CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Z [redacted]
Hearing dates:	13 August 2020 -14 August 2020
Date of findings:	10 March 2021
Place of findings:	Coroner's Court, Lidcombe
Findings of:	Magistrate Harriet Grahame, Deputy State Coroner
Catchwords:	CORONIAL LAW – Death of a child, Death after multiple notifications of Risk of Significant Harm (ROSH), unsolved homicide, Weekly Allocation Meeting (WAM), 'competing priorities', adequacy of FACS (now DCJ) response.
File number:	2012/247793
Representation:	Ms Georgina Wright, Counsel Assisting, instructed by Janet de Castro Lopo, Department of Justice and Communities Legal. Ms Donna Ward, instructed by Ms Erin Hourigan, Maddocks for the Department of Family and Community Services/DCJ Ms Horvath, instructed by Ms Liz Herbert, Makinson D'Apice for the Illawarra Shoalhaven Local Health District Mr Ben Hart instructed by James Howell Solicitor for T [redacted]

Non-publication orders:

Pursuant to s 74 of the *Coroners Act 2009,* a non-publication order is made:

1. With respect to the identity and identifying information of any children or young people, including but not limited to the following individuals:
    - Z [redacted]
    - JE [redacted]
    - JA [redacted]
    - [redacted]

2. With respect to the identity and identifying information of the following individuals:
    - [redacted]
    - [redacted]
    - T [redacted]
    - K [redacted]
    - P [redacted]

3. With respect to information regarding allegations concerning [redacted] being responsible for any injuries suffered by the deceased person prior to his death.

4. With respect to the day care centre attended by the deceased or any information tending to identify that day care centre.

5. With respect to the identity and identifying information of the names of all staff members of the day care centre attended by the deceased.

6. Over the entirety of the [redacted], which appears at tab [redacted] in the brief - except as recorded in the Coroner's findings, when those findings are available.

7. Over the entirety of the report of [redacted], which appears at tab [redacted] of the brief of evidence - except as recorded in the Coroner's findings, when those findings are available.

8. The Court makes the following pseudonym orders in relation to publication. Z [redacted] is to be referred to as "Z". JE [redacted] is to be referred to as "JE". JA [redacted] is to be referred to as "JA". T [redacted] is to be referred to as "T". K [redacted] is to be referred to as "K". P [redacted] is to be referred to as "P".

Pursuant to s 65(4) of the *Coroners Act*, the Court notes that any person who seeks access to the brief of evidence should only be provided with a copy of the brief of evidence which has had redactions applied to protect the information set out in s 29(1)(f) of the *Children and Young Persons Care and Protection Act.*

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Introduction

1. This inquest concerns the shocking death of Z [redacted]. Z [redacted] was just two years, seven months and six days old when he died at Wollongong Hospital on 3 August 2012. He had been taken from his home by ambulance in a critical condition. His extensive injuries were not survivable. Despite a subsequent police investigation and related criminal proceedings, no person has yet been convicted of any offence regarding the actions which caused Z [redacted] numerous injuries or death. Nevertheless, it is clear that during Z [redacted] short life he experienced significant pain and neglect. This occurred in one of his homes, where he should have been safe.

2. As a community, we failed to protect Z [redacted]. This inquest attempted to understand the broader systemic failures that contributed to his death. Tragically the statutory body tasked with the protection of children in NSW had been informed of various significant risks facing Z [redacted] at the relevant time, but failed to take appropriate action. The Department of Communities and Justice (DCJ)[1] has frankly conceded that it held information which should have triggered a face to face meeting with Z [redacted] and his mother prior to his death. This would have allowed caseworkers to properly assess the risks Z [redacted] faced at a critical time and afforded them the opportunity to initiate appropriate action to keep him safe.

3. These proceedings took place many years after Z [redacted] death. The inquest was initially suspended pursuant to section 78 of the *Coroners Act* 2009 (NSW). Unfortunately, at the conclusion of Supreme Court proceedings, the exact circumstances of Z [redacted] death remained an open question. Further police investigations were undertaken which required additional time. This court also needed to review the adequacy of the child protection response and understand what relevant changes had already been made following Z [redacted] death. The proceedings were further delayed by cancelation of proceedings during 2020 due to COVID-19 and the subsequent delays experienced with listing dates at this court. Unfortunately even with the length of time it has now taken to fully review the circumstances of Z [redacted] death, I retain significant concerns that some of the issues identified have not been adequately addressed and that this kind of tragedy could still occur today.

4. Z [redacted] was identified as being at risk of significant harm, yet he was not seen by a caseworker. Shockingly it was revealed during the inquest that it remains the position that DCJ does not provide a statutory response to around 70% of children who are the subject of a Risk of

[1] From 1 July 2019, the Department of Family and Community Services (FACS) and Department of Justice merged to become a single department, named the Department of Communities and Justice. At the time of Z [redacted] death, FACS was the responsible agency and is referred to as such in these findings.

Significant Harm report.[2] As I have said before, this state of affairs is both shocking and completely unacceptable.[3]

5. DCJ is the agency in NSW tasked with a statutory responsibility for protecting children and young people. That is a responsibility that cannot be shifted by creating a culture where overworked or under-skilled staff can close reports, claiming a lack of resources or "competing priorities." These issues must be acknowledged at the highest level and solutions found if resourcing is indeed the issue.

The role of the coroner

6. The role of the coroner is to make findings as to the identity of the 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.[4] A coroner may also make recommendations in relation to matters that have the capacity to improve public health and safety in the future[5]

7. As the identity of Z and the time of his death are clear, the focus of the inquest was upon the manner and cause of his death, and on questions about whether his death could have been prevented. As Z and his siblings had an extensive child protection history, determining the manner and cause of death included a close assessment of the actions or inactions of Family and Community Services (FACS), whether relevant policies or procedures were complied with and whether any failures or deficiencies by FACS had any role in the causation of the death.

The issues

8. A list of issues was prepared before the proceedings commenced and circulated to the parties. The issues explored at the inquest included:

    1. *The cause of Z death.*
    2. *The manner of Z death, including:*
        - *The adequacy of steps taken by the Department of Family and Community Services (now the Department of Communities and Justice) to protect Z from harm;*
        - *The adequacy of procedures governing the management of unallocated cases by FACS, including the closure of unallocated ROSH reports;*
        - *Whether the reports about Z ought to have been referred to the JIRT Referral Unit or local police;*
        - *The adequacy of FACS' internal child death review;*
        - *Information sharing between Health and FACS in light of T hospitalisation between 24-30 July 2012 for an alleged self-inflicted stab wound*

[2] T13/08/2020 p 57.
[3] See for example Inquest into the deaths of BLGN and DCG (8 June 2018)
[4] Section 81 Coroners Act 2009 (NSW)
[5] Section 82 Coroners Act 2009 (NSW)

following argument with her partner (being a time when FACS had recently received multiple ROSH reports suggesting physical abuse of Z).

3. *Any recommendations considered necessary or desirable to make in relation to any matter connected with the death of Z .*

9. Given that there was no fresh evidence about who was actually responsible for Z injuries, the focus of the inquest ultimately centred on the systemic challenges that arose in providing adequate support to Z in the lead up to his death.

The evidence

10. The court took evidence over two hearing days. The court also received extensive documentary material, compiled in a five volume brief of evidence. This material included witness statements, medical and care records, photographs and video recordings, as well as court records. While I do not intend to refer to all of the material in detail in these findings, it has been comprehensively reviewed and assessed.

11. The court also heard oral evidence from two witnesses, Detective Sergeant Olivares the Officer in charge of the investigation and Ms Simone Czech, Deputy Secretary, Child Protection and Permanency in District and Youth Services at the Department of Communities and Justice (**DCJ**).

12. Both Detective Sergeant Olivares and Ms Czech gave thoughtful and considered evidence.

13. The court was greatly assisted by detailed summaries of the evidence prepared by counsel assisting. As will be apparent, I rely heavily on her written submissions which I consider an accurate summary of the evidence and which are used as the basis for these remarks.[6]

Background to the events leading to Z death

14. Z was born on 28 December 2009. At the time of his death, Z resided with his mother and her de facto partner, P four year old sister JE and P six year old son He stayed with his father K on weekends.

15. Z was the youngest of three children born to T and K His nine year old brother, JA lived mostly with K

[6] I thank Ms Georgina Wright of counsel and Ms Janet De Castro Lopo, solicitor for their detailed analysis of the evidence in this inquest and for their assistance in the production of these reasons

16. It is important to place Z life in an historical context. As with many children who come to the notice of FACS, Z family was significantly affected by intergenerational trauma. Z mother is Aboriginal and her family had experienced the damaging effects of past child removal policies. She herself was the victim of sustained childhood and physical abuse. She had significant mental health issues including depression and anxiety consistent with post traumatic stress disorder. T personal history would have made it extremely difficult for her to trust or seek help from FACS.

17. The evidence indicates that Z was born into a situation that was already unsafe. His was a vulnerable family that needed considerable support and assistance if significant harm to the children was to be prevented. Adequate help was not forthcoming.

Cause and manner of death

Criminal Investigation and trial

18. A murder investigation commenced immediately following Z death. On 8 August 2012 Detective Sergeant Christian Olivares assumed command of that investigation, which was based at Lake Illawarra Police Station.[7] He retained control of the investigation right up until the coronial hearing. His dedication to his task was evident.

19. T, P and K were each interviewed by police on 4 August 2012.[8] They were all considered to be persons of interest in the investigation.

20. In addition to all usual investigative techniques, the investigation used covert evidence gathering techniques targeting the three persons of interest, all of whom had cared for Z in the lead up to his death.[9] No admissions were obtained.

21. On 26 June 2013, Z mother was charged with the murder of Z.[10]

22. Between 2 and 26 February 2015, the Director of Public Prosecutions placed T on trial for manslaughter. The jury trial was presided over by Justice Bellew over three weeks. On 26 February 2015 T was convicted of manslaughter on the basis of criminal negligence. The Crown case was that Z appearance in the days leading up to his death would have been such as to alert his mother that his state of health was sufficiently serious to warrant medical help, and that in breach of her duty of care towards Z, she failed to provide it.

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[7] Volume 1 Tab 4 (Statement of Det Sgt Olivares at [5]).
[8] Volume 1 Tab 5 (Statement of Detective Brown at [17]-[19]).
[9] Volume 1 Tab 4 (Statement of Det Sgt Olivares at [5]).
[10] Volume 1 Tab 4 (Statement of Det Sgt Olivares at [7]).

23. At the trial, the Crown called extensive medical evidence about the nature of Z injuries and the symptoms he would have displayed. In reports provided for the trial, the experts gave consideration to whether an age to the various injuries (especially those causing death) could be identified and to whether the injuries could shed light on how they were occasioned. In short, there were (and remain) real difficulties in precisely measuring and assessing the medical evidence in relation to the many injuries occasioned to Z over a period of time.

24. K gave evidence at the trial that Z looked in perfect health during the time he looked after him while T was in hospital between 24 and 30 July and that he noticed no bruising on him.[11] P gave evidence that Z seemed okay when he collected him from K house on 29 July 2012 and that over the ensuing days Z was vomiting and a little tired, and that he "honestly thought that Z had a …gut bug".[12] He maintained that Z "didn't look that ill". This evidence does not sit comfortably with the medical evidence about the symptoms Z would have been displaying, and was clearly rejected by the jury.

25. T was sentenced to a term of imprisonment of four years and six months including a non-parole period of two years and three months. The sentence expired on 25 December 2017. In sentencing T, Justice Bellew stated that he was satisfied that Z outward presentation between 30 July 2012 and 3 August 2012 was that of a child who was clearly unwell and in need of medical treatment.

No person has been charged with causing injuries

26. No person has been charged in relation to the injuries causing Z death.

27. Causation of death was not an element of the offence of which T stood trial and was convicted. In sentencing her, Bellew J made clear in *R v A (No 5)* [2015] NSWSC 670:

> "*it was no part of the Crown case against the offender that she was responsible for inflicting any injury upon Z. It was also no part of the Crown case that the offender was present when any injury was inflicted on Z, or that the offender otherwise had any knowledge of the circumstances of infliction of any injury*." (at [20])

[11] Volume 5, p. 2324, brief (Trial transcript 9/03/2015 p 215).
[12] Volume 5, p. 2413 (Trial transcript 10/02/0215 p 304).

28. This court needed to consider whether there was fresh cogent evidence relating to who had caused Z fatal injury. Detective Sergeant Olivares told the court that all persons of interest were extensively interviewed by investigators during the murder investigation and none of them made any statements directly inculpating themselves or others in the death of Z, including after T was charged.[13] Detective Olivares spoke again to each of T, K and P in the context of the inquest. Unfortunately no new information was revealed.

29. Sergeant Olivares told the court that all investigative avenues had now been explored and were seemingly exhausted.[14] He gave evidence that solving this homicide would require someone to come forward.[15]

30. It should be noted that K P and T were all informed of the coronial proceedings. Only T attended.

The medical evidence

31. There was significant medical evidence before the court and a clear cause of death was established.

32. A comprehensive post-mortem examination was conducted by forensic pathologist, Professor Duflou between 4 and 15 August 2012. He recorded the direct cause of death as multiple injuries.[16]

33. In his Autopsy Report dated 19 February 2013, Professor Duflou states that X-rays of the body taken prior to the autopsy revealed a number of fractures of ribs and long bones, including fractures of three ribs on the left side, both radii, the left clavicle and the left scapula. Multiple bruises on the surface of the body and a number of additional bruises on subcutaneous dissection were identified. There was no skull fracturing.

34. Examination of the head revealed recent bleeding over the surface of the brain in the form of bilateral subdural haematomas and this was the proximate cause of death. This opinion was later modified by Professor Duflou who considered that a more correct proximate cause of death would be "head injury" overall, by which he refers to a constellation of injuries to the brain and its coverings and not only the subdural haematomas.[17] In a supplementary report

[13] Statement at Volume 1 Tab 4.
[14] T13/08/2020 at p 31.
[15] T13/08/2020 at p 30 line 46.
[16] Volume 1 Tab 2 of the brief (Autopsy report).
[17] Volume 1 Tab 2 (Supplementary report dated 24 September 2014).

provided prior to T [redacted] trial for manslaughter, Professor Duflou stated that the most likely final event which directly resulted in the death of Z [redacted] was the head injury.

35. The further range of abnormalities to the brain were identified by Dr Rodriguez, neuropathologist who examined the brain, spinal cord, dura mater and eyes. Those abnormalities were indicative of injuries sustained on a number of occasions, spanning possibly weeks.

36. Professor Duflou also detected a large collection of fluid in the abdominal cavity in the form of peritonitis and a traumatic mass in the back of the abdominal cavity immediately below the level of the pancreas. He diagnosed peritonitis resulting from a forceful blow to, or significant compression of, the boy's abdomen. However, there was no definite bowel rupture or perforation. There was likely early pneumonia. There was also some limited bruising to the inner surface of the scrotum.

37. There was no obvious natural disease in the child. Professor Duflou refers to a prolonged "stress" response in the child. Professor Duflou summarised his overall view as follows in the Autopsy Report:[18]

> "*The injuries overall had the appearance of having been sustained over a period of time, with at least two separate episodes of infliction of such injuries. The fatal head injury appeared relatively fresh – likely sustained not more than one or two days prior to death. There is other injury to the brain which indicates at least one other episode of head injury with brain damage, possibly weeks prior to death. The abdominal injuries and a number of the fractures were sustained probably a week or more prior to death.*
>
> *The photographs of the deceased taken on the* [redacted] *at the* [redacted] *are of generally poor quality and out of focus. There is however identifiable bruising on the right upper quadrant of the anterior abdominal wall. Such bruising could have been sustained during a forceful compression of the abdomen by blunt force, and could result in intra-abdominal injury of the type seen in this case. However, the traumatic pathology seen in the abdomen is likely not as old as 5 weeks – if this is the case, it would follow that there was another episode of injury to the abdomen between that which caused the abdominal bruising, and the death, likely a week or more prior to death.*
>
> *The presence of fresh bleeding without microscopically identified inflammation is generally considered a feature of injury sustained hours prior to death. However, in the setting of severe prior injury such inflammation can be delayed by many days.*"

[18] Volume 1 Tab 2, p 12, brief.

38. In relation to the subdural haemorrhages, Professor Duflou referred to two such haemorrhages. One was up to several days old in the right cerebral convexity. The other was up to several weeks old, in the left and right frontoparietal convexity. A Multifocal subarachnoid haemorrhage was up to several days old. Professor Duflou referred to these subdural haemorrhages and subarachnoid haemorrhage as being due to blunt force head injury.

39. In terms of the bruises, Professor Duflou identified a range of bruises, including bruises to the jawline, the scalp, the left ear, right ear, the bridge of the nose, an abrasion at the right nostril and a small skin tag on the upper lip were identified. Some subcutaneous bruising in the midline of the chin was also found was not visible to the eye. Apart from the head, bruises were also found on the trunk and upper extremities, that is the right elbow, right forearm, left little finger and right hand. In terms of the trunk there were bruises to the left lower quadrant of the anterior abdominal wall, 6 small faint bruises on the left anterior chest wall, on the posterior surface of the trunk and chest wall.

40. Professor Duflou was asked to review his findings in the lead up to the coronial inquest. He confirmed in a report dated 5 August 2020 that, although some individual injuries may have been sustained accidentally in this case, the overwhelming majority of the injuries, and those which have directly caused and/or significantly contributed to death were sustained by physical force being applied by one or more persons. The nature and constellation of injuries cause difficulty in determining precisely when the various injuries occurred and in what circumstances. There were various injuries of various types over a lengthy period. On the balance of probabilities Z [redacted] sustained one of the head injuries, by blunt or significant force having been applied to the head, not more than one or two days prior to death.

41. The medical evidence from the Police investigation and Supreme Court trial also included

- Evidence from Dr Hugh Martin, paediatric surgeon, who gave evidence about the timing of onset of the peritonitis, likely symptoms and cause. His opinion was that the peritonitis was probably several days old at the time of death. Z [redacted] would have been in pain, possibly still drinking, may have been vomiting and have a disturbance of bowel function. He would have been relatively still as movement would cause pain. In his opinion, a carer would have noticed the onset within a few hours or in 8 to 12 hours if the child feared punishment and tried to act normally. His report states that the cause of peritonitis is appendicitis or blunt trauma causing perforation of the bowel. Other causes are extremely rare. In his opinion, Z [redacted] peritonitis was due to blunt trauma causing perforation of the gut. This was based on the fact that the appendix was normal

and there were bruises on the anterior abdominal wall. Left untreated, the peritonitis alone would have caused death.[19]

- Evidence from Dr Kristina Prelog, a paediatric radiologist. Her evidence included an assessment of the age of rib fractures. She said younger children heal more quickly than older children. Based on her clinical experience and studies which she referenced, the age of Z injuries was two weeks in the right humerus, 2 to 3 weeks in the right radius and right scapula and more than 3 weeks in the clavicle and more than 6 weeks in the distal left ulna. Several were likely to be even older than those estimates.[20] The combination of different sites, different fracture ages and numbers of injuries was highly suggestive of non-accidental injury, excluding any correlating traumatic history. She said postero-lateral rib fractures and a scapula (shoulder blade) fracture were highly specific for non-accidental injury. The others were frequently seen in non-accidental injury especially when multiple fractures are present.[21]

- Evidence from Dr Paul Tait of the Child Protection Unit at The Children's Hospital at Westmead. He gave a report, which was adopted by Dr Susan Marks at the trial. They opined that the photos of Z taken on [redacted] were suggestive of a punch with a closed fist, based on the ring like bruise with central clearing above the umbilicus, with the ring having irregular margins.[22] There was another suspicious area of bruising below the right costal margin but the photos were not of sufficient quality to comment further. There was other bruising to his body and face. "*What is striking is the extent of the bruising and the location of specific bruises*"[23] In their opinion, the bruising to the left lower quadrant of his abdomen was consistent with blunt force injuries possibly a blow delivered by a kick given the triangular appearance of the upper aspect of the bruising and the suggestion of a more diffuse, nondescript bruise immediately below. The bruising to the lumbosacral area on Z back also reminded Dr Tait of similar patterns he had seen in other children who had been punched with a closed fist. Based on his clinical experience, Z had been subjected to inflicted injuries over an extended period of time. He referred to the significant head trauma on at least two occasions, with the most recent head trauma occurring probably within the last 24 hours prior to death. However, he noted that this timing is unreliable and would need to be correlated with clinical observations about

[19] Expert report at Tab 25G.
[20] p 1989, brief.
[21] pp 1989-1990, brief.
[22] p 1995, brief.
[23] p 1996, brief.

how the child was in that time period. Z had been "subjected to severe and ongoing physical abuse": report at [20]. The reason he demised over time rather than suddenly was the combination of the severe head injury and the presence of intra-abdominal trauma with peritonitis. Both can lead to steady deterioration. Dr Tait stated:

> *"It is well recognised that most carers who are abusive towards their children will often respond after an abusive incident by delay in seeking help as it would appear that they are more anxious about the consequences for themselves rather than that of their child. Unconsciously or consciously they hope that the child will recover, and in Z case it would appear that he has done so repeatedly in the past, and that their abusive behaviour will not be discovered. It is likely, in this context, that they would withdraw the child from social contact so that injuries are not apparent to others".*

42. I am satisfied to the requisite standard that Z death was not caused accidently, but rather as a result of traumatic force inflicted by one or more persons. His various injuries were inflicted on more than one occasion.

43. At the commencement of the coronial investigation, the court was still hopeful that fresh information could be obtained which might indicate exactly who had injured Z and caused his death. This did not occur and the threshold for referral of a known person or persons, pursuant to section 78 of the *Coroners Act* (2009) NSW was not reached. Nevertheless, in my view it is likely that there may be someone in the community who could still assist. I intend to ask the relevant authorities to consider a reward for information. I also intend to send the matter to unsolved homicide for their further review.

Z circumstances in months leading up to death

44. Z circumstances in the months leading up to his death and on the day in question can be pieced together to some extent from the statements obtained during the criminal investigation, the trial evidence and the number of child protection reports made about him.

45. As noted, Z was in the full time care of his mother T at the time of his death. For approximately eight months prior to his death, Z attended a child care centre one day per week, on Fridays.

46. On 9 May 2012 Z was examined by a GP at Corrimal Health Care Centre for a swollen foot. T told the GP that he had been with his father for the last two weeks and had

come home with swelling to his right foot.[24] An x-ray was taken and there were no fractures. The GP later told police that he suspected that it was a non-accidental injury but he apparently made no child protection report to FACS. He referred Z to Wollongong Hospital casualty.

47. On 8 June 2012 T took Z to [redacted] with regard to bruising and swelling to his right foot, which T s told the doctor he had had for four to five weeks.[25] She told the doctor that Z had injured himself while staying with his father, that her GP had performed an x-ray which was normal and that initially the bruising had improved and he was able to walk. She said that Z had stayed with his father again the previous weekend and returned with a foot that was more swollen and he was unable to walk. He had also sustained an abrasion to his right upper abdomen which she noticed while bathing him. The doctor examined Z and found a linear scabbed healing abrasion 2 x 3 cm on the right upper abdomen and a moderately bruised and swollen foot. He was able to walk. He was anaemic.

48. The doctor explained to T that he would be making a report to FACS due to the nature of the injury and the lack of an explanation as to its cause. P was present during that conversation and asked the doctor why he had to report the injury. The doctor has said that it was not an aggressive inquiry.[26] That doctor made a report to the Child Protection Helpline. (That same doctor led the resuscitation team when Z represented to the hospital in cardiac arrest on 3 August 2012.)

49. Z attended [redacted] on 29 June 2012 and [redacted] took photographs of bruises which they observed.[27] They contacted the Child Protection Helpline on 3 July 2012. Z attended [redacted] on 6, 13, 20 and 27 July.[28]

50. On 24 July 2012 T presented to Wollongong Hospital with an abdominal stab wound. She gave a history of self-inflicting the wound after, she said, an argument with her partner P [redacted] She underwent surgery. She was seen by various health staff at the hospital including a psychiatrist at the request of the surgical treating team. Dr Macfarlane made clinical notes at the time, including that T expressed regret and embarrassment about her impulsive act, that she had no ongoing suicidal thoughts, intent or plan. He noted at the time that she lived at home with her partner and three children and that she denied any domestic violence from her partner. Dr Macfarlane also noted at the time that her "family and partner appear supportive". T was released from Wollongong Hospital on 30 July 2012.

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[24] Tab 25.
[25] Statement of Dr Simons Binks at [8]: Tab 25A.
[26] Statement of Dr Binks at [14]: Tab 25A.
[27] Volume 4.
[28] Statement at Tab 22 of brief at [15].

51. Z was staying at his father's (K) premises when the stab wound had occurred and while T remained in hospital.[29]

52. T hospitalisation occurred at a critical time in terms of the child protection history. However, the doctors seeing T were not aware of that history, or that her child had been the subject of many recent reports to FACS during the same month concerning neglect and physical abuse. No report was made by the hospital to FACS, which did not learn of the stab wound, as a consequence.

53. It appears likely that Z was collected from his father's house by P around 5.30pm on 29 July 2012.[30] At 11.09am the following day P and Z were recorded by CCTV entering Wollongong Hospital. P was carrying Z.[31] At 2.20pm that day, Z and T were recorded leaving the hospital upon T discharge. Z can be seen walking between T and P and holding their hands. He appeared to be walking fine and did not appear to be ill.

54. On Wednesday 1 August 2012 T was recorded by CCTV shopping at a supermarket in Dapto. Her cousin visited the home around lunchtime or mid-afternoon that day and later told police that Z did not look well, describing him as "weak and lethargic" and having a bruise on his head.[32] He was crying. She raised this with T who replied "he's not well, he's not eating".[33]

55. On Thursday 2 August 2012 T was recorded by CCTV at KFC Fairy Meadow at 12.27pm. That morning she also saw her GP Dr Lee at 10am.[34]

56. Dr Lee later gave a statement that T was upset during the appointment, saying that there was a lot of family stress as she had been abused as a child and was taking her father to court.[35] She told the GP that she had stabbed herself the previous Tuesday and had had surgery. The GP examined her abdomen and advised her to return on 6 August 2012 for a check-up. She informed the GP that she had intended to bring Z to the appointment but he was asleep at home currently and she did not want to disturb him. She said that she would bring him to the next appointment. It appears that she had made the appointment of 2 August on 31 July 2012 and that Z had been included in the initial booking.[36]

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[29] Child care worker said that on 27 July, Z and JE appeared particularly happy and relaxed – staying with K Tab 22 p 1781 at [16]. Another worker recalls a time Z hid from his mother when she came to pick him up and cried as she took him out of the centre: p 1786.
[30] *R v A (No 5)* at [10] Coronial brief Volume 5 (trial transcript 9/2/2015 p 271 line 32)
[31] Still photos at Tab 24 of the brief.
[32] Statement of dated 29 August 2012.
[33] Statement of dated 29 August 2012 at [65].
[34] Statement of Dr Bernard Lee: Tab 25E.
[35] Statement of Dr Bernard Lee: Tab 25E.
[36] Statement of Sophia Dimeski: Tab 25E, p 1964, brief.

57. Evidence later emerged that [redacted] was not at home sleeping on 2 August 2012 as claimed by [redacted] but was being minded by his father while [redacted] attended her medical appointment.[37] [redacted] said at [redacted] trial that [redacted] looked "very sick" that day, as a consequence of which he put him to bed. [redacted] gave evidence in the Supreme Court that when [redacted] returned to pick up [redacted] two and a half hours later, he advised her to take him to the doctor.[38] I note that Justice Bellew's remarks on sentence indicate he was not satisfied that [redacted] gave that advice.

58. There is a suggestion in the brief (that is not substantiated) that [redacted] may have stayed at a different premises – with his ex-partner– on the night of Thursday 2 August 2012.[39]

59. On Friday 3 August 2012 at 3.13pm [redacted] and [redacted] were recorded by CCTV in a Bi Lo store in Berkeley.[40] They departed at 3.16pm.

60. At about 4.20pm on 3 August 2012 [redacted] called an ambulance and [redacted] reportedly began CPR on [redacted] An ambulance arrived at the residence at 4.34pm and continued CPR.[41] [redacted] was conveyed to Wollongong Hospital emergency department.

61. Upon his arrival at the hospital, [redacted] had no cardiac output. Attempts to revive him were unsuccessful and life was pronounced extinct by Dr Simon Binks, emergency staff specialist, at 5.50pm.[42] His body was examined by Crime Scene Officer Hollands at the time and that officer noted the bruises on his abdomen, arms and back and scratches on the right side of his skull and scratch to his nose.

62. One of the attending doctors gave a statement that while they were trying to save [redacted] she attempted to take a medical history from [redacted] and [redacted] and to bring them into the resuscitation room so they could see the attempts being made to save his life, however, they were reluctant to come.[43] In 12 years as a paediatrician she had never seen parents so reluctant to be with their child. Both appeared genuinely distraught after seeing [redacted] The doctor remarked on [redacted] "extremely vague" account of the days leading up to [redacted] presentation.[44]

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[37] See *R v A (No 5)* at [12].
[38] Tab 29 brief: pp 2326-2331: Supreme Court trial 9/2/2015, T217-222.
[39] See statement of Tracey Ashton-Bentley at [35]: p 2006 brief.
[40] Tab 24, from p1884.
[41] Statement of Greg Matheson: Tab 25M.
[42] Tab 25A, brief.
[43] Statement of Susan Piper at [13]: Tab 25B.
[44] Statement of Susan Piper at [38].

63. T told attending police that Z had displayed 'flu like symptoms, that he had been off his food for the past few days and had diarrhoea. She said that she had given him some baby Panadol, put him to bed earlier in the day and checked him around lunch time. Upon checking him again later in the day, she saw that he was not breathing and called an ambulance.[45] She told police that she suspected that the bruises on Z had been caused [redacted].

64. Police attended the home and examined Z bedding and noted that the portable cot was on a slight incline, such that his head would have been lower than his abdomen whilst sleeping and there was vomit on the pillow and quilt.[46]

65. Z appears to have been in the care of his mother and P from Sunday 29 July 2012 for the five days leading up to his death, subject to the short period when he was in the care of his father on 2 August 2012.

Z child protection history and the role of Family and Community Services (FACS)

Policy context for decisions

66. Ms Simone Czech, Deputy Secretary, Child Protection and Permanency in District and Youth Services at the Department of Communities and Justice (**DCJ**) gave evidence at the hearing about how FACS (as DCJ was then known) dealt with the reports about Z and his siblings, FACS' internal child death review following his death and the reforms made since 2012. She was an honest, impressive and capable witness who assisted the court to the best of her ability.

67. Ms Czech gave evidence that FACS' 'procedural mandate' (or policy) at the time Z was alive, which is still in force today, is that a case can be closed by a Community Services Centre (**CSC**) after 28 days due to competing priorities (the '**28 day closure policy**').[47] Closure of an unallocated case means that there is no face to face assessment by a child protection caseworker.[48] The reason for the 28 day closure policy is to ensure that reports are not held on to endlessly,[49] however, Ms Czech said that a report requiring a response in "less than 24 hours" should not still be open at the 28 day mark.[50]

68. Ms Czech stated that eight years ago there was a culture in parts of the State that the 28 day closure policy provided a reason or means *not to respond* to a ROSH report. The culture is slowly improving, and there has been "significant improvement on that front".[51] In her view

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[45] Statement of Detective Phillip Brown at [10]: Tab 5.
[46] Photos of the house and cot are at Tab 21 of the brief.
[47] T13/08/2020 p 42; policy at p 1164, brief.
[48] T13/08/2020 p 42 line 5.
[49] T13/08/2020 p 43 line 13.
[50] T13/08/2020 p 43 line 25.
[51] T13/08/2020 p 44 line 44.

DCJ has worked hard to change this culture and ensure that each child is at the centre of decision-making and seen by a caseworker. Nonetheless, Ms Czech acknowledged that the 28 day closure policy could be one of the reasons some cases are not dealt with.[52] Ms Czech considers that the reason some children are not seen is "more about the capacity of the CSC on any given day to actually respond to particular reports".[53]

69. Ms Czech gave evidence as to procedural changes that FACS has introduced since 2012, which may be summarised as follows:

(a) reports received from the Helpline by a CSC are reviewed at least twice a day;[54]

(b) the decisions about allocation or closure of reports are made by two managers casework (being the most senior role within the CSC itself);[55]

(c) the decisions made are recorded in the ChildStory system which replaced the 'KiDS' system in 2016;[56]

(d) ChildStory contains real-time and up to date information about child protection histories and enables staff to download a timeline about a particular child or family. This allows caseworkers to access information about a child, including for weekly allocation meetings (**WAM**) at which decisions are made about prioritising unallocated reports;[57]

(e) a monitoring system is in place, which did not exist in 2012, consisting of a 'resource management dashboard' (**RMD**). The RMD allows the CSC and executive staff to monitor the reports referred to the CSC, how the reports are being responded to, workloads of individual caseworkers and how long reports have been without action. The RMD sources information from ChildStory and contains links to the child protection history about the child.[58] Ms Czech described this system as "incredibly helpful for our casework staff". The ability to see caseworker workloads allows timely decisions to be made that free up capacity to allocate new reports.[59]

[52] T13/08/2020 p 44 line 49.
[53] T13/08/2020 p 44 line 50.
[54] T13/08/2020 p 42.
[55] T13/08/2020 p 41 lines 25-35.
[56] T13/08/2020 p 42.
[57] T14/08/2020 p 10.
[58] T13/08/2020 p 45.
[59] T13/08/2020 p 52 lines 15-30.

70. Ms Czech suggested that in assessing reports, CSCs pay "particular attention" to reports that the Helpline has recommended for a "less than 24 hour response" time,[60] however, this requirement does not appear to be set out in any policy.[61]

71. Ms Czech said that the policies (or mandates) associated with triage, allocation and closure of reports are currently under review, to be completed by September 2020.[62] The revisions to policy will concern case closure and the management of unallocated cases. They will include greater guidance for caseworkers including to escalate reports to higher management within DCJ in the event that a ROSH report cannot be allocated.

72. [redacted]

Reports to FACS Helpline and CSC about [redacted]

73. The court closely examined the history of reports to FACS concerning [redacted] They were summarised by counsel assisting as follows:

    (a) On 3 June 2010 FACS received a report at the Helpline about [redacted] being drunk including when picking up the children [redacted] and having a blood alcohol level of 0.08. The report stated that the house and children were filthy.[63] The report was screened by the Helpline as meeting the ROSH threshold and it was transferred to Wollongong Community Services Centre (CSC) with a recommended response of less than 10 days. It was unallocated and closed under competing priorities on 7 June 2010.[64]

    (b) On 7 October 2011 FACS received a report that the father [redacted] was often intoxicated and the children were regularly left unsupervised. The children were seen walking towards the road, the baby's nappy was filthy, there were three dogs in the home and the home was in an unhygienic state with rubbish inside and out and empty beer bottles on the front lawn. The Helpline assessed this report as requiring a response within 10 days.[65] A WAM event review form indicates that it was considered 'high priority' at WAMs on 20 October and 27 October 2011 and that on 11 November 2011 the case was "closed

[60] T13/08/2020 p 42 line 25; again at p 43 line 30
[61] T13/08/2020 p 44.
[62] T13/08/2020 p 50.
[63] Tab 7A.
[64] p 140, brief.
[65] Tab 7B.

due to competing priorities".[66] Once again there is no cogent evidence to properly assess whether other cases were appropriately prioritised.

(c) On 21 November 2011 FACS received a report that T was seen leaving the children (which at this stage also included two older sons) unsupervised and locked in the home while she visited a new boyfriend 'all day'. It was reported that K had been residing in the home until the previous weekend when he was asked to leave by T. The reporter stated that Z was in his cot banging on window with a fork in his cot. JE had been in same nappy over about 2 days. There is reference in the records to T wanting help with respite care and being referred to a family support service.[67] This report appears to have been screened by the Helpline as meeting the risk of significant harm (**ROSH**) threshold and requiring a response 'within 24 hours".[68] It was transferred to the Wollongong CSC like the previous reports. It was held over at a Weekly Allocation Meeting on 23 November 2011 due to "higher priorities".[69]

(d) On 30 November 2011 FACS received a report to the Helpline reporting that the mother had left the children unattended overnight while she stayed at a neighbour's home.[70] Z had been left in his cot for four hours the previous week while his mother was at a neighbour's house drinking. This report was also given a recommended response time of less than 24 hours by the Helpline due to "neglect" and transferred to the Wollongong CSC.[71] The Helpline advised the caller to contact the Police. On 1 December 2011 a decision was made to "hold over for further review at next WAM" due to "higher priorities".[72] There is no record of any further review at a WAM.[73]

(e) On 7 December 2011 FACs received two reports. K T. K was frequently reporting that T was not feeding, monitoring or clothing the children appropriately and was drinking to excess.[74] The Helpline transferred it to the Corrimal CSC[75] and allocated a response time of less than 72 hours with regard to Z JE and the two .[76] On 30 December 2011 the

[66] pp 209, 2014, 219; see also p 141, brief.
[67] Tab 7C – p 218, brief.
[68] p 220, brief.
[69] pp 239-240, p 152, brief.
[70] pp 231, 250, 264, brief.
[71] p 231, brief.
[72] p 243, brief.
[73] p 152, brief.
[74] p 249, p 143, brief.
[75] p 252, brief.
[76] p 254, brief.

case was closed due to current competing priorities.[77] The other report on 7 December 2011 was that JA was living with K at a boarding house.

The number of reports in late 2011 notably coincides with the end of T relationship with K and the beginning of her relationship with P around the same time.

(f) On 4 January 2012 FACS received a report to the Helpline from [redacted] who attended the home [redacted][78] He observed rubbish everywhere, children locked in their bedrooms with dogs and the 1 year old in his cot screaming. It was noted that a referral had been made to Illawarra Family Support.[79] The assessment records refers to "ongoing significant concerns regarding neglect".[80] The report was transferred to Wollongong CSC and the Helpline recommended a response within 24 hours as children were at imminent ROSH due to hazardous, unsanitary living conditions.[81] Nothing happened and then on 13 January 2012 Wollongong CSC contacted Illawarra Family Service who informed it that it had been involved with the family for 12 weeks and there had been no child protection concerns on two home visits.[82] The matter was closed on 1 February 2012 because of the information from Family Services Illawarra.[83]

(g) On 21 March 2012 FACS received a report at the Helpline and on 31 March 2012 the Helpline contacted the reporter. The reporter expressed concern about the children being cared for by their intoxicated father who seemed to have schizophrenia or mental health issues.[84] The children looked dirty, underfed and neglected. The report was assessed at the Helpline as not meeting the ROSH threshold as support services were in place to address K mental health issues.[85]

(h) On 29 and 30 May 2012 FACS received two reports regarding disclosure made by JE concerning her father. The reports were screened by the Helpline as requiring a response of less than 10 days. On 31 May 2012 the reports were accepted for a JIRT response and transferred to Wollongong JIRT for investigation.[86] JE attended the JIRT Wollongong office on 14 June 2012 with her mother and was interviewed. The matter was closed.

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[77] p 143, brief; Czech statement at [51].
[78] Tab 7E.
[79] p 259, brief.
[80] p 265, brief.
[81] pp 261, 266, brief.
[82] p 144, brief.
[83] p 281, brief.
[84] p 272, brief.
[85] Tab 7F; see also Czech at [78].
[86] Tab 7H, p 299, brief.

(i) On 8 June 2012 FACS received a mandatory report from a hospital that Z had been taken to hospital with unexplained injuries including significant bruising and swelling to the right foot.[87] He also had an abrasion to the abdomen approximately 1cm x 3 cm long.[88] The report states that T said the child returned from the father's twice with the same unexplained foot injury. Information is also included that the child was limping, 2 similar injuries reported in short space of time and in response to questioning, the reporter said that Z would have cried, and that the injury could not have been sustained from falling.[89] This report was screened by the Helpline as meeting the ROSH threshold and as requiring a response within 10 days.[90] That assessment was overridden following consultation with the team leader and assessed as requiring a less than 24 hour response on the basis of the mother's report that the same injury had been occasioned twice while Z was in the care of his father.[91] That assessment record states:

> "*It is deemed urgent that all children need to be physically sighted, the injury sighted & the physical condition of both the mother's and father's residence sighted to determine on the ongoing ROSH for the children*".

The matter was referred to the Crisis Response Team for further assessment as it was a Friday evening.[92] The Crisis Response Team caseworker contacted the hospital. The treating doctor had finished for the day and another doctor was spoken with. It appears that the hospital conveyed to the caseworker that it was not a serious injury and there were no concerns about T care of Z The caseworker reportedly tried to contact T six times by phone that night without success and determined that the matter could be managed by the CSC the following week.[93]

On 13 June 2012 Wollongong CSC telephoned Family Services Illawarra who said their file on the family had been closed on 7 May 2012. The caseworker from Family Services Illawarra said that the family had been referred to Family Services Illawarra by the Department of Housing due to concerns that the mother was leaving the children home alone but the mother had denied this and "it was hard to ascertain the truth".[94]

The only record made about this report was "no longer providing a service". The report was closed.[95] No action was taken.

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[87] p 280, brief.
[88] Tab 7G.
[89] Tab 7G page 280, brief.
[90] p 282, brief.
[91] p 289, brief.
[92] p 145, brief.
[93] Tab 7G, pp 284-285; p 155, brief.
[94] p 294, brief.
[95] p 156 brief; Czech statement at [62] and [115].

(j) On 3 July 2012 FACS received a mandatory report from [redacted] that [redacted] had bruising on 29 June 2012, human bite like small teeth marks on his chest above his belly button, bruising on his right leg around the thigh, a massive bruise on his torso (left side) and a 50 cent piece size bruise on his forehead.[96] The mother had told the reporter, when she dropped the children off, [redacted]. There had been nothing unusual about [redacted] behaviour during the day and he was not complaining of discomfort, but his difficulties communicating at only 2 years old were noted by [redacted] The reporter also noted that he called for [redacted] when having his nappy changed and she was protective of him, and that the children were attending smelling of urine and dirty.

The Helpline screened the report as meeting the ROSH threshold and transferred it to Wollongong CSC with a recommended response time of less than 24 hours.[97] The report was flagged for review at the WAM held on 12 July 2012.[98]

(k) On 6 July 2012 FACS received another mandatory report from [redacted] to the effect that [redacted] had fresh bruises on him.[99] There is reference to him "again presenting with multiple unexplained bruises to his torso" and to them being "significantly different from the bruising that [redacted] presented with last week".[100] So, this is only 3 days after the previous report, albeit a week since he was at the [redacted] But on the available information, his 4th round of injuries if you take into account 2 foot injuries. The Helpline screened the report as meeting the ROSH threshold and transferred it to Wollongong CSC with a recommended response time of less than 24 hours.[101]

The reporter was given advice to speak to the parents [redacted] and to call back if there were further issues. The reporter did call back on the same day to inform the Helpline that she had spoken to the father [redacted] and his reply was that [redacted] appeared to the caller that the father was not overly concerned and did not want to know. The "father" is named in the contact record as [redacted]

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[96] Tab 7H.
[97] pp 300, 311, brief.
[98] p 146, brief.
[99] Tab 7H.
[100] pp 328, 331, brief.
[101] pp 329, 332, brief.
[102] [redacted]

(l) On 9 July 2012 the Intake team at Wollongong CSC recommended contact with the preschool and that both 24-hour reports be added to the Weekly Allocation Meeting (p 347). On the same day the [redacted] reported that they had asked the father about Z [redacted] bruises and his response was that "kids get bruises".

On 12 July 2012 a decision was made to hold the matter over for further review at a WAM meeting the following week. It appears that the case was marked on 12 July for allocation to an identified child protection caseworker, however, the worker's manager then flagged with the Manager Client Services that the caseworker was going on leave, which resulted in the report being held over to the WAM on 19 July 2012.[103]

(m) On 18 July 2012 the [redacted] informed Wollongong CSC that they had asked T [redacted] about Z [redacted] bruising when she attended [redacted] and she had said that "the children play rough" and "often Z [redacted] gets hurt". The worker noted however that during that week each of the parents took one of the children each, the mother taking Z [redacted] and the father taking JE [redacted][104] [redacted]

It is clear therefore that at this point, the Intake team at Wollongong CSC has had contact with [redacted] over 15 days and the focus appears to have been placed on whether the mother and father could reasonably explain Z [redacted] injuries.[105] The [redacted] has twice suggested that the explanations do not withstand scrutiny. Despite the additional injuries to Z [redacted] being reported and the inadequate explanations being reported back to the CSC, the triage decisions did not change.

On 19 July 2012 the matter was discussed at WAM and it was noted as being "up for allocation, however competing priorities and bring back next week".[106] The WAM form being used on 12, 19 and 2 August – pages 342-346 – shows it was missing critical information – no reference to 8 June report or any other report made in 2012 or late 2011 under 'child protection history'. There is no record of any WAM meeting being held in the following week.

(n) On 20 July 2012 the [redacted] telephoned Wollongong CSC to say they had seen more bruising on Z [redacted] including bite marks on both sides of the stomach.[107] They reported

[103] Information obtained in Child Death Internal Review: p 158, brief.
[104] p 335, brief.
[105] See for example statement of Elizabeth Williams, child care worker at [13] re 9 July 2012.
[106] pp 342, 346, brief.
[107] [redacted]

seeing him only once a week and that each week there was new bruising and new bite marks.[108]

This report, which was made directly to the CSC by the [redacted] was *not* reported by the CSC to the Helpline. Despite the Helpline not referring any of the previous reports to the JRU, it cannot be known today whether, had the Helpline received this additional information of 20 July, the information would have triggered a report by the Helpline to the JRU.

(This 20 July report was not referred to in DCJ's statements in the inquest as being a separate ROSH report, but Ms Czech agreed that it should have been reported to the Helpline by the CSC.[109])

(o) A WAM form suggests that the matter was next considered at a WAM meeting on 2 August 2012, however, as referred to during the hearing and outlined below, it may not have been considered at a WAM meeting at all this day. The form contains a note for this date "*No capacity and higher priorities. Leave on for review 9 August 2012*".[110] There is no evidence that the WAM meetings considered the reports or information of 8 June 2012 or 20 July 2012.

74. Z [redacted] died the following day.

75. On 4 August 2012 FACS received a report about Z [redacted] death the previous evening. The records include, for the first time, a reference to T [redacted] mental health and her attendance at the emergency department on 25 July 2012 with self-inflicted injuries.[111] JE [redacted] is recorded as having gone home with [redacted]

Reviews of FACS' response to reports about Z [redacted]

Internal Child Death Review and DCJ's evidence at inquest

76. FACS' Child Deaths and Critical Reports review team conducted an internal child death review in relation to Z [redacted] death. The purpose of that review was to identify any systemic and practice issues and to make recommendations for organisational improvement and learning.[112] It resulted in a report dated June 2013 (**the ICDR report**).[113]

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[108] [redacted]
[109] T14/08/2020 p 12 line 30, 48.
[110] p 346 and see p 148 of brief.
[111] Tab 7I, p 354.
[112] Tab 6 brief.
[113] Tab 6 brief

77. The review used a 'systems approach to serious case reviews'. That type of review involves reviewing key practice decisions that would have had a decisive effect on the way the case developed or was managed. The review identified five key episodes in relation to Community Services' response to reports about Z [redacted]. They were:

1) the response to reports made between October 2011 and January 2012;
2) the response to the report about Z [redacted] of 8 June 2012;
3) the response to the reports about Z [redacted] of 3 and 6 July 2012;
4) the management of capacity issues at Wollongong CSC in 2012; and
5) the involvement of the Joint Investigative Response Team (**JIRT**).

78. Background information in the ICDR report includes that there were two Community Services Centres situated in the Wollongong office at the time, one CSC managed child protection and early intervention services, and the other managed out of home care. The child protection CSC had five child protection teams and one was a triage team. The manager had about 15 years' experience in child protection and had been a manager of client services for the previous eight years.[114] Wollongong CSC covered 54 suburbs.

79. The review focussed upon the triage process in respect of reports received from the Child Protection Helpline, as this is where the process faulted in Z [redacted] case. The ICDR report noted that state-wide Triage Assessment procedures required that triage be conducted by way of weekly assessment meetings or WAMs. The purpose of a WAM was to review and prioritise new reports received at the CSC and consider the capacity of the CSC to allocate each report. A WAM could result in a number of outcomes, such as additional information needing to be gathered, the report being allocated to a child protection worker, the report being transferred to another CSC or program within the CSC, the report being closed, or the report being held over for further review at the next WAM or, if necessary, an interagency case discussion being convened before closing the report. The Manager Client Services would usually attend the WAM meetings.

80. In conducting the Internal review, it took until 26 November 2012 for the review team to interview relevant staff at Wollongong CSC.[115]

81. The main findings with respect to the 5 key practice episodes were as follows.

<u>Key practice episode 1: Response to the reports received between October 2011 and January 2012.</u>

[114] p 132, brief.
[115] p 129, brief.

82. Of the 5 reports received during this period, three were referred to WAMs and none were allocated. The Manager Client Services informed the review team that the CSC was fully staffed at the time, but it had not been possible to respond to all reports.[116]

83. The reports received during this period were predominantly about neglect of Z JE and JA The ICDR report states that the WAM forms were incomplete and staff could not recall what discussions took place between October 2011 and January 2012 when interviewed in November 2012. The ICDR report states that:

> "*It is likely that the extent of the neglect experienced by* Z *and his siblings was not fully understood. There was no evidence that the history, frequency of reports, duration of the children's experience of neglect, likelihood that the children would continue to be at harm or their developmental stage were considered.*"

84. The ICDR report concluded that it was clear that Z and his siblings were at high risk and required a child protection response at this time which the system should have been able to provide.[117]

85. In her evidence at the hearing, Ms Czech agreed with the conclusions of the ICDR report in this regard.[118] Ms Czech considers that all the reports in late 2011 and on 4 January 2012 should have prompted a response.[119] There was no problem with the Helpline's assessment of the reports, but the issue was the capacity of the CSC and its "*ability to make risk assessment when they've got a number of reports in front of them and which ones get allocated when you've got finite resources*".[120]

86. However, Ms Czech could not definitively state that the reports at the end of 2011 would be allocated for an immediate response by DCJ if they were received today, although she considers that it is highly probable that they would result in a face to face assessment occurring. Ms Czech stated that there are many variables for example, how many staff the CSC has, whether there are any vacancies, and what other tasks caseworkers are given, some of whom may be quarantined to do other work such as out of home care rather than face to face assessments.[121]

<u>Key practice episode 2: Response to the report received about Z on 8 June 2012</u>

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[116] p 153, brief.
[117] p 154, brief.
[118] T13/08/2020 pp 52-53.
[119] T13/08/2020 p 54 line 7.
[120] T13/08/2020 p 54 line 25.
[121] T13/08/2020 p 53.

87. The ICDR report notes that this was the first report to FACS about physical injuries to Z and it raised two opportunities for Community Services to respond, firstly through the Helpline Crisis Response Team (**CRT**) and secondly by Wollongong CSC.

88. The CRT was responsible for cases requiring an immediate response outside of regular business hours. The response could include phone calls or a field visit. The ICDR report noted that a response on the Friday night would have provided an opportunity for all the children in the family to be sighted and for the CRT caseworkers to speak with Z about his injuries and see the family home. However, the ICDR report noted that this was the first indication of a pattern of injuries to Z and considered that it was reasonable that the risk was not seen as immediate following the phone call to the hospital. (Ms Czech on behalf of DCJ had a different perspective at the inquest.)

89. As for the CSC's response, the ICDR report notes that this report should have been taken to a WAM, as it was reportedly the second time that Z had sustained injuries to his foot and there was a history of significant neglect. Concerns about him should have been heightened following contact with Illawarra Family Services who said they had ceased their involvement with the family in the previous month and T had been difficult to engage with. The ICDR report notes the lack of record keeping on KIDS about the reason for the CSC's actions. The procedures required a minimum of two managers casework to make the decision and for a child-focussed rationale to be recorded on the KiDS database.[122]

90. The ICDR report also notes that by June 2012 the Wollongong CSC was operating at a lower staffing capacity due to five temporary caseworkers finishing secondments in the first half of the year.[123] The Ombudsman who was critical about the lack of analysis applied by the Child Death Review with regard to claims of a lack of capacity or resources.

91. The effect of Ms Czech's evidence was that the CRT should have visited Z in his home on 8 June 2012. The CRT should not have looked for a reason *not to* go out to the address.[124] Their role is not to gather information to provide a reason *not to do something like a home visit*.[125] Further, the fact the caseworker was not able to speak to the caregiver should have raised alarm bells as to where the family and children were. The CRT would have had access to the child protection history through KiDS database in 2012.[126]

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[122] p 156, brief.
[123] p 155, brief.
[124] T13/08/2020 p 58 line 42.
[125] T13/08/2020 p 58 lines 14-15.
[126] T13/08/2020 p 59 line 24.

92. Ms Czech stated that it is "absolutely" the case that the 8 June 2012 report would be considered urgent today, but she cannot state definitively that the report would receive a statutory response for the same reasons as stated above (at [86]).[127] However, she would be "very, very confident" that this report would receive a response if received today.

93. Ms Czech also said that the record made "no longer providing a service" must have been incorrectly entered by the CSC as DCJ was not in fact providing any service to Z .[128] Ms Herberte's statement says that it "does not make any sense".[129]

94. The reason for the closure of this report without allocation to a caseworker is totally unexplained on the evidence.

Key Practice Episode 3: Response to reports about Z on 3 and 6 July 2012

95. The key points made in the ICDR report about this episode were that:

(a) the WAM form was missing critical information. The person who filled it out following receipt of the report from the Helpline identified the most recent report as being received on 7 October 2011. That is, no reference at all was made to the other reports received in 2012 and, critically, the report of 8 June 2012 regarding Z physical injuries was missing.[130] [See "child protection history" on page 343 of the brief.] Further, the person had summarised the report of 6 July 2012 in only one sentence, which was not sufficient for seeing the escalating risk to Z The ICDR report said that decision-making was compromised as a consequence of these omissions; and

(b) while the Helpline had processed both reports about Z correctly, including by applying the Structured Decision Making tool, allocating a response rating of less than 24 hours for each report and collating a child protection history and analysis, the CSC set aside the Helpline's assessment and conducted its own triage processes.[131] The CSC did not prioritise the matters according to the response ratings, but based its own decisions about which cases to allocate upon capacity issues, the vulnerability of the children and managers' local knowledge about the families. The ICDR report identified that ten cases were allocated by the CSC over the June/July 2012 period, which took priority over Z case. Those other cases were all high risk.[132] The managers at the

[127] T13/08/2020 p 59 line 42.
[128] T13/08/2020 p 62 line 30.
[129] Volume 2.
[130] See p 158, brief.
[131] p 163, brief.
[132] pp 127, 159, brief.

CSC informed the review team that each case was discussed for five to ten minutes at a WAM, that they received a large number of reports about babies born to mothers with a drug addiction around this time and that those matters tended to receive priority.

96. The review team was not overtly critical of the CSC's decision not to apply the Helpline's risk assessment and it accepted that "the CSC did not have the capacity to allocate these reports".[133] However, the ICDR report provided no analysis as to why the CSC did not have the capacity to allocate any of the reports about Z The court is thus unable to properly assess the way priorities were assessed.

97. The ICDR report did note the importance of "thorough and analytical" and "reflective" discussions at WAMs, the inference being that the CSC did not make decisions in this way. The ICDR report refers to the risk of cases not being considered individually but rather as a 'type' of case, and to Eileen Munro's insight that practitioners may take 'mental shortcuts' while making judgments. She has stated that "[r]*ather than considering all of the evidence before reaching a conclusion, which is expensive in time and effort, practitioners 'create rules that reduce difficult judgmental tasks to simpler ones by restricting the amount of information they consider*'."[134] The review team clearly considered that the CSC was making triage decisions in this way.

98. Ms Czech gave evidence that the decisions about Z case were made at WAM meetings. She said that the full child protection history should have been set out in the WAM form used in July 2012.[135] The records suggest, DCJ acknowledges, that in July 2012, the CSC did not have regard to the report about Z made on 8 June 2012, or the previous report about JE in May 2012, or any of the reports about neglect of Z and his siblings in late 2011 or early 2012. [136] This was a very serious set of omissions.

99. Further, although the WAM form suggested WAM meetings were held on 12 July 2012 and 19 July 2012, the way the form was completed suggested that there may not have been any meeting on 2 August 2012, despite the notation made about the decision on that date to hold the case over again.[137] What occurred on 2 August 2012 is not known on the evidence (whether it was a formal WAM meeting[138], a brief conversation or a mere notation without team discussion). Ms Czech was "horrified" by the notations.[139]

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[133] p 161, brief.
[134] p 162, brief.
[135] T13/08/2020 p 65.
[136] T14/08/2020 p 8.
[137] pp 342 and 346, brief.
[138] which was only a 5 minute conversation according to the ICDR report.
[139] T14/08/2020 p 9 line 22.

100. This type of form is still used today in preparation for and at WAM meetings.[140] Ms Czech states that the form or a summary of the outcomes of the WAM meeting should be provided to the Director Community Services, however, this did not occur in Z [redacted] case.

101. Ms Czech stated that the best WAM meetings use ChildStory, to obtain the real-time/up to date child protection history, and the RMD as a workload management tool.[141] All employees have access to ChildStory in WAM meetings as DCJ is "completely mobile". She agreed that the hard copy WAM form used in Z [redacted] case was conducive to human error as information could be missed or not included.[142]

Key Practice Episode 4: Management of capacity issues at Wollongong CSC during 2012

102. The ICDR report states that in June and July 2012, the Wollongong CSC received 295 ROSH reports about 231 children or young people. Of these, 61% were closed due to competing priorities. That was substantially higher than state-wide data about allocation rates for ROSH reports across Community Services (which was around 33%).[143] The ICDR report suggests that because the CSC had a reduced capacity to respond to new reports in June and July 2012 due to the loss of temporary child protection staff, it could have lodged a report known as an Operational Capacity Report to escalate its capacity issues to regional management and head office. Managers at the CSC told the review team that they viewed the Operational Capacity Reports as time consuming and unnecessary.[144] The Director Child and Family also told the review team that staff from other program areas could be used to respond to child protection reports for crisis matters.

103. The report states that "it is undeniably clear that the child protection system should have been able to respond to reports about Z [redacted] injuries" (p 166).

104. There is some ambiguity in the ICDR report, because while it states that "the CSC did not have the capacity to allocate these reports", it also states numerous times that the system should have been able to respond to the reports about Z [redacted] injuries.

Key Practice Episode 5: The involvement of JIRT

105. The criterion for referral of physical abuse to JIRT at the time of Z [redacted] death was "*severe or serious physical injuries to a child or young person that are caused by another person 10 years or over; and are suspicious and/or deliberate and/or are inconsistent with the explanations provided*".

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[140] T13/08/2020 p 65.
[141] T13/08/2020 p 66.
[142] T13/08/2020 p 66; T14/08/20202 pp 9-10.
[143] p 167, brief.
[144] p 167, brief.

106. The ICDR team said that it is tempting to argue that the three reports about his physical injuries of 8 June and 3 and 6 July 2012 should have been referred to the JRU, however, they would not necessarily have met the criteria for referral or acceptance. The ICDR report notes the ambiguity of the expression "severe or serious".

107. In contrast, Ms Czech gave evidence that each of the reports of June and July 2012 met the criteria for referral to the JRU as at the date of the reports.[145]

108. The ICDR report notes that the most serious report of 3 July 2012 would have prompted a detailed examination by the JRU of the child protection history and the JRU would have sought additional from Police and Health. The ICDR report states "it is likely that if additional concerns were identified in the criminal and medical histories the report would have been accepted for a JIRT response".[146] Some of the information that the JRU would have obtained is that the two male carers had convictions for assault.

109. It is puzzling why the ICDR report did not readily accept that the ROSH reports of June and July 2012 clearly met the threshold for referral to the JRU, given the nature of the injuries, Z [redacted] age and vulnerability, his child protection history, the inconsistent explanations given by the caregivers and the concerns of the childcare workers. Ms Czech's evidence is that the reports should have been referred for joint investigation. This aspect of the ICDR report also tends to undermine the integrity of the ICDR process in this case.

110. The criteria used for referral of physical abuse to the JRU is considered further below from [147].

Conclusions of FACS' internal review

111. The ICDR review found that the Structured Decision Making tools were correctly applied at the Helpline and this led to correct risk ratings. However, the system broke down at the time where the reports were received at the CSC and taken to allocation.

112. Ms Czech's evidence generally accorded with this assessment, in that there was no fault at the level of the Helpline's risk assessment. Despite the reports being accurately identified as high priority, the case did not receive a face to face assessment.

113. After analysing those 5 key episodes, the ICDR review team made recommendations and concluded that:[147]

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[145] T14/08/2020, p 24.
[146] p 171, brief.
[147] p 126, brief.

- the reports received in the 12 months prior to Z death demonstrated a concerning picture of escalating and significant risk to Z and his siblings JE and JA

- the reports particularly in the month prior to his death should have received a child protection response but capacity issues did not allow for this to happen;

- managers at Wollongong CSC were concerned about reports of Z physical injuries in July 2012 and tried unsuccessfully to prioritise the case for allocation;

- the Helpline's decision not to refer reports of Z physical injuries to JIRT complied with the JIRT physical abuse referral criteria, but there was ambiguity in the definition of the expression "severe or serious" which was thus open to misinterpretation.

NSW Ombudsman's review

114. The Ombudsman reviewed FACS' internal review report as Z death was a "reviewable death" under the *Community Services (Complaints Reviews and Monitoring) Act 1993*. In a report dated 10 June 2014 the Ombudsman was critical of FACS' response to the ROSH reports regarding Z and of FACS' internal review of the death.[148] He made recommendations, to which FACS responded on 25 March 2015.

115. The Ombudsman criticised the internal review of the death by FACS. In his view, FACS did not properly analyse why the risk reports were not treated as urgently as the evidence at the time warranted. He criticised the review team's readiness to conclude that a lack of available resources partly explained the CSC's inadequate response to the reports. The Ombudsman was very critical that the internal review accepted the CSC's claim about competing priorities without analysing the caseworker caseloads, the nature of the new reports received, and the rationale for the decisions that were made particularly in June and July 2012. Information given to the Ombudsman by the Secretary was that Wollongong CSC in fact had higher caseworker numbers relative to other CSCs at the time. The Ombudsman said the review team was not entitled to draw the conclusions it reached.[149]

116. For example, the Ombudsman identified other cases that Wollongong CSC were given urgent allocation in June 2012, even though the Helpline had recommended only a less than 72 hour response for those matters and they were not as critical as Z He also criticised the fact that no consideration was given by the CSC to asking local police to call on the family to check on Z welfare.

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[148] Tendered separately as Exhibit 2.
[149] Exhibit 2, p13

117. Ms Czech conceded that FACS' internal review into Z death was not adequate. It would not meet FACS' current requirements for internal reviews according to standards applied by the Office of the Senior Practitioner.[150] The quality of the report would not be sufficient, if prepared today, for submission to DCJ's Serious Case Panel Review.[151] I accept this and am aware of that more rigorous reports are now produced. Ms Czech stated that an internal review should be much more comprehensive than the review conducted into Z death. It should address the matters the Ombudsman reflected upon, including by examining the capacity of the system within the CSC and at the district level. In a case like Z this would involve an analysis of the different caseloads and numbers of caseworkers and the decisions which took priority over the reports relating to the child who died.[152] The interviews with staff should also occur much sooner (than the three months it took in this case).[153]

118. There is no real explanation on the evidence as to why the internal review was so poor and it appears that FACS has never comprehensively reviewed the decision-making by the CSC in relation to Z case. This may be partly due to the inadequacy of the records kept by the CSC at that time.

Ms Czech's 's evidence on the child protection response to notifications about Z

119. Z child protection history demonstrates disturbing and repeated inaction by FACS in response to the ROSH reports received.

120. Ms Czech gave evidence that while the CSC acknowledged that Z was a high priority for allocation to a caseworker, there was a culture in Wollongong CSC to not allocate work.[154] She considers that even the first report about Z should have been allocated for a statutory response

121. However, Ms Czech's evidence was to the effect that the CSC did its best at the time to determine the highest risk matters it had in the CSC and allocate those matters within available resources.[155] The CSC's capacity was a factor. She agreed however that deficient decision-making by the CSC was also a causal factor in what occurred.[156] Ms Czech agreed that in the middle of 2012, the CSC was making decisions about priorities poorly and on an *ad hoc* basis.[157] She said that the CSC had relatively non-existent systems for monitoring its own

[150] T13/08/2020 p 63.
[151] T13/08/2020 p 63.
[152] T13/08/2020 p 64.
[153] T13/08/2020 p 64.
[154] T13/08/2020 p 46 line 33.
[155] For example T14/08/2020 p 16 line 25.
[156] T14/08/2020 p 17.
[157] T13/08/2020 p 51 line 48.

capacity at that time.[158] The reason Ms Czech considers that capacity was a factor is that the number of ROSH reports outstripped available resources.[159]

122. In the 12 months to 30 June 2013, in the Illawarra Shoalhaven district, the number of children and young people (**CYP**) who received a statutory response as a proportion of the total ROSH reports received was 23%.[160] 919 were assessed face to face out of a total 4011 CYP reported at ROSH.

123. Ms Czech said that there had been a "significant increase" in terms of how many children were seen in the Illawarra Shoalhaven district in the last year compared to 2012.[161]

124. In the 2019/2020 year the number of CYP who received a statutory response in Illawarra Shoalhaven district as a proportion of the total CYP reported at ROSH was 27% or 1,820 out of 6,820 CYP. (That is, reports were made about 6,820 individual CYP, as opposed to there being a total of 6,820 reports; some children may be reported more than once).[162]

125. DCJ responded to just over 12,000 CYP who were at ROSH in 2010 and 2011, as compared with 35,300 CYP in the 2019/2020 year (of around 110,000 total CYP reported to the Helpline in 2019/2020) on a Statewide basis. Ms Czech gave evidence that the increase in the number of CYP seen has been achieved with a 7% increase in the number of caseworkers.[163]

126. When asked if the situation can be fixed through the allocation of further resources to DCJ, Ms Czech used a stark and somewhat disturbing metaphor. She said "just having more ambulances at the bottom of the cliff is not the answer in and of itself". A service system around the child and family, to support DCJ's work (involving health services, mental health, education supports) is needed to provide ongoing support to those children.[164] Ms Czech fairly acknowledged that evidence-based services are not a substitute for a statutory response.[165] For example, two pilots recently conducted in South Western Sydney[166] and in the Helpline are useful for a particular cohort of children but would not assist a child in Z [redacted] situation who required a statutory response.[167] [168]

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[158] T13/08/2020 p 47 line 11.
[159] T14/08/2020 p 17 line 40.
[160] Exhibit 6.
[161] T13/08/2020 p 49 line 8.
[162] T14/08/2020 p 4 line 30; Exhibit 6
[163] T13/08/2020 p 47.
[164] T13/08/2020 p 48; p 57 line 35
[165] T13/08/2020 p 56 line 44 and p 57 lines 23-27.
[166] The South Western Sydney pilot involves families receiving a service from a non-government organisation where DCJ is not able to allocate a caseworker.
[167] T13/08/2020 p 56.
[168] T13/08/2020 p 56 line 44.

127. It remains the position that DCJ does not provide a statutory response to around 70% of children the subject of a ROSH report.[169] Ms Czech acknowledged this.[170] A "statutory response" means a face to face response to a child the subject of a ROSH report under the *Children and Young Persons (Care and Protection) Act 1998 (*the ***Care Act***).[171]

Was FACS's child protection response to Z adequate?

128. The ROSH reports to FACS made before June 2012 were closed due to "competing" or "higher" priorities. The ROSH report on 8 June 2012 was closed for an unknown reason (DCJ told the inquest that the reason recorded, "no longer providing a service", "does not make sense"[172]).

129. The ROSH reports in July 2012 were held over to WAM meetings on a number of occasions "due to higher priorities" rather than being allocated for an urgent response. (The report of 20 July seemingly did not even receive consideration at a WAM.)

130. No ROSH report made about Z was ever allocated to a caseworker for a response.

131. The contemporaneous records do not shed light on the decision-making as they contain only bare notations that there were "higher" or "competing" priorities within the CSC.

132. The reports showed persistent and increasing risks to Z in the context of neglect, inadequate supervision, family breakdown, carer mental health issues, alcohol misuse, possible sexual harm of a [redacted] and, ultimately, repeated serious physical abuse.[173] Six out of 13 reports were assessed at the Helpline to require a response *within 24 hours*. That recommendation for an urgent response was set aside by the CSC. FACS did not take any action or steps to check on Z or his siblings.

133. The last four reports (8 June, 3, 6 and 20 July 2012) were from mandatory reporters and concerned repeated injuries to Z for which the caregivers offered explanations inconsistent with the injuries: bruising and swelling to his foot, abrasion to his abdomen, multiple bite marks and bruises on his thigh, torso, back and forehead. Why they were not allocated for a statutory response is inexplicable on the evidence. Those reports clearly required a statutory response.

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169 T13/08/2020 p 57.
170 T13/08/2020 p 48 line 13.
171 T13/08/2020 p 57 line 43ff.
172 Statement of Ms Herberte.
173 As the Ombudsman found.

134. There is no basis to conclude that "capacity" or "higher priorities" was a reason for closing the 8 June 2012 report as the records state that the case was closed as FACS was "no longer providing a service". There was a serious failure by both the CRT and CSC to consider this report properly, given:

(a) The injuries to Z [redacted] that were reported, the fact they were reported by [redacted] and the mother was not contactable on the Friday evening;

(b) The child protection history by that stage and the view, as recorded, that there was an urgent need to see the children in their home to assess risk;

(c) The nature of the information received from Family Services Illawarra, being that its involvement with the family had closed on 7 May 2012, the concerns reported that the mother was leaving the children home alone, with the mother denying this, and the caseworker not being able to "ascertain the truth", which left the concerns unresolved;[174]

(d) The inexplicable recording "no longer receiving a service" means it cannot just be assumed that "higher priorities" was a factor; Furthermore, resources or competing priorities was not the reason the Crisis Response Team decided not to conduct a home visit on the night of 8 June 2012.

(e) The report was not referred to a WAM, which also tends to indicate that higher priorities was not a consideration. Rather, there was a failure by the CSC to properly appraise the risk to Z [redacted]

135. I accept counsel assisting's submission, that the ICDR report's conclusion that the CSC did not have the capacity to allocate the reports in 2012 is not well founded. Without evidence I cannot be satisfied that there was ever a proper assessment of Z [redacted] reports against other matters the CSC was dealing with to determine whether it was doing its best to allocate the highest risk matters within available resources. I note that Ms Czech acknowledged that the known information does not allow a conclusion to be drawn whether it was appropriate for the Wollongong CSC to prioritise other cases for allocation over Z [redacted].[175]

136. However, there is strong evidence in Z [redacted] case of flawed decision-making at important junctures. For example, in addition to the submissions above regarding the 8 June report:

(a) The WAMs in July 2012 failed to consider Z [redacted] full child protection history, including most relevantly the 8 June 2012 report. That information was omitted from the child protection history carried over to the WAM form;

[174] p 294, brief.
[175] T14/08/2020 p 19.

(b) There is no evidence that the CSC ever considered escalating the unallocated reports about Z to a higher manager or executive officer despite this being a possible outcome of a WAM (as noted in the ICDR report);

(c) The ICDR report suggests other possible explanations for the decisions to prioritise allocation of other cases over Z case, when it stated that "Managers at Wollongong CSC said that the skill level in the triage team was mixed and that staff often did not have the skills to complete complex triage work";

(d) Ms Czech's evidence that the reports in June and July 2012 met the criteria applicable at the time for referral of physical abuse to the JRU, yet they were not referred, also suggests flawed decision-making.

137. The "higher priorities" explanation was noted when some ROSH reports in 2011 and in the first half of 2012 were closed. Several of those reports about neglect had "less than 24 hour" response recommendations assigned by the Helpline. But the evidence does not permit a conclusion as to the reason none was allocated to a caseworker.

138. DCJ's statutory duty includes, under s 30(a) of the *Care Act*, the obligation to "*to make such investigations and assessment as the Secretary considers necessary to determine whether the child or young* person *is at risk of significant harm*". The 28 day closure policy does not sit comfortably with s 30(b) of the Care Act which provides that, on receipt of a ROSH report, the Secretary "*may decide to take no further action if, on the basis of the information provided, the Secretary considers that there is insufficient reason to believe that the child or young person is at risk of significant harm*".

139. "Insufficient reason to believe" is arguably not satisfied by inaction under s 30(a). The "information provided" is to be derived from the investigation and assessment made, not from the mere effluxion of 28 days. It ought be the case that DCJ never closes a ROSH report that is open and unallocated at the 28 day mark if the report has been assessed as requiring a response and no information has been provided warranting any change to that assessment, particularly if the report is in the "less than 24 hour" category.

140. There is no evidence that CSCs are given guidance to pay particular attention to reports in the "less than 24 hour" category.

141. The current case closure system fails vulnerable children. Sometimes that failure happens because we close files before properly assessing the danger the child faces, as in Z case. If caseworkers are regularly unable to even make contact with children that have been assessed as being at risk of significant harm, the issue must be taken up by the Minister as a

matter of urgency. We cannot accept case closure policies which conceal the nature of DCJ's statutory failure to protect vulnerable children. While cultural change may have occurred, there is still a troubling acceptance by senior management that DCJ will just never be able to see all of the children who are identified as at risk of significant harm.

142. The result of the early failure to properly assess the situation of children such as Z means that appropriate staff never even consider whether a child should be removed.

Information sharing between FACS and Health following T hospitalisation

143. Z mother was in hospital with a stab wound in the last six days in July 2012. Her hospitalisation was not known to FACS. Nor was the child protection history known to the hospital or individual doctors. Z had been admitted to the hospital six to seven weeks earlier with a sore foot, on 9 June 2012, but this was under his surname

144. Dr Macfarlane's statement in relation to his review of T while she was in hospital is that:
"there was no indication that T children were subject to abuse, neglect or displaying difficult behaviours. There is also no record made by other staff caring for T on the ward that any of them had any concerns about T children. If a staff member had raised concerns with me regarding unusual or concerning behaviours on the ward, it is my usual practice to document this. I was not aware of any previous notifications to child protective services at the time of the admission"
And
"in the absence of specific concerns for the children's welfare as noted above, while T mental health difficulties had the potential to impair her ability to parent, my understanding of the relevant child protection policies indicated that a formal notification was not necessary if her partner was able to ensure the safety of the children and that T was actively seeking ongoing treatment for her mental health issue. From my assessment, I felt that both of these conditions were met."[176]

145. It cannot be known in hindsight whether the information would have made a difference to FACS' assessment of the risk posed to Z had it been apprised of the information in late July 2012 that T had been hospitalised with a stabbing wound and mental health issues. Ms Czech considers that it would have raised further concerns and would have needed to be considered as part of a broader assessment.[177]

146. A clinician in Dr Macfarlane's position could have requested information from FACS under Chapter 16A of the *Care Act* to ascertain whether the child or family had been the subject of a

[176] Statement of Dr McFarlane Para 19-20, Tab 12 Brief
[177] T14/08/2020 p 34.

ROSH report or reports, even if he was not making a mandatory report.[178] However in all the circumstances it is understandable that a busy clinician in Dr Macfarlane's position took no further action given the information he was presented with. I am not critical of his response.

No referral to JRU - physical abuse criteria

147. The Helpline did not refer any of the reports of physical abuse of Z to the Joint Referral Unit (**JRU**), which determines whether allegations of abuse require a specialist joint response by JIRT involving FACS, Police and NSW Health (now known as the Joint Child Protection Response Program or JCPRP).

148. It is uncontroversial, and DCJ accepts, that each such report should have been referred to the JRU.

149. FACS' internal review found that the physical abuse referral criterion that the Helpline were required to apply was ambiguous and recommended a review of the ways in which the JIRT physical abuse criteria is communicated to the Helpline and CSCs.

150. Yet nothing was done in the wake of Z death to amend the physical abuse criteria.

151. Ms Czech gave evidence that in around July 2016 the physical abuse criteria was updated. There was no amendment to the phrase "severe or serious injury". The criteria from mid-July 2016 was as follows:

> *Severe or serious injury (see table below) to a child or young person which is:*
>
> - *Unexplained or inconsistent with the explanations provided and/or*
> - *Inflicted (non-accidental) or suspicious and*
> - *Caused by another person aged 10 years or over*
>
> *Consideration should also be given to a history of recurrent bruising or injury. The presence of one or more injuries does not automatically denote a referral to the JRU. You must consider the above criteria **and** the level of severity of the injuries/indicators listed below. The JRU retains discretion to accept cases raising child protection concerns for young persons 16-17 years of age.*

152. The attached JIRT Injury guide table includes under the category of soft tissue injury serious multiple bruises (may appear with different colourings, from red to green), pattern bruising and bruising in unusual locations (and other descriptions of bruising).

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[178] T14/08/2020 p 35.

153. The above criterion is currently in use by the Helpline.

154. After the hearing, DCJ provided a supplementary statement of Ms Czech dated 27 August 2020. In July 2020 the JCPRP Statewide Management Group approved an amendment to the JCPRP referral criteria (the **2020 referral criteria**) but those changes have not yet been implemented at the Helpline. The 2020 referral criteria for serious physical abuse is as follows (emphasis added):

> *Serious physical abuse is indicated by one or a combination of the following, in circumstances where the child has **a serious physical injury** and the person who inflicted the injury was aged 10 years or over at the time of the abuse, or the identity of the POI has not yet been determined:*
>
> *A. Disclosure by the child or young person that they have been physically abused*
> *B. The reported physical abuse has been witnessed by another person*
> *C. The POI has made admissions that they have physically abused the child or young person*
> *D. The injury is unexplained and is suspected of being inflicted*
> *E. The injury is believed to be inconsistent with the explanations provided*

155. The 2020 referral criteria for serious physical abuse sets out a "definition" of "serious physical injury" as follows:

> *From a medical perspective a serious physical injury is any injury which requires immediate medical assessment/care in order to:*
> *a) treat persistent pain*
> *b) identify occult (i.e. hidden) injuries, including internal organ damage, and/or*
> *c) prevent permanent or serious deformity or disability.*
>
> *The Injury Guide Table details indicators and markets of a serious injury and should be considered in the context of the child's age and development.*

156. The Injury Guide Table relevantly sets out for a child over 1 year old that an indicator or marker of serious injury is:[179]

- *Multiple or cluster bruising*
- *Pattern bruising such as slap marks, belt marks, bite marks, marks made with a looped cord or other object marks*
- *Bruising in unusual locations e.g. the back, buttocks or genitals and the abdomen*

157. Other indicators of serious injury are included in the Injury Guide Table which Z [redacted] did suffer, including rib fractures, injury to the abdomen and abusive head trauma, but these particular injuries were discovered after his death.

[179] Page 16 of supplementary statement of Ms Czech.

158. Finally, it should be noted that the 2020 referral criteria for serious physical abuse contains "factors to consider", which are intended to guide decision making and professional judgment but do not replace the criteria[180], to guide the user to take into account a number of facts including the child's age and vulnerability. Regarding a "history of recurring bruising or injury", they state that "*professional judgment should be applied for recurring injuries, however the presence of one or more injuries does not automatically meet the criteria. Consider the level of severity of the injuries*".

159. Ms Czech states that each of the reports of 8 June 2012, 3 July 2012 and 6 July 2012 met the criteria for referral to the JRU and would each meet the criteria for referral today under the 2020 referral criteria.

160. The 8 June 2012 report would do so because the foot injury required immediate medical assessment/care, but it would have done so even if he had not been brought to the hospital because of his pain, the significant swelling and the fact he was limping.

161. The report of 3 July 2012 would meet the criteria because of the extensive bruising, being multiple or cluster bruising, pattern bruising and in unusual locations. [redacted]

162. According to Ms Czech, the bruises reported on 6 July 2012 may not meet the new criteria on their own, but the history of recurrent bruising, his age and vulnerability and his child protection history would mean that the Helpline would refer the report to the JRU.

163. As to this latter point, hopefully the 6 July report would be referred to the JRU as Ms Czech states, but there may be some doubt about this in view of the note included in 'factors to consider' regarding "history of recurring bruising or injury". That note may discourage a referral even in light of recurrent bruising as it states that "the presence of one or more injuries does not automatically meet the criteria. Consider the level of severity of the injuries".

164. Ms Czech does not refer to the report of 20 July 2012. The [redacted] saw more bruising on Z [redacted] including bite marks on both sides of the stomach. It may be assumed that this report would also meet the criteria for referral to the JRU under the 2020 referral criteria for the same reasons as the 6 July report would.

165. The 2020 referral criteria for serious physical abuse, including the definition of "serious physical injury", appear, prima facie, quite restrictive. It is not immediately obvious on the face of that

[180] [29] of supplementary statement.

table that it would encompass bruising of the kind seen on Z in July 2012. However, the Injury Guide Table makes it clear that bruising (cluster, pattern or unusually located bruising) is a marker for serious injury. For a child with Z injuries in July 2012, having reference to the Injury Guide Table may be critical to a proper application of the serious physical abuse criteria.

The need for recommendations

166. The recommendatory power outlined in s. 82 of the *Coroners Act* 2009 (NSW) is the distillation of the coroner's death prevention role, it has been described as "speaking for the dead to protect the living". The court gave careful consideration to whether there was a need for recommendations arising from the evidence in this matter, given the passing of years and the substantial changes made to child protection systems by the DCJ in the intervening time.

167. Unfortunately, Ms Czech was unable to assure the court that a child in Z positon would be seen today. She thought it most likely and pointed out that DCJ are seeing many more children than ever before and doing more to support families and prevent situations deteriorating as they did for Z Nevertheless she properly conceded that the majority of children identified as being at "Risk of Significant Harm" do not receive a statutory response. She stated "the challenge for us for a number of years has been the demand for child protection outstrips our capacity to respond."[181]

168. There is a clear need for greater resourcing of the child protection system in NSW. While I accept such a broad statement is well beyond the proper scope of a coronial recommendation, pursuant to the *Coroners Act* (2009) NSW, it is nevertheless appropriate to acknowledge this fact publicly. Clearly Z family needed comprehensive preventative support well before his death. The brief support offered by Family Services Illawarra in late 2011 and early 2012 was insufficient. Closer to the time of his death an urgent statutory response was also required. Neither occurred. Even with significant reform within DCJ, which I accept has occurred in the last eight years, children such as Z will continue to fall through the cracks unless more is done.

169. At the conclusion of the evidence counsel assisting suggested two very specific recommendations arising out of the evidence.

170. The first called for the abolition of handwritten forms and was directed towards ensuring a child's full child protection history is presented to a WAM. The use of handwritten forms, which apparently still occurs in some Centres, can mean that the complete picture is not available to

[181] T 13/08/2020, page 44

staff at the time of allocation. This occurred in Z [redacted] case, where accurate and up-to-date material was not always presented. The secretary supported this recommendation.

171. The second related to providing policy guidance to CSCs with respect to ROSH reports which have been assessed as needing a "less than 24 hour" response time. In Z [redacted] case this had occurred on multiple occasions over a ten month period and yet none were acted upon. The recommendation was directed to a review of current policy so as to ensure that CSCs are given appropriate guidance to give particular consideration to reports that have been allocated a "less than 24 hour" response time by the Helpline.

172. Ms Czech observed that DCJ is currently undertaking a review of practice mandates and policies. This includes practice mandates and policies in relation to triage, allocation of ROSH reports and closure of ROSH reports. Counsel for DCJ suggested the issue raised might be best raised in this forum. I accept the sense of the submission.

Findings

173. The findings I make under section 81(1) of the *Coroners Act 2009* (NSW) are:

Identity

The person who died was Z [redacted]

Date of death

He died on 3 August 2012

Place of death

He died at Wollongong Hospital, Wollongong

Cause of death

He died of a traumatic head injury

Manner of death

His death was the result of trauma inflicted by a person or persons unknown.

Recommendations pursuant to section 82 *Coroners Act 2009*

174. For reasons stated above, I make the following recommendations:

The Secretary, Department of Communities and Justice

That DCJ consider abolishing reliance on handwritten forms in weekly allocation meetings (or wherever decisions are being made by a CSC about responding to a Risk of Significant

Harm report) in favour of using the ChildStory timeline to obtain the most up to date and accurate child protection history for each child.

That DCJ consider, in the course of the current practice mandate review providing guidance to casework staff with respect to:

a) The allocation and assessment of ROSH reports with a priority response time of less than 24 hours; and
b) escalating ROSH reports with a priority response time of less than 24 hours to senior management within DCJ in the event that a ROSH report cannot be allocated for a response.

Commissioner, NSW Police Force

a) I recommend that that the death of Z [redacted] be referred to the Unsolved Homicide Unit of the NSW Homicide Squad for further investigation.

b) I recommend that the NSW Police Force apply for and support the provision of a reward relating to information which leads to the arrest and conviction of a person or persons in relation to injuries causing the death of Z [redacted].

Conclusion

175. I thank counsel assisting Ms Georgina Wright and her instructing solicitor Ms Janet de Castro Lopo for their enormous assistance and great skill in preparing this inquest. I thank Detective Sergeant Olivares for his comprehensive investigation.

176. Z [redacted] deserved a better life than he had. I acknowledge his pain and feel great sorrow that we failed to keep him safe. The tragedy remains that children, such as Z [redacted] will continue to die in pain until further resources are committed to the child protection system in NSW.

177. I close this inquest.

Magistrate Harriet Grahame
Deputy State Coroner
March 10 2021
NSW State Coroner's Court, Lidcombe