a lounge, small kitchen, laundry, toilet and garage. The lounge had a sofa, coffee table and a kitchen table wedged underneath the staircase. There was a portable child's bath or cot on the table underneath the stairs and an infant swing chair in the corner next to the television.[46] A mattress was also on the floor of the lounge with some bedding.

36. The kitchen was in disarray and contained food scraps, dirty dishes, piles of clothes, children's toys and soiled cushions and clothes. There was no edible food in the kitchen. Police found a broken ice pipe on top of a baby bottle warming device in the kitchen.[47]

37. The laundry (which contained a toilet) contained clothes piled onto the floor.

38. The garage contained stacked furniture and children's toys.[48] Investigating police also found a bong, small plastic resealable bags, foil wrapper and a homemade ice pipe.[49]

39. A child safety gate was installed at the bottom of the stairs in the unit. The gate was closed but broken and could not be unlatched. Sergeant Salafia had to step over the gate in order to walk up the stairs.[50] AD told Constable O'Neill at the scene that the gate did not open.[51] This broken safety gate is consistent with evidence that the family spent most, if not all, of their time downstairs and did not frequently go upstairs. AC said that it was "very hot upstairs", which may have been a factor.[52]

40. The upstairs contained three bedrooms and a bathroom.

41. Bedroom one contained (among other things) a cot frame that was overturned and broken, two single unmade beds covered in clothes, a wardrobe and piles of clothes

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[45] Senior Constable Spurway, tab 10 and floor plan, tab 42, p. 573.
[46] Senior Constable Spurway, tab 10, photographs at p. 165, 166.
[47] Senior Constable Spurway, tab 10, p. 156 and photograph at p.173, 174.
[48] Constable O'Neill, tab 9, p.143.
[49] Senior Constable Spurling, tab 10, p. 157 and photograph at p.182-185.
[50] Sergeant Salafia, tab 8, p. 133. Although the gate was fixed to the stairs when police arrived at the scene, the forensic photographs show that was removed at some stage following attendance by police.
[51] Constable O'Neill, tab 9, p 138.
[52] Transcript AC 13/02/18, page 44, line 7 onwards.

on the floor.

42. Bedroom two (the main bedroom) contained an unmade double bed, a white cot, a white change table and a mattress on the floor in the walk-in wardrobe. Next to the mattress was found a child's bottle and texta pens, with texta drawings on the wall.[53]

43. Bedroom three contained a single child's bed (in the shape of a car) covered in a sheet only and a wardrobe.

44. The bathroom was unclean with clothes on the floor.[54]

45. There is no reasonable basis to suggest that anyone other than AD, AC and the three children lived in the house. AF has expressed concern that AD was renting out one of the rooms to a female drug dealer named Naomi and her partner.[55] However, there is no foundation in the evidence for such a concern and it was not raised in her comprehensive record of interview dated 21 May 2014. It is likely founded in gossip in the years following BLGN's death.

BLGN's cot

46. On the day of BLGN's death, the white cot contained a mattress that was fitted with a sheet, an adult-sized pillow, a cot size doona, a small tea towel, some clothing, a blue stained blanket, two feeding bottles containing milk and numerous soft toys.[56]

47. BLGN usually slept downstairs, either on a mattress on the floor, in a portable cot or in a swing seat. AU says she never saw AD put any of the children to sleep upstairs and that she had only seen BLGN in the bouncer, the swing or the bassinet on the table.[57] AC also says that BLGN normally slept downstairs either in the swing or in her bassinet.[58]

48. AF visited the house on numerous occasions and never saw BLGN sleep in her cot. She says that AD, AC and the children all slept downstairs (with BLGN on a mattress with AD, in a portable cot underneath the stairs or in her

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[53] Constable O'Neill, tab 9, p. 144.
[54] Sergeant Salafia, tab 8, p. 133.
[55] AF, tab 24, p 384 and tab 25, p. 386.
[56] Constable O'Neill, tab 9, p. 139 and photographs at p.194 – 202.
[57] AU, tab 27, p. 398.
[58] AC, tab 22, p. 309.

swing seat).[59]

49. Just over a week before BLGN's death, AU went over to AD's house to help decorate the bedroom. AU said in evidence that she thought "there was too much" in the cot and informed AD that this was a risk for the baby. AD responded that it did not matter because "she doesn't sleep in her cot."[60] AU never saw BLGN asleep in the cot, only in the bouncer or the swing downstairs. AU had also observed AD feeding BLGN by propping her up on pillows and resting a bottle on a blanket on her chest.

50. It was AD's evidence that the first time she ever put BLGN to sleep in the cot upstairs was mid-morning on the day of BLGN's death. AC's evidence before this Court was that she went upstairs during the night of 9 April 2014 and saw BLGN asleep in the cot upstairs and that was the first time she had ever seen BLGN sleep in the cot.[61] This was not mentioned in her statement to police and is inconsistent with AD's account.

51. In evidence before this Court, AD agreed that she had been given a pamphlet on Sudden Infant Death Syndrome ("SIDS") at the Westmead Hospital before BLGN was born. She told the Court that she "didn't kind of notice" and certainly "didn't read every line."[62] She agreed that she was now generally aware of the dangers of having numerous soft items in a cot with a baby and the dangers of co-sleeping. She said that she "didn't think too much of it" and explained that she had co-slept with both her boys without incident in the past. AD readily accepted that she now knew that the contents of the cot created a SIDS risk.

The day of BLGN's death

52. In the early hours of the morning of 10 April 2014, a neighbour Eliana Cabrera heard a baby crying hysterically in [redacted] (AD's house). She got up and looked out the window and could not see anyone.[63]

53. At 10.30am AU entered her unit (diagonally opposite to AD's unit). She had moved out the day before and returned in order to clean it. She cleaned until 1.30pm and then slept until 3pm. She says someone was walking up and down the

[59] AF ERISP, tab 23, p. 341.
[60] AU, tab 27, p. 397.
[61] Transcript AC, 13/02/18, pages 33 to 34, line 8 onwards.
[62] Transcript AD, 12/02/18, page 63, line 35 onwards.
[63] Eliana Cabrera, tab 29, p. 402.

stairs at AD 's house and in the morning she tried to call AD on her mobile and it was switched off.[64] AF also made repeated attempts to call AD on her mobile phone on this day because she wanted to make arrangements to see BLGN .[65]

54. At midday AC woke up on the mattress downstairs. She recalls AD went across the road to have a shower but returned because she could not get inside.[66]

55. AC says that at 1pm AD checked BLGN and found her unresponsive. She says that AD came downstairs carrying BLGN , and then ran around with her outside. After this AD brought BLGN back inside and removed mucus from her nose with a sucking implement. AC and AD attempted to resuscitate her. AC says was aware that BLGN was cold and knew she could not be revived.[67] AC 's assessment of time is likely unreliable.

56. At 2.29pm AC called emergency services.[68] The ambulance records state she said: "Baby not waking up", "Patient purple", "Not awake not breathing" and "Vomit in mouth."[69]

57. At 2.37pm the ambulance arrived at the house. Ambulance officer Kylie Knight entered the house and saw AD kneeling by BLGN while AC was sitting on the couch. BLGN was cold to touch and blue in colour.[70]

58. BLGN was taken out to the ambulance and ambulance officer Jennifer Potter observed her to be extremely pale and waxy with dependent lividity. Rigor mortis had "set in" as the arm was difficult to flex at the elbow.[71] BLGN was placed on a stretcher and brief attempts were made to resuscitate her. It was "obvious" to the ambulance officers that BLGN was dead.[72] Tragically AD did not appear to understand what had happened. She rushed to get her pension card and Medicare card so that she could travel with BLGN to the hospital, still hoping for recovery.[73]

59. Ambulance officer Potter informed AD that BLGN had died and AD fell to

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[64] AU , tab 27, p. 398.
[65] AF ERISP, tab 23, p. 328.
[66] AC , tab 22, p. 309.
[67] AC , tab 22, p. 309.
[68] AC , tab 22, p. 309.
[69] Incident Detail Report of '000' emergency call, tab 16.
[70] Kylie Knight, tab 14, p.222.
[71] Jenny Potter, tab 13, p. 220.
[72] Jennifer Potter, tab 13 and Kylie Knight, tab 14.
[73] Transcript AD , 12/02/18, page 54, line 30 onwards.

the ground crying and sobbing.[74] AD said she had put BLGN down to sleep "about four hours ago" (likely approximately 10.30 to 11am), and then tried to wake the baby "half an hour ago" (likely approximately 2.15pm).[75]

60. Ambulance officer Potter overheard AD tell AC that BLGN had died. AC responded with surprise and asked "if that was true."[76] Ambulance officer Knight believed AC was either under the influence of a substance or had cognitive delay.[77] The ambulance officers observed that the other children, AB and AA, appeared dirty, hungry and one had an overly full nappy.[78]

61. Around this time AC called AF and said to her "the baby's gone" and "she's passed away."[79]

62. At around 2.30pm to 3pm, AU was woken from sleep by the sound of AD screaming.[80] AU entered the house and saw AD with an ambulance officer in the lounge room. She took AB and went upstairs to gather some clothes for him. AU went into the main bedroom and in her statement comments that it was "strange" that there was a blue blanket in BLGN's cot because AD usually used pink items for the baby.[81]

AD's interview with Sergeant Salafia

63. At 2.45pm Sergeant Salafia arrived at the scene in response to a call regarding a deceased infant.[82]

64. AD told Sergeant Salafia that she:[83]

1. Fed BLGN at 10am that morning;
2. Put BLGN in the cot upstairs before 11am;
3. Checked on BLGN at about 2.25pm;
4. Could not wake BLGN and saw a blanket partially covering her face;

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[74] Jennifer Potter, tab 13, p.220.
[75] Jennifer Potter, tab 13, p. 221.
[76] Jennifer Potter, tab 13, p. 220.
[77] Kylie Knight, tab 14, p. 223.
[78] Jennifer Potter, tab 13, p. 220.
[79] AF ERISP, tab 23, p. 332.
[80] AU, tab 27, p. 398.
[81] AU, tab 27, p. 398.
[82] Sergeant Salafia, tab 8, p. 130.
[83] Sergeant Salafia, tab 8, p. 132.

5. Went downstairs to get [redacted], went back upstairs, and took [redacted] downstairs to the lounge; and

6. Noticed [redacted] felt cold and stiff.

[redacted]'s interview with Constable O'Neill

65. At 3.06pm Constable O'Neill arrived at the scene.[84] He observed [redacted] wearing a stained singlet top and underwear-type shorts, and had messy hair and the appearance of having not bathed. She was quiet but responsive, although easily distracted.[85] [redacted] told Constable O'Neill that she: [86]

1. Fed [redacted] upstairs at around 10am to 11am;

2. Put her on her back in the cot dressed in a nappy and jumpsuit;

3. Covered her with the doona and blue blanket;

4. Checked on [redacted] some hours later as she had not woken up;

5. Saw [redacted] in the cot with her face partially covered by the blue blanket;

6. Saw a bubble coming out of her nostril and vomit in her mouth;

7. Went downstairs to [redacted];

8. Returned upstairs, picked up [redacted] and took her downstairs;

9. Attempted to breathe into her mouth and noticed her mouth was stiff (described as "CPR");

10. Ran out into the courtyard to see if there was anyone around to assist; and

11. Returned to the house and saw [redacted] on the phone to the ambulance.

66. [redacted] told Constable O'Neill that [redacted] would normally go to bed at 8.30pm and sleep until 6am. She was usually given 3 to 4 bottles of 120ml milk formula each day. She usually slept between feeds for between 1 to 4 hours at a time.[87]

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[84] Constable O'Neill, tab 9, 137.
[85] Constable O'Neill, tab 9, p. 140.
[86] Constable O'Neill, tab 9, p. 140 – 141.
[87] Constable O'Neill, tab 9, p. 141.

AD 's first record of interview on 24 June 2014

67. AD was interviewed by Senior Constable Maybury approximately six weeks after the death. AD gave an account consistent with the two accounts given to police at the scene on 10 April 2014.

68. In her first record of interview, AD said she:[88]

1. Put BLGN to bed upstairs at around 9.45pm;
2. Slept upstairs with AA, both in her bed;
3. Fed BLGN a bottle at 8 to 8.30am and put her back to sleep;
4. Fed BLGN a bottle on waking again at 11 to 11.30am;
5. Watched a movie in her bed with AA;
6. Played with BLGN in her bed during the movie for a while;
7. Put BLGN back down in the cot "Laying down on a pillow with her head this way", with "[head] facing the wall" and "on the pillow from the chest up and then the rest on the mattress";
8. Wrapped BLGN "in a blue blanket and the doona was pulled up to about here (chest region)";
9. Went downstairs with AA to get the kids something to eat;
10. Walked over to AU 's house to have a shower;
11. Found AU 's house locked and the power off outside;
12. Returned to her own house and did not check on BLGN;
13. Went upstairs around 2.30 to 2.45pm because BLGN had not woken up from sleep;
14. Found BLGN unresponsive in the cot;
15. Saw "a snot bubble but it was yellow" from the nose and "I popped it and that's how I felt her skin at first";
16. Took BLGN downstairs and "went to pass her to mum but mum wouldn't

[88] AD , first ERISP, tab 18, p. 238 – 242.

take her" and "then I ran outside to see if anyone was home";

17. Returned inside and AC had called emergency services; and

18. Attempted to resuscitate BLGN: "I gave her mouth to mouth and then the ambulance got there."

AD 's oral evidence

69. AD 's oral evidence was generally consistent with the other accounts she provided to police about the circumstances of BLGN 's death. She did her best to be honest with the Court and was relatively frank about the limitations of her parenting. She was frank about her drug use and long-standing addiction. AD maintained that she went to bed upstairs at around 9.30 to 9.45pm on 9 April 2014. BLGN and AA slept in the bed with her.

70. AD maintained she slept through the night on her bed upstairs and did not hear any crying from BLGN. This is despite:

1. her own firm memory that BLGN was generally fed every 3 to 4 hours and would always wake for a feed during the night;

2. the fact that, if BLGN woke up the next morning at around 8.30am and was fed, this would mean she had not been fed for nearly 12 hours; and

3. her evidence that BLGN slept in the bed with her overnight (and was accordingly very close to her).

71. AD said that she woke in the morning at around 8.30am and fed BLGN and played with her on the bed. She took AA downstairs for food. She then went over to AU 's house to take a shower and took one or both boys with her. Before leaving the house, she put BLGN in the cot upstairs because she did not want to leave her on the bed. BLGN was in her sleeping bag with a doona over her legs and AA 's blue blanket up to her chest. She was placed on her back with her head on the pillow and face tilted to one side.

72. AD then went downstairs and outside to AU 's house, with either AA or with both boys. She could not enter the house because the door was locked. On returning to her house, AD stayed downstairs. She watched television and did not check on BLGN. She stated that around 2pm she said to her mother "I better

go and check she's still breathing", climbed over the broken safety gate and went upstairs.

73. AD gave evidence that she saw BLGN in the cot with a yellow bubble coming from her nose. She touched BLGN 's skin and felt that it was cold and shiny. BLGN was in the same position in the cot but the blanket was higher than where it was left, and it covered her bottom lip, part of her cheek and ear. AD then grabbed her, took her downstairs, to her mother and then out the door into the driveway. She spoke to a neighbour across the road and her mother called for an ambulance. She removed mucus from BLGN 's nose and attempted to resuscitate her as guided by the emergency services.

Resolution of the evidence of the day of BLGN 's death

74. AD 's evidence was that BLGN (and AA) slept with AD in her bed during the night of 9 April 2014. Her evidence is that the first time she had ever put BLGN to sleep in the cot upstairs was mid-morning on the day of her death. By contrast, AC 's evidence was that she went upstairs during the night of 9 April 2014 and saw BLGN asleep in the cot upstairs. This was not mentioned in her statement to police and is inconsistent with AD 's account.

75. AD has consistently maintained she put BLGN to sleep in the cot upstairs in the mid to late morning and did not attend to her again until sometime after 2pm. AC was often vague in her account of these events and at times contradicted herself in evidence. Her evidence is not sufficiently reliable and where it conflicts with AD 's version, AD 's evidence is preferred.

76. There is some discrepancy in AD 's recall and estimated timing of events during the day. Her evidence that BLGN did not wake for a feed during the night is likely to be unreliable. Rather, it is more likely that BLGN did wake for a feed but AD did not hear her as she was coming down from the drug ice and sleeping heavily. Also, it is not clear why AD put BLGN in her cot on the day when she says she had never done this before. However, there is no reliable evidence to contradict AD 's account. AD 's account is reasonably consistent and credible. In my view it is sufficiently established that BLGN was in her cot and not supervised or checked on from about 11am in the morning until she was found, deceased, on or after approximately 2pm.

The role of AT

77. AT ("AT") was a drug dealer and friend of AD and AC. He supplied them with ice and regularly attended the house in early 2014.[89] AT was at AD's house in the middle of the night of 9 April 2014 for the purpose of picking up some clothes. AD and AC both agreed that AT had left clothes at the house previously. He drove to the house with his friend AS ("AS"). Both were under the influence of ice. He knocked on the door and entered through the ground floor window when there was no answer. He removed a flyscreen to do so.[90] AS stayed in the car while AT was inside. Both AC and AD accepted AT's account of entering the house and did not express concern that he had done so while they were both asleep. It did not appear to be unusual for people to come and go from the household in this way.

78. AT saw AC asleep on a mattress with two small boys. He walked up the stairs and saw AD asleep on a bed. He did not see BLGN but heard a baby crying upstairs while he was in the house.[91] He retrieved his suitcase of clothes that was in the room "upstairs to the right".[92]

79. AT estimates he was in the house for approximately five minutes before returning to the car and leaving the premises. AS says AT was "flustered" when he returned to the car and she was under the impression he had sex with the woman inside. They argued in the car about the fact that AT ignored a baby crying in the house.[93] AT offered to turn around and go back to the house but this did not occur.[94]

80. The following day AT was informed by either AD or AC that the baby had died.[95] He drove to the house to support the family.[96] He called AS and told her that the baby at that house had died.[97] AS was angry with him and suggested that he must have had something to do with the death.[98] He was indignant at this suggestion and flatly denied any involvement. As he said in his

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89 AT ERISP, tab 35, p. 450.
90 AT ERISP, tab 35, p. 444.
91 AT ERISP, tab 35, p. 446.
92 AT ERISP, tab 35, p. 440.
93 AT ERISP, tab 35, p.448 and AS, tab 32 p. 412.
94 AT ERISP, tab 35, p. 462.
95 AT ERISP, tab 35, p. 462.
96 AT ERISP, tab 35, p.441 and p.447.
97 AS, tab 32, p. 412.
98 AT ERISP, tab 35, p. 465 and AS, tab 32, p. 412.

ERISP: "Why would I hurt a baby?"[99]

81. This account was challenged by AT's former girlfriend AR ("AR"). AR alleged she was with AT and AS on the night.[100] She further alleged that AS had later relayed AT's confession that he had placed his hand or a pillow over the baby's mouth while inside the house to stop the baby from crying.[101]

82. AR, AS and AT all gave evidence at the inquest. AR said that at the time she was a friend of AS and in a relationship with AT. She was using drugs on a daily basis. Around this time AR fell pregnant to AT and terminated the pregnancy after the relationship ended and without his knowledge. AR was adamant she was present in the car on the night and said that AT entered the house through the front door, although the other two say he entered through the window. She maintained that AS told her AT himself had actually confessed to suffocating the baby. AR displayed real animosity towards AT. She was an obstinate witness and dismissed the conflicting accounts provided by AS and AT without reasonable explanation. Her demeanour was troubling. At times she laughed inappropriately. Her evidence was in a number of respects inherently implausible. She told the Court that after AS told her that AT had admitted to killing the baby, she "forgot about it until police arrived" months later.[102]

83. It may be that after AS told AR about her suspicions in relation to AT, AR has embellished the story to include a confession and invented part of the narrative to include herself as present at the scene on the night. It is impossible to know.

84. AS gave evidence that she too was a regular drug user at the time of BLGN's death. She was certain that AR was not present on the night of the incident. She accepted that she later conveyed her concerns to AR about AT's potential role in the baby's death but was clear that AT had not confessed to her and clear that she did not tell AR that AT had actually confessed. She readily agreed that she was angry at AT and that she

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99 AT ERISP, tab 35, p. 465.
100 AR, tab 26, p. 388.
101 AR, tab 26, p. 390.
102 Transcript AR, page 79, line 10 onwards.

suspected he was having sex with AD. She also agreed she questioned him about it on the phone the following day. Although AS was a reluctant witness at times, her evidence was consistent with her previous account to police and consistent with AT's recollection. She had no apparent motivation to lie and did not attempt to improve any factual detail in order to justify her suspicions about AT. She agreed that she had no actual evidence to suggest AT killed BLGN, it was "just something she thought herself".[103]

85. AT has consistently strongly denied any role in BLGN's death, both in his interview with police and before the Court. He volunteered information about his drug use and the role he played in supplying drugs to AD and AC. He was candid about his sexual and drug-related exploits with both AS and AR. He gives a plausible explanation that excludes AR from the car that night, in that he was sexually involved with both women at the time and "I don't mix my girls."[104] He was incredulous and emphatic in his denial of any role in the death. I had the opportunity to observe him closely in the witness box. I accept the evidence he gave and reject any suggestion that AT had any involvement in BLGN's death.

BLGN's autopsy

86. An autopsy was performed by Dr Istvan Szentmariay and the cause of death was recorded as undetermined.[105] There were no drugs or alcohol found in BLGN's blood.[106] The report found no suspicious external or internal injuries and no haemorrhages. The report noted that BLGN had contracted a parainfluenza viral infection at seven weeks and she had received her scheduled immunisations without incident two weeks before her death.[107] The cardio-vascular system was normal and there were no other abnormalities detected. She was described as well developed and nourished.[108]

The role of the FACS

87. FACS provided evidence in this inquest in the form of statements by Simone Walker and Kate Alexander. Simone Walker is the Acting Deputy Secretary of the Northern

[103] Transcript AS 14/02/18, page 12, line 46
[104] AT ERISP, tab 35, p. 471.
[105] Autopsy report, tab 5, p. 20.
[106] Certificate of Analysis, tab 3, p. 13.
[107] Autopsy report, tab 5, 21.
[108] Autopsy Report, tab 5, p 6

Cluster and has state-wide responsibility for child protection and FACS out of home care. Kate Alexander is the Senior Practitioner of the Office of the Senior Practitioner. Both witnesses gave oral evidence before me. Both impressed the Court as compassionate and skilled professionals who have very genuine commitments to implementing ongoing improvements to the child protection system in this State. It was clear to me that both witnesses were open and cooperative in their attempts to find out what had gone wrong with the role of their department in relation to this family.

88. FACS received numerous reports in regard to AA, AB and BLGN prior to BLGN's death. It is necessary to briefly examine the reports in an attempt to understand the circumstances in which BLGN was living at the time of her death.

11 August 2010 report

89. A report was made about AA and AB to the effect that AD and AC were addicted to methamphetamines and the reporter had seen them smoking ice, AA was crawling around rubbish on the floor and there was never any food in the house.[109] The report met the threshold for risk of significant harm ("ROSH") and was transferred to St Marys Community Services Centre ("CSC"). The report was not allocated but enquires made about the state of the house. Information was received that the family had moved and there were no reports from any housing service, and the report was subsequently closed.[110]

90. The risk assessment was inadequate. The report should have been transferred to Hawkesbury CSC for consideration of a safety assessment. FACS should have confirmed whether the family still lived at the house and a greater focus should have been on the alleged use of drugs and apparent lack of supervision of the children.

25 September 2010 report

91. A report was made that ice and marijuana were found by police in AC's car and that both AD and AC were dealing ice. The report contained a specific concern that AC was exposing AA to serious danger as he was with her while she

[109] Simone Walker, tab 122, p. 1756 and tab 126, p.1830.
[110] Simone Walker, tab 122, p. 175 and tab 129, p. 1846.

couriered drugs.[111] The FACS Crisis Response Team attended the relevant police station and AD 's house and assessed AD and AC . The Crisis Response Team recommended that Hawksbury CSC:[112]

1. Consider a referral to the Brighter Futures Program;
2. Assist AD to move away from AC ;
3. Assist with day care and possible employment;
4. Refer AD to a parenting program; and
5. Contact police for the outcome of the investigation. AD was reported to be open with caseworkers and willing to engage in the Brighter Futures program, and they discussed a safety plan. AC agreed not to take AA from the home at night and not to use drugs around him. AC also agreed that it was best that AD and AA did not live with her.[113]

92. Hawksbury CSC obtained AD 's criminal history but no action was taken in regard to any of the recommendations above.

93. The report was not allocated and was closed on 15 November 2010 for competing priorities.[114] There is no explanation or record as to how this assessment over competing priorities was made. The report should have been allocated for an immediate response.

12 October 2010 report

94. A report was made in similar terms to that of 25 September 2010 above. The report was screened out because the information had already been reported to the Child Protection Helpline ("the Helpline").[115]

95. This screening out is inexplicable and concerning. If the information contained in the report was screened in as reaching the threshold for ROSH in the previous report, then it should have been screened in again for this report.

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[111] Simone Walker, tab 122, p. 1758 and tab 130, p. 1849.
[112] Simon Walker, tab 122, p. 1760 and tab 134, p. 1871.
[113] Simone Walker, tab 122, p. 1759 and tab 133, p. 1863.
[114] Simone Walker, tab 122, p. 1760.
[115] Simone Walker, tab 122, p. 1760 and tab 136, p. 1878.

13 January 2011 report

96. A report was made that AD and AC were ice users and the house was a 'drug house'.[116] This report was screened out as the information had already been reported to the Helpline previously. For the reasons set out above, it should have been allocated for an immediate response.

25 January 2011 report

97. A report was made that police had attended AD and AC 's house in response to an incident where AD had been arguing with two men and a shot was fired. The report again included allegations of ice use and also domestic violence.[117] This report was considered for allocation at the Weekly Allocation Meeting ("WAM") and closed for competing priorities.[118]

98. The report should have been allocated for an immediate response. There is no explanation of the basis on which the report was closed. Further, it is difficult to understand how this report did not result in an immediate response from FACS in the form of a home visit by a caseworker and/or follow up with investigating police.

26 February 2011 report

99. A report was made following the execution of a search warrant at the house in regards to the recovery of stolen property and prohibited drugs. Police found AD on the floor with AA and drug use inside.[119] This report was screened in as meeting the threshold for ROSH and was considered for allocation at the WAM. The report was then closed for competing priorities.[120]

100. Again, there is no explanation of the basis on which the report was closed due to other priorities. It should have been allocated for an immediate response.

26 May 2011 report

101. A report was made that AD had been arrested in front of AA , who was screaming and crying when police attended. The report included further information that the house had no food a week earlier and was unhygienic. This report was

[116] Simone Walker, tab 122, p. 1760 and tab 138, p. 1890.
[117] Simone Walker, tab 122, p. 1761 and tab 140, p. 1897.
[118] Simone Walker, tab 122, p. 1762 and tab 140, p. 1900.
[119] Simone Walker, tab 122, p. 1763 and tab 142, p. 1911.
[120] Simone Walker, tab 122, p. 1763.

screened in as meeting the threshold for ROSH and transferred to another CSC. It was not allocated and over two weeks later was closed for competing priorities.[121] It should have been immediately allocated.

10 February 2012 report

102. A report was made by AD herself seeking assistance because she had been living with AC and had been evicted.[122] The Crisis Response Team arranged for temporary accommodation and the report was transferred to Blacktown CSC. It was then closed for competing priorities.[123]

14 November 2012 report

103. A report was made that AD was at a refuge while pregnant, that drug paraphernalia was present at the refuge, and that she had given birth to AB and had not returned to the refuge. The newborn AB had been collected from hospital by the father and it was believed that AD was with AC.[124] The report was screened out as not meeting the threshold for ROSH. It is difficult to understand how this set of circumstances did not meet the threshold and some action taken. It should have been screened in.

27 September 2013 report

104. A report was received that it was believed that AD, AC and the children were living in their car in a car park, and that police officers had attended the car park to check on their welfare.[125] The Helpline determined that the report did not meet the threshold for ROSH as police had sighted the children and the family had been identified as having a place to stay that night, and therefore were not homeless. The report was screened out.[126]

24 November 2013 report

105. A report was received that police officers were called to AD's home when AB and AA were seen playing on the driveway unsupervised (and in the care of

[121] Simone Walker, tab 122, p. 1763 and tab 143, p. 1919.
[122] Simone Walker, tab 122, p. 1764 and tab 145, p. 1927.
[123] Simone Walker, tab 122, p. 1764 and tab 147, p. 1933.
[124] Simone Walker, tab 122, p. 1765 and tab 148, p. 1936.
[125] Simone Walker, tab 122, p. 1766 and tab 149, p. 1941.
[126] Simone Walker, tab 122, p. 1766.

AC).[127] The report was screened in as meeting the threshold for ROSH and transferred to St Marys CSC. The Helpline allocated the priority as further assessment within ten days but there was no such further assessment. The report was closed for competing priorities. The report should have been taken to a WAM and assessed for allocation and should have been assessed as priority for allocation. An operational capacity report should have been completed and available in FACS records for the week. These inadequacies have been acknowledged by FACS.[128]

4 December 2013 report

106. A report was made by a Mission Australia caseworker[129] that police were called to AD 's home when AB and AA were again playing unsupervised in the driveway, with a pram wedged under the garage door to keep it open. AC was present at the house and AD was sleeping. There was a further report that two days prior AA had cut out the screen from the front window and climbed outside, with AC asleep on the couch and AD not present.[130] The report was screened in as meeting the threshold for ROSH with a response required within 10 days. The report should have been taken to a WAM and assessed for allocation and allocated. There were two WAMS and an operational capacity report undertaken during this week but this report was not considered at either WAM. Nevertheless, the report was closed because the family were already involved with Mission Australia, because AC had been assisting AD with the children and because of completing priorities.[131]

107. The report should have been taken to a WAM and should have been allocated. The report should have been allocated regardless of the competing priorities at the time. These inadequacies are acknowledged by FACS. FACS has acknowledged in these proceedings that on no view did the competing priorities justify the closure of the [redacted] case.[132]

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[127] Simone Walker, tab 122, p. 1766 and tab 150, p. 1946.
[128] Exhibit 4, FACS letter, 9 February 2018, p. 7 – 8.
[129] Helen Lunn, tab 172, p. 2289 and p. 2303.
[130] Simone Walker, tab 122, p. 1767 and tab 151, p. 1957.
[131] Simone Walker, tab 122, p. 1768 and tab 152, p. 1963.
[132] Exhibit 4, FACS letter, 9 February 2018, p. 9.

24 February 2014 report

108. A report was made about AD 's use of ice in front of the children, in circumstances where BLGN was only weeks old and had just been discharged from hospital following her influenza. The caller was also concerned about AA 's aggressive behaviour and the continued lack of supervision of the children in the driveway.[133]

109. The report was screened in as meeting the threshold of ROSH and transferred to St Marys CSC for further assessment within 10 days. The report should have been assessed at the Helpline stage as requiring a response within 24 hours. The report should have been taken to a WAM and allocated for an immediate response. There was a WAM conducted but this report was not considered. It is not known whether an operational capacity report was completed. The report was closed.[134] This was a wholly inadequate response. FACS acknowledges that the decision to close the report was wrong and that the report should have been allocated regardless of the competing priorities at the time.[135]

7 March 2014 report

110. A report was made by a Mission Australia caseworker[136] that AB was outside and in danger of being hit by a car. The report indicated that the children were taken back to the house, AC was "off her face" and AD not home.[137] This report was initially made by Mission Australia to the St Marys CSC but the reporter was redirected to make a report to the Helpline. There is no record of the call to St Marys CSC and follow up by St Marys CSC at this time.[138]

111. The report was then made to the Helpline by the Mission Australia caseworker. During the call, the Helpline worker requested further information from Mission Australia about the incident and instructed the Mission Australia caseworker that she would call back in half an hour. The further information was obtained by Mission Australia but the FACS Helpline worker did not call back as promised.

112. In any case, the report was screened in as meeting the threshold for ROSH and transferred to St Marys CSC for further assessment within 24 hours. There is no

[133] Simone Walker, tab 122, p. 1769 and tab 153, p. 1966.
[134] Simone Walker, tab 122, p. 1769.
[135] Exhibit 4, FACS letter, 9 February 2018, p. 10.
[136] Helen Lunn, tab 172, p. 2289 and p. 2308.
[137] Simone Walker, tab 122, p. 1770, tab 154, p. 1969.
[138] Helen Lunn, tab 172, p. 2289.

FACS record of any WAMs or operational capacity reports conducted over the next three weeks. The report was closed for competing priorities on 2 April 2014.[139] Again, this was a wholly inadequate response.

113. FACS acknowledges that the report should have been categorised as requiring urgent allocation and received an immediate response. FACS also acknowledges that, if St Marys CSC was unable to allocate the report due to competing priorities, the Director of Community Services should have been notified in order to ensure a response was provided. FACS acknowledges that the closure of this report was wrong and that the report should have been allocated regardless of competing priorities.[140]

The role of Mission Australia

114. Mission Australia played a substantive and relevant role in the provision of support to the [redacted] family in the months leading up to the death of BLGN [redacted]. Helen Lunn, State Leader of Regional NSW for Mission Australia, gave evidence at the inquest.

115. Ms Lunn explained that Mission Australia conducted the Fairfax House Program, which provided short to medium term accommodation and case management support to families at risk of homelessness. The program owned and operated the housing complex in [redacted].[141]

116. On 22 October 2013 AD [redacted] was referred by Mission Australia to the Fairfax House Program and assigned a caseworker. On 25 October 2013, the caseworker (Ms Editha Agula-Planes) met with AD [redacted], AB [redacted] and AA [redacted] and undertook an assessment.[142] Mission Australia contributed the rental bond and first two weeks rent for the unit.

117. On 19 November 2013 the caseworker developed a case plan to identify goals for AD [redacted] in order to meet her tenancy obligations.[143]

118. On 22 November 2013 the caseworker observed AA [redacted] and AB [redacted] outside and

[139] Simone Walker, tab 122, p. 1970.
[140] Exhibit 4, FACS letter, 9 February 2018, p. 12.
[141] Helen Lunn, tab 172, p. 2281.
[142] Helen Lunn, tab 172, p. 2283.
[143] Helen Lunn, tab 172, p. 2284.

unsupervised.[144] The police were contacted and AD was warned by the caseworker about the lack of supervision and further warned that any future incidents would be reported to FACS.[145]

119. Between 17 December 2013 and 7 January 2014 the caseworker attempted on five occasions to contact AD to discuss her concern about the care of the children and to provide assistance to the family.[146] Ms Lunn made it clear in her evidence that repeated attempts were made by the Mission Australia caseworker to make contact with the [redacted] family throughout this time.

120. On 8 January 2014 the Mission Australia Specialist Housing Manager contacted AD in hospital (following the birth of BLGN) to confirm whether the family were still living in the house.[147]

121. On 20 March 2014 AD's tenancy was terminated for failure to pay rent. As at the date of BLGN's death, vacant possession had not been provided by the [redacted] family.[148]

122. It is clear that Mission Australia attempted to provide support to AD and her family.

Communication between FACS and Mission Australia

123. Following the report of 7 March 2014, a FACS caseworker attempted to telephone Mission Australia on 7, 10, 11, 12 and 18 March 2014. There was no other action taken by FACS during this period.[149]

124. On 18 March 2014 the FACS caseworker had a telephone conversation with the Mission Australia caseworker. FACS was informed of the lack of supervision and neglect of the children, that the family "does not want to be helped" and that the mother "does not engage with services."[150]

125. On 19 March 2014 the Mission Australia caseworker received a call from a caseworker at St Marys CSC asking about the [redacted] family. The FACS caseworker complained that Mission Australia had not returned her call.[151] The

[144] Helen Lunn, tab 172, p. 2298.
[145] Helen Lunn, tab 172, p. 2288 and p. 2298.
[146] Helen Lunn, tab 172, p. 2289.
[147] Helen Lunn, tab 172, p. 2289.
[148] Helen Lunn, tab 172, p. 2285.
[149] Simone Walker, tab 155, p. 1974
[150] Simone Walker, tab 155, p. 1974-1975.
[151] Helen Lunn, tab 172, p. 2318.

FACS caseworker then asked the Mission Australia caseworker whether the [redacted] children were at risk and whether the incidents of concern had been reported to police.[152] It is not clear whether this FACS caseworker accessed the history of reports for the children.

126. On 28 March 2014 the Mission Australia Specialist Housing Manager contacted St Marys CSC to discuss concerns about the [redacted] children. This manager was told the caseworker was unavailable and that the caseworker would call her back. FACS did not return this call.[153] FACS has no record of this contact from Mission Australia and no explanation as to how and whether a caseworker had been allocated at all.

127. On 31 March 2014 the Mission Australia caseworker contacted FACS to report concerns for the welfare of the children. The caseworker was advised that the case was unallocated. The Mission Australia caseworker left a message for the triage officer to return the call.[154]

128. Ms Alexander of FACS accepted that where a fellow social worker (such as a social worker from Mission Australia) gives FACS information about significant risk of harm to a child, "great store" should have been put on that information; it should have been treated as serious information and acted upon.[155]

129. On 2 and 8 April 2014 the report was discussed at allocation meetings at St Marys CSC. At these meetings, allocation to the program "Strengthening Families" was considered but not allocated due to competing priorities.[156] Both FACS witnesses accepted that it should have been "obvious", given the mandatory reporter was a caseworker from Mission Australia and had indicated the family was not engaging with their service, that the [redacted] family was not appropriate for a voluntary program like Strengthening Families.[157]

130. On 9 April 2014 a FACS caseworker informed a Mission Australia caseworker that the case would be closed for competing priorities. The Mission Australia

[152] Helen Lunn, tab 172, p. 2318.
[153] Helen Lunn, tab 172, p. 2290 and p. 2312.
[154] Helen Lunn, tab 172, p. 2319.
[155] Transcript Kate Alexander, 14/02/18, page 74, line 43 onwards. See also transcript Simone Walker, 15/02/18, page 64, line 10 onwards.
[156] Simone Walker, tab 122, p. 1770.
[157] Transcript Kate Alexander, 14/02/18, page 69, line 20 onwards; Transcript Simone Walker, 15/02/18, page 61, line 16 onwards.

caseworker expressed serious concern about this decision and asked "why [FACS] is closing the family's file when they have not even investigated the notifications." FACS was informed during this phone call that the [redacted] family had been evicted and they would soon be vacated from the property by a sheriff.[158] The FACS caseworker informed the Mission Australia caseworker that the file would be closed because the 28 day allocation had lapsed.[159]

131. The record taken by the FACS caseworker of the telephone call concludes: "[The Mission Australia caseworker] stated that she did not want blood on her hands and I stated no-one wanted that. I expressed that I had concern for the family however at the moment the matter could not be allocated."[160] The following day BLGN [redacted] died.

The inadequacy of FACS' response

132. Ms Walker of FACS accepted in her evidence that, well prior to BLGN [redacted]'s death, FACS was on notice that:

1. AD [redacted] was addicted to methamphetamines;
2. AD [redacted] used methamphetamines in presence of children;
3. AD [redacted] co-slept with her children;
4. AD [redacted] had an association with criminal activity;
5. AD [redacted] had neglected her children and had limited parenting capacity;
6. AC [redacted] was addicted to methamphetamines;
7. AC [redacted]'s supervision of the children was inappropriate;
8. AC [redacted] had an association with criminal activity;
9. the family was often transient in terms of homelessness and moving house; and
10. AD [redacted] was reluctant to engage with services in terms of cooperating and

[158] Helen Lunn, tab 172, p. 2321.
[159] Helen Lunn, tab 172, p. 2321.
[160] Simone Walker, tab 155, p. 1974-1975.

seeking assistance.[161]

133. It is abundantly clear that the response to the [redacted] family by FACS was wholly inadequate.

134. As discussed below, under the case closure policy at the time, a report was only able to be closed *after* an assessment had been made about the level of risk posed by the report and a determination made that the risk required a caseworker to undertake an assessment.

135. At the very least, and even without reference to earlier ROSH reports, the objective information contained in the 7 March 2014 ROSH report, in conjunction with the information provided by Mission Australia, should have been more than sufficient to ensure that the [redacted] family was allocated a caseworker at that time to undertake an urgent assessment.

136. If reference had been made to earlier ROSH reports, the need for an urgent response would have been even more obvious. In this respect, in making the assessment about the level of risk, FACS was required to review information in all ROSH and non-ROSH reports for the child to assist in gauging the level of risk posed by the latest report. In particular, it was FACS' express policy that a check must be done as to whether the "child has had more than 10 ROSH reports. The number of previous reports must be considered in the triaging process."[162]

137. The 7 March 2014 ROSH report was the 10th ROSH report received in relation to the [redacted] children. It is apparent that, when the FACS Assessment Records for these ROSH reports are reviewed, they contain no acknowledgement or analysis of the number of prior ROSH reports received in relation to the children (or that by the time of 7 March 2014, there had been 10 ROSH reports received in relation to the children).

138. Ms Alexander accepted that it was "seriously inadequate" that there was no assessment or analysis by the triager as to the risk posed by the number of prior ROSH reports.[163] She found it "extremely troubling" that there was, in effect, no analysis in the Assessment Records in relation to the [redacted] children as to why

[161] Transcript Simone Walker, 15/02/18, pages 36 and 37, lines 15 to 37.
[162] Triage Assessment, tab 123, p. 1775.
[163] Transcript Kate Alexander, 14.02.18, page 65, line 20 onwards; see also, transcript Simone Walker, 15.02.18, page 46, line 20 onwards.

there were so many ROSH reports or the risk that they posed prior to the decision to close the matters without taking action.[164] Given the lack of acknowledgement or analysis of the prior ROSH reports in relation to the children in the Assessment Records, the natural inference is that, in breach of policy, these prior ROSH reports were not checked and therefore not factored into any assessment of the risk that the latest ROSH report posed.

139. As set out above, the FACS caseworker informed Mission Australia that the file would be closed because the 28 days allocation had lapsed.[165] This was not just a one-off misunderstanding of the policy. Ms Alexander accepted that there seemed to be a culture where, even though a matter was serious enough to require allocation to a caseworker, if it had not been dealt with within 28 days it would be closed.[166]

140. FACS did not assess the final ROSH report within the necessary time frame and did not adequately respond to the risk of ongoing lack of supervision, neglect and physical and psychological harm to the [redacted] children posed by ongoing drug use by [redacted] and [redacted]. No attempt was made to engage with the family, conduct a risk assessment or implement a safety plan. There was no consideration of any intervention other than referral to a voluntary program/s which had already been attempted by Mission Australia. There was no useful attempt to obtain valuable information about the family from Mission Australia. Engagement by the [redacted] family in a voluntary program was patently unsuitable. FACS was clearly aware the family had been evicted, were in crisis and were not engaging with any voluntary support.

141. No competing priorities justified the lack of response. FACS accepts that, given none of the ROSH reports ever went to a WAM, an accurate decision about competing priorities was not made.[167]

142. FACS should have responded to the report by way of an urgent home visit. A pre-assessment consultation should have occurred between the manager casework and the caseworkers, during which they should have discussed the family history, current risks and concerns, family strengths, cultural considerations and the issues

[164] Transcript Kate Alexander, 14.02.18, page 68, line 42 onwards.
[165] Helen Lunn, tab 172, p. 2321.
[166] Transcript Kate Alexander, 14/02/18, page 70, line 10 onwards. See also transcript Simone Walker, 15.02.18, page 61, line 48 onwards.
[167] Transcript Simone Walker, 15.02.18, page 5, line 16 onwards.

that needed to be explored at the visit. A safety and risk assessment should have been undertaken on all children at the house. Enquires should have been made with other agencies and services, including Mission Australia and the NSW Police Force.

143. FACS acknowledges that, in the event the above occurred, it is likely that it would have been considered that the children were at risk of significant harm and that protective action was necessary. It is likely that action would have been taken such that the children were either assumed or removed and placed in out of home care.[168]

The FACS reviews of BLGN [redacted]'s death

Initial review - 2014

144. On 16 April 2014, five days after BLGN [redacted]'s death, an initial review was undertaken by FACS ("the Initial Review"). The Initial Review did not comment on issues of capacity of the involved CSCs or the closing of reports due to competing priorities. Relevantly, the Initial Review did not identify any significant issues with the FACS response to the [redacted] family. FACS now accepts that this assessment in the Initial Review – that there were no significant issues – was incorrect and inadequate.[169]

145. In her oral evidence, Ms Alexander accepted that:

1. a "significant failing" of the Initial Review report is that it did not include any analysis as to why there had been such a large number of ROSH reports in relation to the [redacted] children and yet FACS did not assess the family face-to-face at any point;[170]

2. another significant issue that warranted further review in this case was the apparent practice of CSCs closing matters for "competing priorities" without a proper assessment having been done of the actual seriousness of the reports;[171]

3. one of the issues that was plainly raised as part of this review was how it is

[168] Exhibit 4, FACS letter, 9 February 2018, p. 13.
[169] Kate Alexander, tab 121, p. 1723.
[170] Transcript Kate Alexander, 14.02.18, page 47, line 20 onwards; page 54, line 48 onwards; page 55, line 3 onwards.
[171] Transcript Kate Alexander, 14/02/18, page 47, line 25 onwards. .

that these matters were closed under "competing priorities" even though they had never been to a WAM to work out what the priorities in fact were at that local CSC;[172]

4. it is apparent from the Initial Review that the reason why there had been limited face-to-face assessments of the family is because FACS failed to engage with the family (and yet there was no analysis of that);[173] and

5. the overall tenor of the Initial Review is that neither the review writer nor the Manager signing off on the review viewed this case as being unusual or problematic.[174]

Further review - 2016

146. Ms Alexander explained that the Serious Case Review Unit ("SCR unit") (previously known as the Child Deaths and Critical Reports unit) has since changed the manner in which it undertakes child death reviews. All FACS internal child death reviews are now referred to as serious case review reports. Further, in 2016 the Serious Case Review Panel was established to address governance concerns regarding the FACS response to recommendations from child death reviews.

147. In October 2017, after this coronial investigation was commenced, the SCR Unit conducted a further review of BLGN's death and identified numerous deficiencies in the FACS response to the [redacted] family.[175] This review did not identify any deficiencies in the drafting or implementation of relevant policies.

Triage assessment policy

148. The triage assessment policy in force at the time of BLGN's death provided that, when FACS received a report in relation to risk to a child, the Helpline would screen the report by assigning it a category of seriousness and allocating an indicative time in which a response should be made. Where a report was screened in as a ROSH report, the report was sent to the appropriate CSC and a process of triage assessment undertaken.

149. The triage process required a report to be sorted into one of the following four

[172] Transcript Kate Alexander, 14.02.18, page 52, line 20 onwards.
[173] Transcript Kate Alexander, 14.02.18, page 50, line 28 onwards.
[174] Transcript Kate Alexander, 14.02.18, pages 49 to 50, line 49 onwards.
[175] Kate Alexander, tab 121, p. 1725 - 1728.

categories:[176]

1. Urgent allocation;
2. Priority for allocation;
3. Brighter Futures ROSH referral; or
4. Closure.

Category 1

150. If the assessment was that the report was to be given an "Urgent" allocation (category 1), the report was required to be allocated immediately. If there was no capacity for such Urgent allocation, the policy required that the Director, Community Services be informed. The purpose of this escalation was to ensure that resources would be made available for allocation.

Category 2

151. If the assessment was that the report was to be given a "Priority" allocation (category 2), and if a report in this category was unable to be allocated that day or before the next WAM, the policy required that it be taken to the WAM meeting for review and determination of follow-up as deemed appropriate.

Category 3

152. An assessment that the report was to be given a "Brighter Futures RoSH Referral" allocation (category 3) allowed a CSC Manager Triage to make a referral to the voluntary program Brighter Futures if it was determined that the program could provide an appropriate response to the type of abuse and risk of harm identified.

153. The priority for the allocation of category 3 reports that had not already been allocated was to be considered at a WAM, which were attended by managers and casework specialists. The purpose of the WAM was to review the operational capacity of the CSC and determine which matters would be allocated caseworkers and in what priority. FACS required CSCs to complete a WAM report and an operational capacity report for this purpose.

Category 4

[176] Simone Walker, tab 125, p. 1788.

154. A report could be allocated to the "Closure" category (category 4):

1. if the available information did not suggest that the risk fell into one of the other three categories; and

2. "as a result allocation cannot be supported in light of higher priority matters."

155. Ms Alexander accepted that one of the most important parts of the triaging process is a decision to close a report without allocating it to a caseworker (because a closure decision effectively puts those matters out of the system).[177]

156. Under the first criterion for Closure, by definition a report is only able to be closed if the risk does not fall into one of the first three categories (being allocation Urgent or Priority allocation or Referral). As such, the first criterion in fact required FACS to make an assessment about the level of risk posed by the report and, inter alia, a determination that the risk did not fall into one of the first three categories.[178]

157. As a general matter, the material that is documented in the Assessment Records is superficial and sparse. It is apparent, as FACS has accepted, that a proper assessment of the risk that the ROSH reports in relation to the [redacted] children posed was not undertaken. In fact, and as FACS has also accepted during this inquest, a proper assessment of the risk these reports posed would have led to the conclusion that they required either an Urgent or Priority allocation (being category 1 or category 2).

158. Instead, these reports were closed for "competing priorities" without any proper assessment having been done as to what priority those reports should be given (as no proper assessment was done of what risk they posed).[179]

159. The second criterion for Closure was referred to by FACS staff by the shorthand moniker "*competing priorities.*"[180] This allowed a ROSH report to be closed prior to ever being compared to, or considered in light of, the operational capacity of the CSC at a WAM.

160. It was at the WAM that the operational capacity of the CSC to allocate reports, and

[177] Transcript Kate Alexander, 14.02.18, pages 70 to 71, line 45 onwards.
[178] Transcript Simone Walker, 15.02.18, page 47, line 10 onwards; page 48, line 21 onwards; page 49, line 14 onwards.
[179] Transcript Kate Alexander, 14.02.18, page 62, line 4 onwards; page 63, line 43 onwards.
[180] Transcript Kate Alexander, 14.02.18, page 65, line 27 onwards; Transcript, Simone Walker, 15.02.18, page 47 line 28 onwards.

the priority that should be given to each of these reports (in light of the other reports that the CSC had to deal with), would be considered. As such, the policy allowed a ROSH report to be closed without any proper assessment as to how the priority of these reports "competed" with other reports being dealt with by the CSC (as the report was never presented to a WAM).

161. Ms Walker gave evidence that it was only at the WAM that the CSC would have proper visibility and an ability to assess different matters and to assess what those priorities were.[181] She agreed that to close a matter for "competing priorities" at the threshold triage stage (prior to the report being considered at a WAM) was "pre-empting the analysis of what other priorities there were."[182]

162. Ms Alexander also agreed that, given these matters were not considered at a WAM, the triage manager could not in fact have made a proper determination as to whether there were higher priority matters.[183]

General issues with case closure policy

163. There are a number of more general issues with the case closure policy.

164. Ms Alexander accepted that the triaging decisions in the [redacted] case involved, over a number of years by multiple triagers across two large CSCs, a fundamental misunderstanding of the case closure policy (given that the policy in fact only allowed closure of matters *if* a decision had been made that they were not serious enough to be allocated).[184]

165. Ms Alexander acknowledged in her evidence that the following are distinct "conceptual questions":

    1. an assessment of *risk* (namely, whether a report requires a response); *as opposed to*

    2. an assessment of the priorities at a CSC (namely, an assessment of the priority in which a response should be taken in light of other reports that require a response and their respective priorities).[185]

[181] Transcript Simone Walker, 15.02.18, page 51, line 3 onwards.
[182] Transcript Simone Walker, 15.02.18, page 51, line 19 onwards.
[183] Transcript Kate Alexander, 14/02/18, page 63, line 49 onwards.
[184] Transcript Kate Alexander, 14/02/18, page 65, 38 onwards; page 66, 14 onwards.
[185] Transcript Kate Alexander, 14/02/18, page 47, line 37 onwards.

166. Even though those two concepts are distinct conceptual questions, in order to close a case, the triager is called upon to make an assessment of the seriousness of the report *at the same time as* an assessment of the priorities at the CSC. This is a potentially difficult (if not impossible) task to undertake prior to a WAM. So much was acknowledged in evidence by both Ms Alexander and Ms Walker.[186]

167. Ms Alexander agreed that a "danger" with the concept of "competing priorities" at this initial triaging level is that, in practice, it allows triagers to avoid the more difficult task of assessing how serious a matter in fact is.[187] At worst, it creates an incentive or an easy way of getting rid of matters.[188] As such, even though the case closure policy did not in fact allow closure of these matters, the concept of "competing priorities" creates "a real risk it'll be used as sort of a dumping ground for [an] overworked caseworker" even though the seriousness of the reports actually has not been assessed.[189]

168. In this respect, it is noted that the report entitled *Nepean Blue Mountains FACS District – Intake & Assessment Performance Improvement Project* (22 May 2015)[190] sets out statistics detailing the very high percentages of cases "closed for competing priorities" at Penrith and St Marys CSC in 2014 to 2015.

169. Ms Alexander accepted that, in relation to a number of the ROSH reports about the [redacted] children, there was an acceptance by the relevant FACS workers that the report was serious and required allocation but because of "competing priorities" they were closed.[191] Ms Alexander accepted that closing reports for competing priorities was a "catch all" category that matters were tipped into in a way that meant that the seriousness of these matters were not, in fact, properly assessed.[192] Ms Alexander's breadth of knowledge was impressive. She gave evidence in a thoughtful and compelling manner, demonstrating both skill and sensitivity. Her analysis of the problem posed by the FACS culture of file closure for "competing priorities" was disturbing and thought-provoking. It is clear that policies which support the growth of such a culture must be dismantled.

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[186] Transcript Simone Walker, 15/02/18, page 51, line 3 onwards. Transcript Kate Alexander, 14/02/18, page 63, line 49 onwards.
[187] Transcript Kate Alexander, 14/02/18, page 75, line 45 onwards.
[188] Transcript Kate Alexander, 14/02/18, page 75, line 49 onwards.
[189] Transcript Kate Alexander, 14/02/18, page 76, line 10 onwards. Transcript Simone Walker, 14/02/18, pages 54 to 55, line 47 onwards.
[190] Produced by FACS on 28 March 2018 (after the hearing) (see in particular pp 25, 28).
[191] Transcript Kate Alexander, 14/02/18, page 61, line 7 onwards; page 61, line 47 onwards.
[192] Transcript Kate Alexander, 14/02/18, page 62, line 4 onwards; page 64, line 38 onwards. .

170. Ms Walker agreed in her evidence that the reason for the absence of any analysis of the seriousness of the ROSH reports was because the CSC was focused on "competing priorities."[193] She agreed that these cases are an example of where the mixing together of the concept of "seriousness" with the concept of "priorities" at this threshold triaging stage can create an easy way out for an overburdened CSC to place matters into the closure category.[194]

171. Both FACs witnesses agreed that considering the concept of "competing priorities" at that point leads to confusion with the separate, and logically anterior, requirement to assess the seriousness of the report (and decide whether a response is warranted).[195] This leads to genuine confusion as to what, in fact, the decision-maker is assessing at that point.[196] What the decision-maker should be assessing at that point is the threshold question of the seriousness of the ROSH report.[197]

172. Both FACS witnesses agreed that it would be clearer to have a policy that made it apparent to triagers that the threshold decision (being the assessment of the objective seriousness of the report) is critical and that the question of priorities should be put to one side at the point at which the decision about the seriousness of the report is made.[198]

173. Ms Alexander and Ms Walker both agreed that these two distinct concepts should be unbundled in the triage process.[199] They should be expressly demarcated as separate decisions that must be made independently of each other. Ms Walker suggested in her evidence that a good option would be to consider a new approach whereby the risk/seriousness decision is made by one person and the prioritisation decision is made by another (in order to avoid the apparent confusion about the proper role of the triager at this point).[200]

174. Ms Alexander agreed that the [redacted] case is an archetypal example of the

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[193] Transcript Simone Walker, 15/02/18, page 50, line 22 onwards.
[194] Transcript Simone Walker, 15/02/18, page 50, line 27 onwards.
[195] Transcript Kate Alexander, 14/02/18, page 35 onwards; page 87, line 20 onwards. Transcript Simone Walker, 15/02/18, page 55, line 5 onwards.
[196] Transcript Kate Alexander, 14/02/18, page 86, line 35 onwards; page 87, line 20 onwards. Transcript Simone Walker, 15/02/18, page 55, line 5 onwards.
[197] Transcript Kate Alexander, 14/02/18, page 86, line 35 onwards; page 87, line 20 onwards.
[198] Transcript Simone Walker, 15/02/18, page 50, line 5 onwards. Transcript Kate Alexander, 14/02/18, page 87, line 26 onwards.
[199] Transcript Kate Alexander, 14/02/18, pages 87 to 88, line 46 onwards.
[200] Transcript Simone Walker, 15/02/18, pages 58 to 59, line 36 onwards.

confusion that could arise as to the proper role of the triager. That is, the triagers were not properly assessing how serious the ROSH reports were but rather they were going to the second part of the analysis (namely, looking at priorities) and closing on that basis.[201]

175. These practices resulted in the repeated and systematic failure at the involved CSCs to properly assess and respond to the risk posed to the [redacted] children.

176. This policy is no longer in operation. However, as set out below, the new policy still allows ROSH reports to be closed for "competing priorities."

New case closure policy

177. The case closure policy was revised in late 2017 and located in the triage assessment policy under the heading "Closing a report without proceeding to a WAM."[202] The policy sets out three criteria for the closure of a ROSH report:

1. the available information is not sufficient for allocation;
2. other reports for allocation are higher priority;
3. the report has remained unable to be allocated for more than 28 days.

Ambiguities

178. The first issue with the new case closure policy is that it introduces additional ambiguities.

179. For example, there is a significant ambiguity as to whether only one or all three of the above criteria must be satisfied in order to close a report. Both FACS witnesses were unclear as to what this part of the policy actually meant and agreed it was ambiguous.[203]

180. Both FACS witnesses also agreed that it was "not clear" in relation to the first criterion as to whether it is directing a triager that the report can be closed because there is not enough information available or whether it can be closed because the

[201] Transcript Kate Alexander, 14/02/18, page 87, line 41 onwards.
[202] Exhibit 4, Annexure A, Triage assessment, p. 3.
[203] Transcript Kate Alexander, 14/02/18, pages 80 to 81, line 35 onwards. Transcript Simone Alexander, 15/02/18, page 53, line 20 onwards.

triager thinks the report is not serious enough.[204]

181. Further, as a general matter, Ms Walker agreed that the new policy is not clear as to how to determine which matters should be treated as urgent (and allocated immediately) as opposed to not urgent but requiring a response from a FACS caseworker.[205] Ms Walker agreed that the new policy should be amended to set out the criteria that a triager should follow in making a decision as to what should happen to a ROSH report.[206]

182. Both FACS witnesses accepted that one of the most important parts of the triaging process is a decision to close a report without allocating it to a caseworker.[207] Therefore, FACS' policies need to articulate with clarity the exact criteria that must be applied in terms of making such an important decision.[208]

183. Ms Alexander agreed that the ambiguities in the policy should be clarified as a matter of some priority.[209]

Use of "competing priorities" concept in new case closure policy

184. Both FACS witnesses accepted in evidence that the second criterion in the current case closure policy is, effectively, the concept of "competing priorities" and that is how FACS workers treat that criterion.[210] The current case closure policy is therefore essentially the same as the previous version in this respect.[211]

185. As such, the current case closure policy still poses the issues identified in relation to earlier policy in place at the time of BLGN 's death.

186. In this respect, both FACS witnesses were of the view that the use of "competing priorities" to close ROSH reports is "problematic."[212] Notwithstanding that, the new case closure policy (which has only very recently been introduced) still allows a

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[204] Transcript Kate Alexander, 14/02/18, page 82, line 45 onwards. Transcript Simone Walker, 15/02/18, pages 53 to 54, line 36 onwards.
[205] Transcript Simone Walker, 15/02/18, pages 65 to 66, line 16 onwards.
[206] Transcript Simone Walker, 15/02/18, page 66, line 11 onwards.
[207] Transcript Kate Alexander, 14/02/18, pages 70 to 71, line 45 onwards; page 71, line 32 onwards, page 82, line 25 onwards. Transcript Simone Walker, 15/02/18, pages 48 to 49, line 35 onwards.
[208] Transcript Kate Alexander, 14/02/18, page 71, line 38 onwards. Transcript Simone Walker, 15/02/18, page 53, line 32 onwards.
[209] Transcript Kate Alexander, 14/02/18, pages 83 to 84, line 15 onwards.
[210] Transcript Kate Alexander, 14/02/18, page 84, line 27 onwards. Transcript Simone Walker, 15/02/18, pages 51 to 52, line 49 onwards; page 54, line 7 onwards.
[211] Transcript Kate Alexander, 14/02/18, page 84, line 27 onwards.
[212] Kate Alexander, tab 121A at [7]. Kate Alexander, 14/02/18, page 76, line 18 onwards; pages 85 to 86, line 7 onwards. Transcript Simone Walker, 15/02/18, page 54, line 34 onwards.

ROSH report to be closed for "competing priorities" at an early stage. In my view, it is well and truly time to dismantle this policy.

Closure of reports after going to a WAM

187. The new policy (like the previous policy) also allows for a ROSH report to be closed, even after going to a WAM, if "other reports for allocation are higher priority and the report has remained unable to be allocated for more than 28 days."[213]

188. Ms Walker agreed that, on the face of that new policy, it confers an open discretion on a CSC to close a report after a WAM if (because of competing priorities) it has not been allocated within 28 days, even if a report has been categorised as a ROSH report by the Helpline and then triaged as requiring an assessment by a FACS caseworker.[214]

189. Ms Walker agreed that the policy should be amended so that it is made clear that it is the "least preferred option" for a report to be closed in such circumstances, and that alternatives to closure should be specifically identified and emphasised in the policy.[215]

Resourcing of FACS

190. It is noted that the Helpline screening tool whereby a report would be given a rating of "ROSH" was built on the assumption that all ROSH reports would receive an assessment by a caseworker.[216] However, in practice, a "vast majority" of ROSH reports never receive a response from a FACS caseworker.[217] It is, in my view, a broken tool. In the 2013 to 2014 period, only some 27% of reports at the St Marys CSC categorised as ROSH by the Helpline received an assessment by a caseworker.[218] In the year 2016 to 2017, both the volume of reports and the volume of children seen by FACS caseworkers increased. However, this increase resulted in FACS caseworkers still only seeing approximately 25% of children deemed at risk of significant harm.[219] Ms Walker agreed that this could suggest

[213] See Tender Bundle, Annexure 2a, p. 7 of 9.
[214] Transcript Simone Walker, 15/02/18, pages 62 to 63, line 41 onwards.
[215] Transcript Simone Walker, 15/02/18, pages 63 to 64, line 45 onwards.
[216] Transcript Kate Alexander, 14/02/18, page 59, line 14 onwards. Simone Walker, 15/02/18, page 39, line 20 onwards.
[217] Transcript Simone Walker, 15/02/18, page 40, line 20 onwards.
[218] Transcript Simone Walker, 15/02/18, page 40, line 13 onwards.
[219] Transcript Simone Walker, 15/02/18, page 41, line 44 onwards.

that the St Marys CSC is not adequately resourced.[220]

191. FACS is the agency in NSW tasked with a statutory responsibility for protecting children and young people from risk of significant harm. That is a responsibility that cannot be shifted by creating a culture where overworked staff can close reports, claiming a lack of resources or "competing priorities." Failures of the kind made in relation to the [redacted] family should not be swept under the carpet. The Minister and the Secretary must be made to grapple openly with these issues at the highest level and to find solutions to the resourcing issues identified.

Background in relation to DG [redacted]

192. DG [redacted] was the daughter of AD [redacted] and AG [redacted] ("AG [redacted]").[221] DG [redacted] was an aboriginal child.

193. On 8 November 2014, AD [redacted] was involved in a serious, high-speed motor vehicle accident while pregnant with DG [redacted]. She was admitted to Westmead Hospital with lacerations, a rib fracture and a (L1 spinal) transverse process fracture. She also tested positive for opioids, benzodiazepine, amphetamines and methamphetamines.[222] She underwent an obstetric ultrasound that demonstrated a sub chorionic haematoma encompassing approximately 50% of the gestational sac.[223]

194. On 25 January 2015, while still pregnant, AD [redacted] was reportedly punched in the head by AG [redacted]. Police attended AD [redacted]'s residence but AD [redacted] refused to make any statement.[224] Throughout her pregnancy and after the birth (and removal) of DG [redacted] there were a number of other reports of serious violence perpetrated by AG [redacted].[225] In evidence, AD [redacted] acknowledged the level of violence but suggested the dynamic was more complicated, She told the Court, "we were both as bad as each other really."[226]

195. AD [redacted] smoked ice and cigarettes during her pregnancy with DG [redacted].[227] She said in

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[220] Transcript Simone Walker, 15/02/18, pages 41 to 42, line 46 onwards.
[221] Casey Ralph, tab 87, p. 907.
[222] Westmead Hospital clinical notes, tab 115, p. 1473.
[223] Westmead Hospital clinical notes, tab 113, p. 1357.
[224] COPS entry E57070048, tab 96.
[225] COPS entry E59140746, tab 97.
[226] Transcript AD [redacted] 12/02/18, page 72, line 20 onwards
[227] AD [redacted], second ERISP, tab 91, p. 27.

oral evidence that ice use was "not regular"[228] but she agreed that she smoked ice for one week during the pregnancy, which was the week of the anniversary of BLGN 's death.

196. AD told the Court that she had been in touch with a FACS caseworker soon after she fell pregnant and that she had been told "there's going to be nothing until baby's born".[229]

197. On 26 May 2015, FACS received a high-risk birth alert for the unborn DG .[230]

198. DG was born at Westmead Hospital on .

199. On 12 June 2015, FACS caseworkers interviewed AD in hospital and assumed DG into the care of the Minister, on the basis of a risk of neglect, a risk of the child being drug affected and a risk of an unsafe environment following discharge.[231]

DG 's medical history

200. On 10 June 2015, DG 's birth, an antenatal scan was performed on AD . This scan was reported as showing a large pulmonary artery and a large tortuous left pulmonary artery.[232] The entry for the scan read: "USS today, large retroplacental haematoma 13 x 2.9 x 8cm), prominent pulmonary artery 2 x size aorta. Torous L. pulmonary artery."

201. On DG was born by caesarean at 38 weeks. Her birth weight was 2750 grams with normal Apgar scores. She was admitted into the special care nursery for suspected cardiac abnormality and monitoring for neonatal abstinence syndrome.[233]

202. On the morning of 12 June 2015, DG was seen by Dr Daphne D'Cruz, staff specialist in neonatology. DG was feeding well with bottle formula and had passed urine and stools. Her neonatal abstinence scores were normal. Her blood glucose level, full blood count and haemoglobin were all within normal range.

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[228] Transcript AD , 12/02/18,page 72, line 35.
[229] Transcript AD , 12/02/18 page 72, line 44 onwards.
[230] Julie Freckelton, tab 85, p. 886.
[231] Julie Freckelton of 27 August 2015, tab 85 at [15] and Westmead clinical notes, tab 98, p. 1039.
[232] Mervis report, tab 94, p. 2 (page number of report).
[233] Dr Daphne D'Cruz of 21 June 2016, tab 93, p. 989.

Dr D'Cruz requested review by a paediatric cardiologist.[234]

203. In the afternoon of 12 June 2015, Dr Mervis assessed DG. He found she had a structurally and functionally normal heart and did not require further cardiac review.[235]

204. On 14 June 2015 DG was reviewed by Dr Sasikesavan, Registrar, and Dr Jani, Neonatologist. Her observations were normal.

205. On 15 June 2015 DG was again reviewed and her total fluid rate ("TFR") of feeds was increased to 140ml/kg/day.

206. On 16 June 2015 DG was further reviewed and her TFR again increased to 160ml/kg/day.

207. On 17 June 2015 Dr Sasikesavan documented that DG had bilateral red reflex in her eyes, no heart murmur and no clicks in the hips. Dr Sasikesavan then prepared the Neonatal Discharge Summary.[236]

The role of FACS and DG 's assumption into care

208. On 17 June 2015, DG was discharged from hospital into the care of an authorised carer.[237] She remained with her carer without incident until 30 June 2015.

209. On 18 June 2015 FACS filed an application initiating care proceedings in the Children's Court of NSW seeking an order that the Minister be allocated parental responsibility in relation to DG.[238]

210. On 19 June 2015 the Children's Court made interim orders placing DG in the care of the Minister and FACS made arrangements for her to be placed in out of home care through the Aboriginal agency KARI.[239]

211. AD gave evidence that it was only days after DG 's birth that she was informed that FACS would definitely remove DG from her care.[240] She had been hoping to go with DG to AH 's ("AH ") house. AH was DG 's

[234] Dr Daphne D'Cruz, tab 93, p.989-990.
[235] Westmead Hospital clinical notes, tab 98 at p. 1030.
[236] Dr Sasikesavan, tab 92, p. 987 and discharge summary tab 98, p. 1011.
[237] Julie Freckelton of 27 August 2015, tab 85, p. 889.
[238] Application initiating proceedings, tab 85, p. 891.
[239] Julie Freckelton of 27 August 2015, tab 85 at 889.
[240] Transcript AD 12/2/18, page 73, line 22 onwards.

paternal grandmother and was already caring for two of [redacted]'s other children at the time. [redacted] was trying to make changes to her life. She told the Court, "I had already started all the domestic violence counselling, the grief counselling, and everything like that. I actually had my first appointment, grief counselling for [redacted] and then four days later [redacted] passed away."[241]

212. In her family statement to the Court, [redacted] spoke movingly of her efforts to have [redacted] placed with her, rather than with a foster carer from outside the family. Her ongoing efforts to achieve this were not successful before she received the tragic news of [redacted]'s death. [redacted]'s ongoing work in keeping Aboriginal families together and in offering support to community members struggling with ice and other drug addiction is to be commended. [redacted]'s enormous and non-judgemental support for [redacted] was evident to the Court and I am sure her strength and kindness will never be forgotten.

213. Although it is an issue well beyond the scope of this inquest, it is perplexing to see the haste with which [redacted] was taken from her extended family against the complete lack of support provided to [redacted] in the months before [redacted]'s death and indeed during the course of her pregnancy with [redacted]. [redacted]'s situation was well known before [redacted] was born, and yet the requisite planning that needed to occur to ensure the child's safety seems to have been left to the last minute. [redacted] believed, even after [redacted]'s birth, that she could agree to a safety plan that would keep her child within the family.[242] This was apparently not the case. The removal was traumatic for both [redacted] and [redacted]. Nevertheless, [redacted] told the Court that after [redacted] was taken from the hospital she was "100% certain" that she would do all she could to get [redacted] back. Tragically, [redacted] died before this could happen.

214. Despite her grief that [redacted] had been taken into temporary care, [redacted] accepted that when she saw [redacted] after interim orders had been made, [redacted] appeared "well looked after."[243]

The day of [redacted]'s death

215. At 6.30am on 29 June 2015, [redacted]'s carer woke and fed [redacted]. Later that morning she took [redacted] to the cinema with friends. She bathed and fed [redacted] in

[241] Transcript [redacted] 12/02/18, page 74, line 8 onwards.
[242] Transcript [redacted] 12/2/18, page 73, line 27 onwards.
[243] Transcript [redacted] 12/2/18, page 73, line 27 onwards

the evening.

216. At 11pm on 29 June 2015, DG was fed, wrapped in a blanket and placed in her bassinet.

217. At 2am on 30 June 2015, DG was fed again and had her nappy changed. The carer reported that DG was making "grunting noises." Between 7am and 7.30am the carer returned to DG and touched her lips and noticed she was not moving and not responsive. There was no food or vomit in her mouth.[244] She attempted resuscitation and contacted emergency services.

218. At 7.37am on 30 June 2015, an ambulance arrived at the home of DG 's carer. Ambulance officers entered the house into DG 's bedroom. DG was observed to be cyanosed (bluish skin) with no pulse or heartbeat.

219. At 8.20am on 30 June 2015, DG was pronounced deceased.[245] Police were called and Detective Senior Constables Pietruszka and Gibson attended the scene. Investigating police formed the view that DG was well cared for by her carer and there were no suspicious circumstances surrounding the death.[246]

DG 's autopsy

220. Dr Rianie Janse Van Vuuren performed the autopsy and found the cause of death to be sudden unexplained death in infancy ("SUDI").[247] There were no suspicious injuries and the baby had normal age appropriate development. There was no alcohol or drugs found in DG 's blood.[248]

221. The internal post-mortem examination showed a slightly enlarged right pulmonary artery. The summary of the microscopic examination referred to mild pulmonary hypertension, right ventricular endocardial fibrosis, and mild septal myocardial disarray.[249] However, in the body of the report there is also a reference to mild epicardial fibrosis in the right ventricle. Dr Van Vuuren confirmed in oral evidence at the hearing that the reference to epicardial fibrosis was a typographical error and that she only found endocardial fibrosis in the right ventricle.

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[244] Transcript of 000 call, tab 84, p. 881.
[245] Michael Maunder of 26 September 2015, tab 78 at 844-846. See also Harry Richards, tab 79.
[246] Detective Senior Constable Pietruska, tab 70, p. 750.
[247] Autopsy report, tab 65, p. 695.
[248] Certificate of analysis, tab 67, p. 717 - 718.
[249] Autopsy report, tab 65, p. 696.

222. The neuropathology report identified that DG had some focal bilamination in the dentate gyrus (an abnormality in the hippocampus in the brain which has been associated with SIDS).[250]

The medical evidence

The conclave of medical experts

223. The Court heard from three relevant medical experts in conclave: Professor Byard, Associate Professor Evans, and Dr Van Vuuren. These experts gave valuable evidence and ultimately agreed that the cause of death of both infants falls within the overarching term of SUDI but remains undetermined.

BLGN 's cause of death

224. The opinion of Professor Byard, paediatric pathologist and specialist on SIDS, was sought in order to assist the Court to determine the cause of death of both BLGN and DG .[251] The accepted definition of SIDS, which is a sub-category within the overall category of SUDI, is the sudden unexpected death of an infant under one year old, with onset of the fatal episode apparently occurring during sleep, that remains unexplained after a thorough investigation, including performance of a complete autopsy and review of the circumstances of death and the clinical history.[252]

225. Professor Byard identified the risk factors for SIDS as prone sleeping, cigarette smoke exposure, hyperthermia and bed sharing. He stated that many families where SIDS deaths occur have been termed "chaotic" due to housing environments, social problems and drug use.[253]

226. SIDS is a diagnosis of exclusion and can only be made after other causes of sudden death are explored and rejected. Professor Byard provided a list of possible causal mechanisms responsible for SIDS. This list is broad and includes causes such as positional asphyxia, smothering, viral infections, sepis, vertebral artery compression and cardiac chamber compression.

227. Professor Byard recommends careful post-mortem examination, comprising of

[250] Neuropathology report, tab 66 at p. 6.
[251] Byard report, tab 101, p. 1095 and supplementary report, tab 101A.
[252] Byard report, tab 101, p. 1102.
[253] Byard report, tab 101, p. 10 – 12 and 14.

external examination of the deceased, including clear documentation of the pattern of lividity. He commented that an internal examination of the deceased will usually result in findings of congested lungs haemorrhages in the thymus gland, over the heart and over the lungs.[254]

228. The rate of SIDS is less than one in 1000 births in areas where risk campaigns are undertaken. Mothers of SIDS infants tend to be young, of a lower socio-economic status and have had a number of children over a short period of time.[255]

229. Despite some of these risk factors being present in the case of BLGN, neither Professor Byard nor the other experts attribute BLGN's death to SIDS. In her case, the possibility of accidental suffocation from an item in the cot has not been excluded.[256] Professor Byard explained that the scene of the cot at the time of BLGN's death was dangerous. Professor Byard and others gave evidence about the educational initiatives which already exist in relation to "safe sleeping."[257] Unfortunately, it is beyond the scope of the evidence presented at this inquest to recommend how these initiatives can be extended or improved to reach mothers such as AD.

230. The experts also agreed that there were no findings at autopsy to suggest that BLGN died as a result of aspiration of milk from feeding. The autopsy report did not include any reference to any milk in the airways.

DG's cause of death

231. The experts were also of the view that the cause of DG's death falls within the category of SUDI but is undetermined. Professor Byard explained that the criteria for SIDS is not met because of the unexplained existence of post-mortem findings of cardiovascular and brain abnormalities. He stated in his report and confirmed in evidence that "specifically endocardial fibroelastosis and hippocampal asymmetry are not normal findings in SIDS infants and thus preclude the diagnosis."[258] The particularly relevant post-mortem findings are:[259]

1. Enlargement of the right pulmonary artery;

[254] Byard report, tab 101, p. 1104.
[255] Byard report, tab 101, p. 1107.
[256] Byard report, tab 101, p. 1108.
[257] Transcript Professor Byard , 15/02/18, page 29, line 42 onwards.
[258] Byard report, tab 101, p.15 and 17.
[259] Byard report, tab 101, p. 1109.

2. Mild pulmonary hypertension;

3. Right ventricular endocardial fibrosis;

4. Mild septal fibre disarray; and

5. Bilamination of the dentate gyrus.

DG 's heart abnormalities

232. Dr Van Vuuren confirmed that DG had a structurally normal heart. She also explained that the right pulmonary artery was slightly enlarged (with the circumference of the right artery measured at 11mm and the left artery at 5mm). Professor Byard confirmed in evidence that endocardial fibroelastosis was present in DG 's heart, evident from analysis of a microscopic slide from post-mortem.[260]

233. All the experts agreed that these findings should be considered minor and would not be expected to have caused the death of DG . However, these abnormalities are such that they affect the classification of the cause of death and are a basis to exclude a diagnosis of SIDS.

234. The experts further agreed that the cardiac assessment of DG by Dr Mervis, paediatric cardiologist, while she was in hospital was appropriate. It is noted that Dr Mervis prepared a report in regard to DG which is evidence in these proceedings. He is of the view that DG did not likely suffer from any cardiac abnormality or cardiac condition that may have caused or contributed to her death.[261] He has reviewed her clinical notes and echocardiogram and reaffirmed that DG had a structurally and functionally normal heart. She also had a tiny patent foramen ovale and a small patent ductus arterosus, both fetal shunts required for normal fetal circulation. However, he could not exclude the possibility of an underlying inherited channelopathy which could result in a cardiac arrhythmia, and noted that one in five SIDS deaths carries a mutation in a cardiac ion channel-related gene. The post-mortem diagnosis of a channelopathy would have required a molecular autopsy, which did not occur.[262]

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[260] Byard supplementary report, tab 101A.
[261] Mervis report, tab 94, p. 3 (page number of report).
[262] Mervis report, tab 94, p. 3 (page number of report).

[redacted]'s brain abnormalities

235. The autopsy showed a minor hippocampal asymmetry; a cyst; enlarged lateral ventricles; and mild reactive changes. The minor hippocampal asymmetry was the most significant finding, likely congenital, and the primary reason why Professor Byard was of the opinion that the cause of death could not be attributed to SIDS.

236. Dr Van Vuuren explained that the cyst was likely acquired, either in utero or after birth, and is a chance finding. [redacted]'s enlarged lateral ventricles were likely either congenital or acquired and with no likely real significance. The mild reactive changes included some gliosis (or scaring), which would have been caused by a reaction to an external factor such as an insult to the brain. The experts were asked whether these changes could have been a result of [redacted]'s motor vehicle accident. Professor Evans was of the opinion that any insult to the brain from this cause would have been more devastating and, as such, this was probably not the cause.

237. Professor Evans also gave evidence about the effects of the drug ice on [redacted] in utero. In his report, he explained that there is no known clinical link between [redacted]'s death and [redacted]'s car accident and amphetamine use while [redacted] was in utero.[263] In evidence he explained that ice use in the mother can cause problems in the formation of the brain and kidneys, but that such links are speculative in nature. In response to family concerns both Professor Byard and Dr Van Vuuren stated that they believed [redacted]'s death was likely to have happened quickly and painlessly while she slept.[264]

A genetic cause of death?

238. The inquest has also explored a genetic cause of death for [redacted] and [redacted]. To this end, a report was obtained from Associate Professor Edwin Kirk at the University of New South Wales. A genetic cause of death for one or both infants could be either a metabolic condition (such as a deficiency of the acyl-CoA-dehydrogenase enzymes) or a cardiac condition (such as an arrhythmogenic channelopathy). However, Professor Kirk is of the view that a metabolic disorder is very unlikely to have caused either death because there were no relevant features

[263] Evans report, tab 107, p. 1315.
[264] Transcript Professor Byard, 15/02/18, page 29, line 17 onwards.

at autopsy and both babies had normal results from newborn screening. [265]

239. An inherited cardiac condition is also very unlikely to be the cause of death of either infant. The onset of symptoms for such conditions is usually between pre-teen years and middle age, and not in infancy. Further, AD does not have any symptoms of a cardiac condition.[266]

240. Although it is very unlikely that an inherited condition can explain the cause of death of either BLGN or DG, Professor Kirk suggests that the parents of the infants (that is, AD, AE and AG) all consider undertaking a cardiac assessment. Dr Mervis also recommends genetic screening for surviving family members in order to explore whether there are any underlying inherited channelopathies.[267]

Findings pursuant to section 81 *Coroners Act 2009* for BLGN

241. The identity of the deceased is BLGN. BLGN died between 11am and 2.30pm on 10 April 2014 in her cot at her home in [redacted], Sydney. Her sleeping environment contained known risk factors. Her death was sudden and unexpected. BLGN's cause of death is SUDI but otherwise undetermined.

Findings pursuant to section 81 *Coroners Act 2009* for DG

242. The identity of the deceased is DG. DG died between 3am and 7.30am on 30 June 2015 in her bassinet in her bedroom in [redacted] Sydney. Her death was sudden and unexpected. The cause of DG's death is SUDI but otherwise undetermined. DG was assumed into care soon after birth. She received appropriate care and attention from her carer throughout her short life.

The need for recommendations

243. Section 82 of the *Coroners Act 2009* confers on a coroner the power to make recommendations that he or she may consider necessary or desirable in relation to any matter connected with the death with which the inquest is concerned. It is essential that a coroner keeps in mind the limited nature of the evidence that is presented and focuses on the specific lessons that may be learnt from the particular

[265] Kirk report, tab 104, p. 1292.
[266] Kirk report, tab 104, p. 1293.
[267] Mervis report, tab 94, p. 6 (page number of report).

death.

244. The Court was able to rule out the possibility that BLGN 's death was suspicious in any way and I hope that offers some comfort to her family. The medical evidence was complicated but there was no suggestion that either girl died as a consequence of inadequate medical care or careless diagnosis. There were factors in relation to BLGN 's death which suggest unsafe sleeping practices but the Court is unable to say that these were responsible for her death. It is certainly possible that some still unidentified medical issues existed.

245. On reflection, there was only one policy area where the possibility of recommendations arose. The evidence demonstrated that there were very significant failures in relation to the level and nature of support offered to AD by FACS. Her struggles were well known to FACS by the time BLGN was born. Her difficulties only increased and, by the time of BLGN 's death, AD was facing growing addiction and imminent eviction. It is significant that in the lead up to BLGN 's death, a Mission Australia worker was so concerned by FACS's lack of a coherent response that, in a desperate effort to make someone listen, she told the FACS worker to whom she spoke that "she did not want blood on her hands." It appears that the FACS worker documented the call, agreed with the concerns but explained that nothing could be done because there were no resources to allocate the matter. There were "competing priorities."

246. The picture that emerged of the local CSC was one of overwhelming hopelessness. There appears to have been a culture in existence in which workers came to accept that most matters could never be allocated. The substantial failings that arose because of the allocation and case closure practices that existed at the time of BLGN 's death certainly call for closer examination.

The response of FACS

247. It was reassuring that FACS recognised that the evidence, as it emerged at the inquest, raised systemic and ongoing issues in relation to the process of triaging reports and in relation to the allocation of cases. FACS enthusiastically participated in the recommendation process and its contribution has been carefully considered and greatly valued. It was extremely positive that most of the proposed recommendations were put forward cooperatively and endorsed by all of the parties

involved in the inquest.

248. FACS presented evidence which it said showed that "a seismic shift" in the organization had already occurred over the last few years.[268] Relying primarily on the evidence of Ms Walker and Ms Alexander, FACS submitted that there is now better training, a larger number of caseworkers, better data collection and more focus from the top down on how each CSC is performing. However, quite properly, FACS also accepted that more needs to be done.

249. FACS put forward the idea that rather than a "Case Closure Policy" in the CSCs, FACS and its clients might be better served by an "Allocation Policy" which would entirely change the emphasis and place greater importance on allocation and escalation rather than on closure.[269] FACS accepted that the "entire tone", and not just the wording of the triage policy, needs to be "re-thought". However, it resisted the concrete recommendation put forward by counsel assisting, as it was submitted that it might actually inhibit FACS making even more significant changes to the triage process.

250. This Court applauds the notion that FACS is anxious to review and comprehensively redesign its triage and case closure policies. Fundamental change is certainly called for. It is clear that the culture which operated in at least some CSCs at the time of BLGN 's death, and which may still operate, endorses and legitimizes a dangerous practice of closing files, without proper review, "for competing priorities." It is a culture which must be completely and comprehensively abandoned. If this inquest can permanently banish the words "competing priorities" from the FACS lexicon, then some small thing will have been achieved.

251. A detailed redraft of the current policy was recommended by counsel assisting to alter the triage and allocation process in a practical attempt to ensure that matters are properly reviewed and escalated where resourcing is identified as an issue. However, FACS suggested that rather than a detailed recommendation based on current practice, the Court should consider a more general approach which takes into account the work already being done as part of the redesign of the child protection and wellbeing access system under the *Their Futures Matter* reform (the "Access System Redesign"). FACS submitted that the work of that review is

[268] See Submissions made on behalf of Family and Community Services (attached to Court file).
[269] See Submissions made on behalf of Family and Community Services, page 3.

expected to "address some of the systemic failings identified in the inquest, including the need to provide effective and timely responses to ROSH reports."[270]

252. FACS also submitted that it was about to commence two pilot programs which would also inform the Access System Redesign process. It was suggested that these pilots may find that there are better ways of allocating directly and that the WAM may become an unnecessary administrative step for many CSCs in the future. FACS submitted that to make a recommendation incorporating the WAM may in effect tie FACS to an outdated process. I understand that FACS was also concerned that it would be a waste of resources to educate staff about changes to an interim process when more significant change may be in the air. FACS noted that recommendations from the Access System Redesign are slated to commence in 2019. I have considered these submissions carefully.

253. This Court accepts that the Access System Redesign process is necessarily based on more comprehensive data than has been presented at this inquest and one can only hope that its recommendations will, as a consequence, be significantly more far-reaching than any recommendation made as a result of the circumstances arising from this inquest. Nevertheless, this Court must grapple with the problem it has identified and I intend to make the recommendation on the information currently before me. If the Access System Redesign is able to make more sweeping change, I will applaud it. While the Court readily accepts FACS faces complex and much broader redesign issues than have been highlighted in this inquest, it cannot accept the mere promise of future change.

254. The problem is clear and urgent. We are currently failing children who need our help. Sometimes that failure happens because we give up before we have properly assessed the danger they face. If this problem is a resourcing issue, then it needs to be escalated to the highest level. If we regularly cannot even make contact with children who have been assessed as being at risk of significant harm, the issue must be taken up by the Minister, rather than dismissed pre-emptively by an overworked caseworker at a local CSC. We cannot accept case closure policies which conceal the nature of FACS's statutory failure to protect children.

[270] Submissions made on behalf of Family and Community Services, page 3.

Recommendations pursuant to section 82 *Coroners Act 2009*

255. For reasons stated, I make the following recommendations to both the Minister for Family and Community Services and the Secretary of the Department of Family and Community Services, I recommend,

1. That FACS undertake a review of the types of ROSH reports currently being allocated, referred to services or "closed for competing priorities" at triage (including during weekly allocation meetings), so that the FACS Executive team (comprising of senior officers at monthly executive meetings in districts) can better monitor, consider and review resource allocation and address the need for any procedural changes.

2. That FACS require all Managers Client Services to use the Resource Management Dashboard to monitor and report to the Director Community Services (using existing monthly executive meetings) on:

    a) children reported at ROSH who have an open plan at a CSC, with no triage activity and an allocation decision pending for over 28 days, and

    b) children reported at ROSH where the report was closed after 28 days.

3. That the FACS Quarterly Business Review between the Deputy Secretary Northern Cluster and Deputy Secretary Southern and Western Cluster, which examines the performance of each district and allows for discussion of any business risks, is to include:

    a) monitoring of adherence to, and progress of, the Office of the Senior Practitioner's serious case review and practice review recommendations,

    b) monitoring of adherence to weekly group supervision requirements in line with the group supervision framework,

    c) a measure capturing the volume and geographic data of reports reported at ROSH but then closed in each CSC to be implemented (both on a monthly and quarterly basis).

4. That on every occasion that a FACS Serious Case Review Panel is convened for a child death review, it undertakes critical assessment of any

applicable FACS policy and comments on any deficiencies in the drafting, implementation and compliance with such policy in the Serious Case Review Report prepared in relation to that death.

5. That FACS consider urgently amending its current policies that deal with allocation of a ROSH report that has been assessed by a triager as requiring allocation to a caseworker (herein referred to as an "unallocated ROSH report") to provide as follows:

   a) An unallocated ROSH report cannot be closed prior to assessment of that report at a WAM or such other meeting at which the allocation of such reports at the CSC is considered (herein, collectively referred to as a "WAM").

   b) If an unallocated ROSH report cannot be allocated (and an increase in capacity is not expected by the next WAM), the CSC is to record this information in the Resource Management Dashboard and ensure that the Director Community Services is notified. The Director Community Services must then consider the lack of capacity at the CSC and decide whether to allocate additional resources to that CSC to enable the report to be responded to.

   c) The closure of an unallocated ROSH report may only occur:

      i) after a triage assessment of the level of risk in the report;

      ii) after consideration has been given to allocation at a WAM;

      iii) after notification to the Director Community Services in accordance with b) above has occurred;

      iv) after consideration of an appropriate checklist of other options available (to ensure that a report is only closed as a last resort).

   d) The closure of an unallocated ROSH report may not occur for "competing priorities" (or equivalent concept) prior to assessment of that report at a WAM.

Conclusion

256. I thank those assisting me for all their hard work in preparing the material set out in

these findings. I also thank senior FACS staff who attended the inquest to give evidence. Their open and positive attitude in identifying real opportunities for change is to be commended.

257. Finally, I offer my sincere condolences to the families of both girls. In particular I offer my condolences to AD, whose love and affection for her girls was so evident before me. Her terrible grief was palpable when she spoke of the "angels" she had lost. Particular mention should also be made of the girls' paternal grandmothers, AF and AH. Both women tried to help and support AD and provide care for their granddaughters. I thank them for their attendance at the inquest and for their compassion for AD in such tragic circumstances.

258. I close this inquest.

Magistrate Harriet Grahame

Deputy State Coroner

8 June 2018