CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of CS
Hearing dates:	17 to 27 May 2021
Date of findings:	15 July 2022
Place of findings:	Coroners Court of NSW, Lidcombe
Findings of:	**State Coroner, Magistrate Teresa O'Sullivan**
Catchwords:	CORONIAL LAW – manner of death - death by presumed drowning – consequence of acts of mother – grandmother raised alarm - family known to the Department of Families and Community Services – child protection – mental health services – cross-border policing – NSW Police Force – Victoria Police – Murrumbidgee LHD – ESTA – Catholic Education Office
File number:	2017/69591

Representation:	
	(1) Counsel Assisting: Ms K Stern SC with Ms E Sullivan of Counsel, instructed by Mr J Pender, Ms A Jez and Ms C Hill of the NSW Crown Solicitor's Office (2) The Commissioner of the NSW Police Force ("**the NSW Commissioner of Police**"), New South Wales Police Force ("**NSWPF**"), Senior Constable Tyler Bryce, Senior Constable Nicholas Burnell, Former Leading Senior Constable Matthew Holloway, and Former Leading Senior Constable Lisa Hyne: Ms M Rabsch of Counsel, instructed by Mr C Norman of NSWPF Office of General Counsel (3) The Chief Commissioner of Victoria Police ("**the Victorian Chief Commissioner of Police**"), Victoria Police, Leading Senior Constable Darren Scherger, Sergeant Jason McDermott, Leading Senior Constable Chris Goyne: Ms N Hodgson of Counsel, instructed by Mr D McQualter and T Gracie of Maddocks (4) The Department of Communities and Justice ("**DCJ**") known at the time of CS' death as the Department of Family and Community Services ("**FACS**") and Corrective Services New South Wales ("**CSNSW**"): Mr M Fordham SC of Counsel, instructed by Ms J Windsor of Norton Rose Fulbright (5) The Murrumbidgee Local Health District ("**MLHD**"): Mr R Cheney SC of Counsel, instructed by Mr L Sara and Ms J Hackett of Hicksons Lawyers (6) The Emergency Services and Telecommunications Authority ("**ESTA**"): Ms J Greenham of Counsel, instructed by Ms K Liu and Ms A Smith of K&L Gates (7) Catholic Education Office Wilcannia Forbes: Mr S Cash of Counsel, instructed by Mr C Spain of Wotton + Kearney (8) CS' grandmother, SJ: Mr A Joseph of Counsel, instructed by Mr D Brooks of Brooks Lawyers

Findings:	**Identity**: The deceased person was CS. **Date of death:** CS died at approximately 18:15 on 2 March 2017. **Place of death:** CS died in the waters of the Murray River in Moama, NSW. **Cause of death:** The cause of death was presumed drowning. **Manner of death:** CS died as a consequence of the acts of his mother, LS.

<table>
<tr>
<td>Recommendations:</td>
<td>
Directed to the NSW Commissioner of Police:
That NSW Commissioner of Police:

Consider the addition of the following features to the Apprehended Violence Order application system within COPS:
<ol type="a">
An alert which identifies to an adjudicating NSWPF officer his or her obligations pursuant to s. 38 of the Crimes (Domestic and Personal Violence) Act 2007 (“CDPV Act”) (including a reference to the potential existence of indirect violence); and
A mandatory field requiring that any reasons as required by s. 38 of the CDPV Act be recorded in writing.

Review of the Domestic Violence Standard Operating Procedures (“DV SOPs”) and associated training to ensure that the significance of listing children as Persons In Need of Protection (“PINOPs”) is well understood;
Give consideration to the extent to which the tragic circumstances of CS’ death, in de-identified form, might form the basis for ‘case studies’ emphasising the significance of listing children as PINOPs, including as regards the availability of police responses;
Ensure greater emphasis on ‘critical analysis’ of reports made to the NSWPF for concerns for welfare relating to missing persons reports including:
<ol type="a">
Making prompt and suitable inquiries to inform any risk assessment for the purpose of determining whether or not a missing persons report is warranted, including consideration of the following avenues of inquiry;
<ol type="i">
Personal knowledge of the people involved;
Information provided by the person reporting;
Information provided by any other person at the scene or elsewhere;
Interrogation of the COPS system, including intelligence reports via MobiPol;
Criminal histories; and
Other environmental factors.

</td>
</tr>
</table>

	b. Ensuring that consideration is given to the following risk factors by officers when assessing whether a missing persons report should be taken: i. Mental Health; ii. Health (drugs and/or alcohol); iii. Care and Protection Orders; iv. Domestic Violence related; v. Employment/Education issues; vi. Significant family conflict/abuse related; and vii. Unusual behaviour. c. Giving clear guidance as to when the taking of a child from a parent could constitute an abduction, and when there is the need to investigate circumstances, even where orders have not yet been made; d. Performing and documenting a risk assessment when a child is removed from their usual residence without the consent of their usual carer, to determine whether a missing persons report should be made; e. Utilising procedures to ensure all known information that could be relevant to a risk assessment is accessed for the purpose outlined in (d) above; and f. Adopting a 'cautious' approach where vulnerable persons (such as children) are involved, and associated policy and training as to this aspect. 5. Consider the extent to which the tragic circumstances of CS' death, in de-identified form, might form the basis for 'case studies' emphasizing the importance of a cumulative and holistic consideration of information held by agencies. **Directed to the Victorian Chief Commissioner of Police:** That the Victorian Chief Commissioner of Police: 6. Give consideration to improving policies and practices so as to ensure clear guidance as to: a. The need for active consideration of the missing persons policy when a child is removed from their usual residence without the consent of their usual carer, including the performance and

	documentation of a risk assessment to determine whether a missing persons report should be made; b. Procedures to ensure all known information that could be relevant to a risk assessment is accessed for the purpose of determining whether a missing persons report should be made; and c. The need for a 'cautious' approach where police are called to conduct a welfare check on vulnerable persons (such as children), and associated policy and training as to this aspect. 7. Consider the extent to which the tragic circumstances of CS' death, in de-identified form, might form the basis for 'case studies' emphasizing the importance of a cumulative and holistic consideration of information held by agencies. **Directed to ESTA:** That ESTA: 8. Consider the circumstances of this incident (as appropriately anonymised) as the basis for a training module or case study, highlighting the importance of accurate reference to the content of a Computer Assisted Dispatch ("**CAD**") event. **Directed to DCJ:** That DCJ: 10. Ensure that DCJ officers and employees receive training as to: a. The significance of whether orders in relation to care and custody are in place in the event that a child or children are removed from their usual carer; b. The significance of whether an ADVO naming a child or children as a PINOP is in place in the event that a child or children are removed from their usual carer; c. The importance of assessing the risk that a child may be removed from their usual carer when information suggesting a possibility of that is received by DCJ.

	11. Prepare a simple fact sheet along the lines of that prepared in 2017 in respect of health and education to be used by DCJ employees, and upon which DCJ employees should be trained. 12. Ensure that DCJ officers receive training in relation to steps that can be taken in the event that a child is removed from their usual place of residence, including: a. Appropriate means of communicating that information, and updating information, to police; b. What information is of particular relevance for the purpose of 000 calls and other communications with police; c. Interstate communication of information; d. The need for risk assessment on an ongoing basis in such circumstances, and the appropriate sources of information that should be accessed, including from other agencies; e. The need for ongoing communication with police to inform them of any relevant information and any risk assessment; f. The range of orders and warrants that are available, and the circumstances in which employees of DCJ should seek or should provide input for the purpose of others seeking those orders or warrants. **Directed to the MLHD** That the MLHD: 13. Prepare a local written protocol or procedure concerning the transfer of information between Corrective Services NSW ("**CSNSW**") and MLHD in relation to persons released from custody; 14. Provide the Ministry of Health with a copy of the: a. Submissions of Counsel Assisting dated 17 September 2021; b. Submissions of MLHD dated 29 October 2021; identifying the issues raised by this inquest concerning a potential protocol or procedure for the transfer of information between CSNSW and Local Health Districts in relation to persons released from custody, for consideration of the appropriate officer within the Ministry of Health. 15. Review applicable policies and procedures to ensure:

	a. Emphasis upon the need for practitioners to obtain collaborative/corroborative background information regarding consumers; b. Relevant sources of such information (for example, general practitioners, family members) are set out. 16. Introduce a fact sheet regarding the operation of s. 16A, *Children and Young Person (Care and Protection) Act 1998* (NSW) ("**CYP Act**") and the exchange of information between agencies with responsibility for the safety, welfare or wellbeing or children or young people. **Directed to the Catholic Education Office** That the Catholic Education Office: 17. Review the policy entitled 'Child Protection Policy: Managing Risk of Significant Harm and Wellbeing Concerns' to ensure they stipulate that when a mandatory report is made to the Department of Communities and Justice pursuant to the *Children and Young Persons (Care and Protection) Act 1998* (NSW), the reporter must consider making a subsequent report to NSW Police by calling 000.
Non-publication orders	**Annexure A** contains the details of non-publication orders made by the State Coroner and is available upon request from the Court Registry.

Table of Contents

Introduction **10**

The purpose of an inquest and role of the Coroner **10**

The proceedings **11**

SJ’s role as primary carer of CS and DS 12

The immediate circumstances of CS’ death 12

Fact finding and chronology of events 13

Background to the events leading up to CS’ death 13

LS’, DS’ and CS’ interactions with FACS 13

LS’ involvement with Victoria Police and the NSWPF 22

SJ’s recollection of her interaction with FACS in 2016/2017 28

LS’ interactions with Community Corrections and CSNSW 29

LS’ consultation with Dr Magee – 13 February 2017 31

The events of 1 to 2 March 2017 31

Findings as to Matters in Issue **68**

Evidence of SJ 68

Evidence of Mr Miles Rogers 70

CSNSW / Community Corrections 71

FACS / DCJ 76

Victoria Police 85

NSWPF 93

NSWPF and Victoria Police 113

MLHD 115

Catholic Education Office and Ms Murphy 124

ESTA 126

Conclusion **128**

Introduction

1. This inquest concerns the tragic death of CS. CS (born 3 May 2011) was aged 5 years and 9 months at the time of his death.

2. On 2 March 2017, CS was drowned by his mother, LS. The factual matrix surrounding those events is set out in the decision of his Honour Button J in *R v Struthers* [2018] NSWSC 1824, in which a special verdict of not guilty by reason of mental illness was returned. The basis of the special verdict was unanimous expert psychiatric opinion surrounding LS' complex mental health conditions. Following the final determination of the criminal proceedings involving LS, this inquest commenced pursuant to s. 79 of the *Coroners Act 2009* ("**the Act**").

3. CS was a much-loved younger brother to DS and adored by his grandparents, SJ and FJ. He was described as full of life from an early age. He loved to play games and attend the local park. He was very outgoing and always carried a toy truck or ball.

4. SJ and FJ attended every day of the inquest and their continued grief at the loss of their grandson was unmistakeable and palpable. They conducted themselves with dignity and grace, notwithstanding the obvious difficulty in hearing some of the evidence concerning the last days and hours of CS' life. The heartache of CS' loss continues to be felt daily by CS' family and the wider Deniliquin community. In making these findings, I offer CS' family my sincere and heartfelt condolences. It is hoped that from the inquest process, some small measure of solace comes in the form of information, answers and agency accountability.

5. In the preparation of these findings, I have been assisted by the written submissions of Counsel Assisting, Kristina Stern SC and Emma Sullivan. I have also been assisted by the submissions of counsel for the interested parties.

The purpose of an inquest and role of the Coroner

6. The inquest is a public examination of the circumstances of CS' death. Unlike some other proceedings, the purpose of an inquest is not to blame or punish anyone for the death. The holding of an inquest does not itself suggest that any party is guilty of wrongdoing. Rather, the function of an inquest is to identify the circumstances in which a death has occurred.

7. The role of a Coroner, as set out in s. 81(1) of the Act, is to make findings as to the:

   a. Identify of the person who died;
   b. The date and place of the person's death; and

c. In the case of an inquest that is being concluded – the manner and cause of the person's death. The manner of a death relates to the circumstances in which the person died.

8. In this inquest, the identity of the deceased, the date, time and place of their death, and even the specific manner and medical cause of CS' death are not in issue.

9. Pursuant to s. 82(1) of the Act, the Coroner may also make any recommendations that the Coroner considers "necessary or desirable to make in relation to any matter connected with the death". This involves consideration of whether anything should or could be done to prevent a death in similar circumstances in the future. These recommendations are made, usually to government and non-government organisations, in order to seek to address systemic issues that are highlighted and examined during the course of an inquest.

10. A coronial inquest takes places, necessarily, after the event. It follows that, unavoidably, a coronial inquest is conducted with the benefit of hindsight.

11. However, in performing the role set out in ss. 81 and 82 of the Act, it is accepted that a Coroner must judge the appropriateness of steps taken or not taken by an involved person or organisation against the information that was available to that individual or organisation at the time, and not, as has been pointed out in submissions, through the prism of the tragic outcome of the case. Indeed, coronial inquests routinely examine whether, armed with the knowledge available to the relevant individual or organisation at the time, a party could have or should have acted differently in the particular circumstances that presented themselves. This is, in my view, entirely appropriate, and indeed a fundamental aspect of the coronial jurisdiction.

The proceedings

12. The hearing of the inquest into the death of CS was held at Deniliquin Local Court from **17 to 27 May 2021.**

13. A list of issues noting 28 specific issues to be examined in the inquest was distributed to parties identified as having a sufficient interest in the subject matter of the proceedings. The list of issues is attached to these findings at **Appendix 1**.

14. The central focus of the evidence received during the inquest was upon acts and omissions or, systemic issues within, the various agencies or organisations involved with CS' mother, LS. This entailed exploring potential shortcomings or inadequacies in the responses of involved agencies and those who acted on their behalf regarding the events that transpired prior to and on 1 to 2 March 2017, including in terms of compliance with applicable procedures and policies and the adequacy of those procedures and policies.

15. In addition to the brief of evidence tendered at the hearing, as well as the oral evidence of the witnesses who appeared at the hearing, I have received the following written submissions:

    a. Counsel Assisting's Submissions dated 17 September 2021;
    b. Submissions on behalf of the Family dated 1 October 2021;
    c. Submissions on behalf of DCJ (formerly FACS) dated 22 October 2021;
    d. Submissions on behalf of the MLHD dated 29 October 2021;
    e. Submissions on behalf of the ESTA dated 29 October 2021;
    f. Submissions on behalf of the Catholic Education Wilcannia Forbes and Bernadette Murphy dated 29 October 2021;
    g. Submissions on behalf of the Chief Commissioner of Police – Victoria Police dated 29 October 2021;
    h. Submissions on behalf of the NSW Commissioner of Police, NSWPF, Senior Constable Tyler Bryce, Senior Constable Nicholas Burnell, Former Leading Senior Constable Matthew Holloway, and Former Leading Senior Constable Lisa Hyne dated 2 November 2021; and
    i. Counsel Assisting's Submissions in Reply dated 4 February 2022.

16. A small bundle of further material referred to in the written submissions of the interested parties was tendered in Chambers on 2 November 2021 without objection.

SJ's role as primary carer of CS and DS

17. For some time prior to his death, CS had been living with his maternal grandmother, SJ, at a residence in Deniliquin, together with his older brother DS (then aged 9 years). CS' mother, LS, was in custody between March 2016 and her release to parole on 1 February 2017. From the date of her release, LS was also living at SJ's home in Deniliquin, residing in a caravan at the rear of the property.

18. For at least the 18 months preceding CS' death, SJ had been the primary carer for the children. SJ had sought legal advice and planned to formalise these care arrangements through the Family Court. However, LS remained the children's legal parent and was entitled to legal custody of them.

19. LS had relevantly come to the attention of FACS for child protection concerns in 2015, with matters escalating throughout 2016. During the 14 months prior to CS' death, FACS received seven reports about CS and DS being at risk of harm from their mother.

The immediate circumstances of CS' death

20. As noted above, the immediate circumstances of CS' death are not the central focus of this inquest. They are canvassed in some detail by Button J in *R v Struthers* [2018] NSWSC 1824.

21. By way of summary, the evidence establishes that sometime after 5:30pm on Thursday, 2 March 2017, LS, DS and CS arrived at a residence in Moama, NSW. LS then took CS and DS down to the banks of the Murray River. Shortly after that time, DS entered the water and LS attempted to drown him. He broke free before being attacked by a dog belonging to the owners of the residence. LS then forcibly held CS underwater until he stopped resisting.

22. DS sustained serious injuries (including bite wounds from the dog attack) and was immediately driven to the Echuca Hospital Emergency Department (in Victoria) by LS' friends.

23. At around 11:30am on 4 March 2017, CS' body was located by divers from the NSWPF in the Murray River, near Moama – some 400 metres downstream from the property that LS had attended with the children on 2 March 2017.

Fact finding and chronology of events

24. In their written submissions, Counsel Assisting provided a very detailed review of the evidence before this Court. I rely on that document to set out the factual background, chronology of events, and to outline the expert evidence received in connection with this inquest. I accept Counsel Assisting's summary of the evidence as accurate and reproduce much of it below.

Background to the events leading up to CS' death

25. LS was born on 19 February 1990. From a young age, she presented with learning difficulties, self-esteem issues and experienced challenges in forming peer relationships. LS was home-schooled from late 2003/early 2004 and there were reports of suicidality.

26. On 31 August 2003, LS was diagnosed as presenting with a major depressive disorder associated with a dysthymic disorder. LS was also reported (amongst other things) to have experienced second person auditory hallucinations. She was known to FACS from a young age.

27. On 19 November 2007, LS gave birth to her first son, DS.

28. On 3 May 2011, LS gave birth to her second son, CS.

LS', DS' and CS' interactions with FACS

29. In their written submissions, Counsel Assisting helpfully outlined the operation of key concepts within the child protection system which inform the various reports received by FACS. Before turning to consider the various reports received by FACS in relation to LS and the children, I note the following:

a. As regards the Child Protection Helpline ("**Helpline**"), "risk of significant harm" ("**ROSH"**) and screening process:
   i. The Helpline is the 'frontline', providing the first opportunity for an assessment of information received about a report raising child protection concerns;
   ii. The responding caseworker considers the reported concerns in conjunction with the child protection history in the electronic database ("**KiDS**" – Key Information Directory System);
   iii. The Helpline then determines the most appropriate reaction. If the matter meets the ROSH threshold, a response level is assigned to the report and it may be "screened-in" according to the Structured Decision Making screening tool;
   iv. A matter satisfies the ROSH threshold if current concerns exist for the safety, welfare or wellbeing of the child or young person because of the presence, to a significant extent, of the circumstances identified in s. 23 (1) of the *CYP Act*;
   v. The response times which may be allocated to any given matter are: "< 24 hours; < 72 hours; < 10 days"; and
   vi. A matter may also be "screened out", as not meeting the threshold of ROSH.
b. For a household in respect of which a ROSH report has been received, a Safety and Risk Assessment ("**SARA**") is completed. As regards the SARA:
   i. The safety assessment assesses present danger to a child and current protective interventions existing in relation to that child;
   ii. For a new report, the safety assessment is completed during the first face-to-face contact and a 'preliminary safety decision' is made by the caseworker;
   iii. A safety decision is either (a) 'Safe'– no dangers were identified; (b) 'Safe with a plan – one or more dangers are identified and the caseworker is able to identify sufficient protective abilities that lead the caseworker to believe that a safety plan can mitigate the danger; or (c) 'Unsafe' – the child/young person cannot be safely kept in the home even after consideration of the range of interventions;
   iv. The risk assessment is future focused and looks at the likelihood of future ill-treatment. The risk assessment is based on a scale of 'very high, high, moderate or low' probabilities of abusing or neglecting their child/young person in the future;
   v. The risk assessment should be completed within 30 days of the initial safety assessment; and
   vi. The risk level determines whether the case remains open for ongoing casework or should be closed.

The first ROSH report – 2010

30. In 2010, one ROSH report was made in respect of DS which recorded serious violence from DS' father towards LS whilst she was pregnant with CS.

31. The report was transferred to the 'Brighter Futures Unit' by the Helpline and subsequently closed citing "competing priorities". A review conducted by the Office of the Senior Practitioner, Serious Case Review Unit (FACS), Internal Serious Case Review, in April 2017 (**"the ISCR"**), found that the decision to close this report was a "missed opportunity".

Further reports to the Helpline - 2015

32. Up to 2015, SJ regularly provided informal care to both CS and DS. In late 2015, FACS received multiple reports regarding LS' deteriorating mental health, drug use, violence and the consequent risk to CS and DS.

    a. On 4 December 2015, the Helpline received a report that LS and DS could not be contacted. The reporter stated that LS had moved to Deniliquin and may have been dealing/using ice. The reporter also indicated that DS had been left in SJ's care for up to a week at that time. The case was closed by the Helpline after being assessed as non-ROSH.

    b. On 9 December 2015, the Helpline received a further call from the same reporter who was following up on the earlier report. The report was closed with the matter again being assessed as non-ROSH.

33. It is apparent from these reports that in 2015 the Helpline had received information that LS may have been using drugs, namely ice. The evidence before me at the inquest establishes that the known use of ice carries with it child protection concerns including anti-social home environments, limited parental supervision, neglect and other impacts on a parent's mental health which may result in a propensity for violence.

Contact with Deniliquin Community Service - 2016

34. In 2016, SJ attended the Deniliquin Community Service Centre ("**Deniliquin CSC**") on numerous occasions and expressed concerns in relation to LS and the children. Those concerns were disclosed in the context of informal discussions with caseworkers about CS and DS.

35. At some point whilst LS was in custody, SJ attended Deniliquin CSC and produced a letter written by LS. That letter referred to LS' intention to take the children to Queensland upon release. LS had previously expressed to caseworkers that she did not want SJ caring for the children.

36. Despite those attendances and disclosures, the KiDS system did not record any information to that effect and the evidence establishes that it was not placed on any formal or informal record. The ISCR found that the failure to record information obtained during the course of those attendances was problematic because "not only is valuable information lost and not captured in formal records, it is also not available to others who might work with the family now or in the future" and significantly, "it cannot be used to inform assessments and decisions about how to best work with families".

Events and reports made throughout 2016

37. Throughout 2016, a number of reports were made regarding concerns for DS and CS based on what appears to be a marked deterioration in LS' mental health and escalating behaviour.

<u>*January 2016*</u>

38. On 8 January 2016, LS reportedly yelled in the streets of Deniliquin, stating that she had attacked her former partner and threatened to kill herself. Both CS and DS were present at the time and it was noted that LS appeared to be drug affected, was punching herself in the face, slamming her head against a fence, had cuts to her eyebrows and had a 30 cm long butcher's knife in her car. As a result of those reports, police attended and scheduled LS. She was conveyed to Albury Hospital for assessment and the Helpline referred a ROSH report to the Deniliquin CSC. A "less than 10-day response" was recommended in relation to that report.

39. Later that day, a second report was made reporting concerns for CS and DS due to LSs heavy drug use. The report included information that LS was intravenously using ice twice a week and smoking 2 grams of marijuana each day. The Helpline forwarded this information to Deniliquin CSC.

40. Following those reports, Deniliquin CSC allocated the family a caseworker, Tim Pearson, for the purpose of completing a SARA. On 12 and 13 January 2016 respectively, caseworkers attempted to visit LS at home but she was not present at the residence. SJ was home and expressed concerns to caseworkers regarding the children when they were alone with LS. She told caseworkers that LS had been consuming drugs and alcohol.

41. Subsequently, on 18 January 2016, LS attended Deniliquin CSC and presented with bruising on her arm. There was a discussion about violence in the home and LS told caseworkers that she had been using ice on a daily basis except for in the last month. LS also told caseworkers that she had been diagnosed with bipolar disorder, was on Valium and took antidepressants. Significantly, LS acknowledged that she could not look after CS and DS when she was mentally unwell and that SJ looked after the children most of the time. LS was told by caseworkers that they would be concerned if she took CS and DS from SJ's care. Plans were made for a SARA to be conducted.

42. On 20 January 2016, caseworkers again visited SJ's home and LS was not present. Both CS and DS were at the home at which time caseworkers provided SJ with contact details for Legal Aid and expressed concerns around LS caring for the children. It was suggested to SJ that she contact them for the purpose of discussing options surrounding formal care arrangements. The caseworkers also said they were worried LS would take the children from SJ if she became unwell.

43. A safety assessment was conducted at that time and CS and DS were assessed as 'safe'. That assessment was based on the fact they were in SJ's daily care. As a result, no safety plan was developed. On 21 January 2016, a risk assessment was completed which recorded the children as at 'high risk' in LS' care due to her mental health issues, drug use, and CS and DS' exposure to her violent behaviour. However, the assessment ultimately noted that the children were at 'low' risk by virtue of SJ's involvement in their daily care.

44. On 16 February 2016, the Casework Manager, Pamela Vesty, finalised the assessment and declared the children 'safe' as they were in SJ's care. It appears the matter was then closed.

45. On 28 January 2016, SJ presented to Deniliquin CSC in a distressed state. Mr Pearson attended SJ who stated that she had been assaulted by LS, and that LS had been trying to take the car keys to go to Echuca. SJ further indicated that CS and DS had not slept and were scared. The caseworkers called police and took SJ home to await their arrival.

46. As SJ and the caseworkers were waiting for police, LS exited the caravan in a seemingly drug affected state with track marks visible on her left arm. LS stated to caseworkers that she did not want the children to stay with SJ any longer and was going to take them to Echuca. Caseworkers observed that CS and DS were upset and told SJ that the children needed to remain in her care as LS appeared drug affected. Police subsequently arrived and the caseworkers left.

47. A ROSH report was made to the Helpline which noted "if the current situation continues, it can be reasonable to conclude that serious harm will occur in the near future". A less than 10 days priority was assigned and the report was allocated to Deniliquin CSC for assessment.

48. On 31 January 2016, a further report was made to the Helpline but was deemed not-ROSH. It was screened out but merged with the 28 January 2016 ROSH report. The further report noted that CS and DS lived with LS in the caravan which was described as being in an "untidy and not entirely clean state", that LS was charged with an assault, that an interim ADVO was obtained for the protection of SJ, and that LS had a history of assaulting a previous partner.

49. On 1 February 2016, a copy of the interim ADVO was provided to caseworkers by SJ. The ADVO was formally made in May 2016. This ADVO is addressed in further detail below at paras [89]-[94].

February 2016 Risk Assessment

50. On 2 February 2016, a further risk assessment was conducted by caseworkers at Deniliquin CSC. The risk assessment was again assessed as 'low' because the children were living with SJ but would otherwise be assessed as 'high' if the children resided with LS. SJ was recorded as having displayed protective factors in keeping the children from harm. Finally, it was recorded that no case planning or further action was required by FACS by virtue of the fact SJ was seeking care orders through the Family Court.

51. At this juncture, I note that the ISCR identified several shortcomings in the aforementioned risk assessment including that caseworkers were:

    a. selective about the information they relied upon;
    b. did not give real consideration to SJ's concerns about LS wanting to take the children; and
    c. did not appreciate that as SJ could not protect herself from LS' violence, she was less able to protect CS and DS.

52. On 8 February 2016, LS telephoned a caseworker who could not follow what she was trying to say. The caseworker told LS that she required a mental health assessment as she appeared to be "self-medicating". The caseworker noted that LS' "mental health is very high today, as she was not making sense and it was hard to understand her."

March 2016

53. On 11 March 2016, a ROSH report was made to the Helpline that LS had attended the Emergency Department on 10 March 2016 affected by drugs and was involved in a violent relationship. LS indicated that CS and DS were being cared for by SJ. Of particular concern, is LS' report to hospital staff that her boyfriend had placed her four-year old son in the freezer and she had to remove him. LS further reported significant family violence including a rape two weeks earlier. She stated that she might kill her boyfriend as she was afraid he would kill her first and indicated that she was using ice to stay awake as she feared him harming her whilst she was asleep.

54. The ROSH report recommended a 'less than 72 hours' response and the Helpline recorded that SJ was seeking legal orders through the Family Court, but that "the mother could probably go and get the children if she wants as there are no current legal orders other than an AVO which does not prevent her from having the children with her".

55. On 15 March 2016, without undertaking any sort of further assessment, Deniliquin CSC closed the report and noted: "the information was already known to FACS as a caseworker [was] already working with the family." A further record noted that the children were safe and living in Deniliquin with SJ who was seeking care orders, whilst LS was in Echuca.

56. The ISCR identified a number of failings in relation to the above, including but not limited to the fact there was nothing to stop LS from exercising her parental rights to take the children, no consideration of the troubling allegation that CS had been placed in a freezer and the lost opportunity to appropriately engaged with LS. In particular, LS' reports of abuse and use of ice with a view to keeping herself safe could have been better managed including via appropriate community interventions.

57. Relevantly, the ISCR concluded that LS needed to be viewed "not only as a person causing harm, but also as a person who was being harmed and needed help".

Early 2017

58. In her statement, Pamela Vesty indicated that in early 2017, SJ attended Deniliquin CSC and sought advice about LS possibly being paroled to her residence. SJ did not want LS to return to her home and wanted to know what her options were. Ms Vesty advised SJ to contact the person who called her in relation to LS' impending release and inform them that she did not want LS living there. A short time later, SJ left Deniliquin CSC.

59. During her oral evidence, Ms Vesty noted that on this day, SJ furnished the letter LS sent her which indicated that she wanted to take the children and move to Queensland upon release. It was accepted by Ms Vesty that she should have identified there was a real risk of LS taking the children away from SJ upon release. Ms Vesty also accepted that she should have made another report and undertaken a further assessment following SJ's presentation.

LS' release to parole

60. Notwithstanding SJ's concerns, on 1 February 2017, LS was released to parole and moved back into the caravan at the back of SJ's home.

61. On 6 February 2017, SJ once again attended Deniliquin CSC and spoke with Ms Vesty. SJ said that she had still not obtained formal care orders and was worried LS might take CS and DS. The ISCR noted that SJ did not tell Ms Vesty that LS had returned to her residence. However, I am satisfied that Ms Vesty was aware that LS was to be released from custody, that probation and parole wanted to release her to SJ's home and that SJ did not want that to happen.

62. Of this discussion with SJ, Ms Vesty recalled SJ advising that LS was in a "good spot" and that they were going to attend Brooks Hall Lawyers for the purpose of LS signing over custody. Ms Vesty states that around this time she made contact with the law firm and "confirmed that SJ was in the process of having custody of [CS] and [DS] signed over to SJ".

63. Ms Vesty further states that on 10 February 2017, SJ attended Deniliquin CSC and indicated that LS had signed over custody of the children. During the course of her oral evidence, Ms Vesty accepted that she never told SJ that FACS could assist in seeking court intervention to formally allocate care of the children to SJ. She also never suggested to SJ's solicitor that FACS could assist, notwithstanding that she had contact with Brooks Hall Lawyers.

Scotts Park Incident

64. On 4 February 2017, police attended Scotts Park in Deniliquin after receiving reports that a woman was observed screaming at her children. The screams could be heard some 100 metres away. LS was alone with the children at this time. Police later spoke with SJ who told them that LS had recently been released from prison and had been difficult. Police recorded that LS had been recently released from custody and had possible mental health issues as a result of her drug use.

65. On 8 February 2017, police made a ''Child/Young Person at Risk' report. Further evidence regarding this incident is canvassed below at [97]-[103].

66. The Helpline assessed the report as ROSH and transferred it to Deniliquin CSC recommending a response within 10 days.

67. On 13 February 2017, Ms Vesty created a 'Secondary Assessment Stage 1' and recommended that the matter be closed. This seems to have occurred at a 'Weekly Allocation Meeting' ("**WAM**") as a result of competing priorities. The WAM discussion noted that "due to the mother signing the children over matter will be closed as there are no concerns for the children in the grandmother's care, the mother has agreed to place the children in the grandmother's care legally, grandmother is protective of the children." It does not appear that any steps were taken to confirm the status of any court orders.

68. On 24 February 2017, Ms Vesty's recommendation was approved and, on 27 February 2017, the case was formally closed.

69. The ISCR recorded that this was the seventh report received about CS and DS being at risk of harm whilst in LS' care. It identified that caseworkers appeared to rely solely or almost solely on information from SJ about the Family Court proceedings, without seeking confirmation from either LS or SJ's solicitor. The caseworkers also had no

knowledge of the nature of the orders being sought, the status of those proceedings and how long it would take for those care arrangements to be finalised.

70. During the hearing, Ms Vesty gave candid evidence and appropriately accepted the criticisms of the ISCR, specifically regarding her recommendation to close the case.

Steps taken by Brooks Hall Lawyers regarding custody arrangements

71. As noted above, in early January 2017 whilst LS was in custody, SJ sought legal advice regarding the care of CS and DS. SJ showed her lawyer letters that LS had sent to the children which indicated that they would be moving to Queensland soon. SJ also expressed that she was "extremely concerned" about the children's welfare if they were to return to LS' care.

72. SJ's lawyer, Fiona Paterson, telephoned FACS and spoke with Mr Pearson about the possibility of 'Care Protection Orders'. In her statement, Ms Paterson stated that Mr Pearson advised "the case has been closed however if [LS] returns home we may consider re-opening the matter". Ms Paterson then began preparing the necessary application for orders in the Federal Circuit Court.

73. On 2 February 2017, upon finding out that LS was being released to SJ's residence, Ms Paterson contacted Community Corrections to advise that SJ did not want this to occur. Ms Paterson noted the existence of the ADVO for the protection of SJ.

74. Ms Paterson also made contact with Ms Vesty, who she states advised that "there was nothing they could do until [LS] was back in the house with the children and the case would remain closed". Ms Vesty denies this, but accepted during the course of her oral evidence that she did not suggest any positive steps that FACS could have taken to assist SJ.

75. On 3 February 2017, SJ called Ms Paterson and informed her that LS had attended her home and would be staying there for a few days. Ms Paterson encouraged SJ to notify FACS. Ms Paterson stated:

> "I telephoned FACS and spoke with Tim Pearson hopeful that this would now allow FACS to open the matter and help [SJ] and the children. I explained to Mr Pearson that [LS] had returned and that [SJ] was incredibly worried about her behaviour and appearance and her repeated statements of wanting to relocate with the children to Queensland. Mr Pearson advised that FACS primary concern about the children was in regards to [LS'] partner [EE] and not [LS] herself, he said that if [LS] was to rekindle her relationship with [EE] or if she began visiting Echuca where [EE] resided that we should notify FACS".

76. Later that month, SJ attended Brooks Hall Lawyers and advised that LS had agreed to sign orders granting SJ primary care of the children. The application was then changed

to 'Consent Orders', however these were never filed and it appears that they were not raised with LS.

77. On 2 March 2017, SJ telephoned Ms Paterson regarding the whereabouts of CS and DS. Ms Paterson directed SJ to contact the police and indicated that she would contact Mr Pearson.

LS' involvement with Victoria Police and the NSWPF

78. An understanding of LS' criminal history and prior involvement with Victoria Police and the NSWPF is relevant to her later interactions with police and in particular the events of 1-2 March 2017.

79. LS' interactions with police in Victoria includes an assault on her by her former partner and property offences in 2014/2015. Notably, the Law Enforcement Assistance Program ("**LEAP**") personal history report for LS recorded on 7 August 2014 that she appeared to be drug affected but denied using drugs. A report created on 26 March 2015 records that LS:

    a. "Stated [she] has given her children to her mother as she [cannot] control them when she is taking 'ICE'. Mother [SJ] … looks after children. [LS] stated no DHS involvement at the moment"; under the heading 'Health': "Using 'ICE' on a frequent basis. States does not sleep much and uses 'ICE' to keep functioning".

17 October 2015 - Concern for welfare

80. On 17 October 2015, the NSWPF responded to reports that LS had threatened to drive into a tree with CS and DS following an argument with SJ. A COPS event report was generated in relation to this incident and records that LS stated "nobody listens. Now you will all listen. I am taking the kids and we will all be together." NSWPF officers subsequently located LS and the children in Echuca and recorded "no concerns for [LS'] wellbeing". The COPS event further records that Victoria Police, who also responded, had taken over carriage of the matter and made enquiries as to LS' welfare.

July 2015 - Aggravated break and enter

81. On 16 July 2015, LS and her former partner broke into the residence of an acquaintance and threatened her life. They were subsequently arrested and LS made certain admissions before being charged. LS was again arrested on 29 August 2015 for failing to appear in court in connection with this charge. Relevantly, the NSWPF Facts noted that LS is believed to be involved in the illicit drug scene in Echuca.

11 December 2015 - Common assault (DV) and ADVO

82. On 11 December 2015, LS was charged with common assault of her former partner. The related Police Fact Sheet indicates that CS and DS were present at the scene. It records that police "obtained details and checked on the welfare of the accused's two children with nil issues raised". An ADVO was made against LS.

3 January 2016 - Drug possession

83. On 3 January 2016, LS was found in possession of cannabis, with a corresponding NSWPF COPS Event recording: "KNOWN DRUG OFFENDER OBSERVED PARTICIPATING IN A 'TAKEAWAY' AT KNOWN DRUG LOCATION".

8 January 2016 - Concern for welfare check

84. On 8 January 2016, police attended a Priority 2 concern for welfare check following reports that LS began acting erratically, threatening self-harm and punching herself in the face. It was further recorded that LS' behaviour escalated and she began hitting herself in the face causing a laceration above her right eye, as well as hitting the rear of her head against a wall to "relieve frustration". Police were contacted after a neighbour overheard LS saying, "You want me to kill myself?".

85. Upon arrival, police observed that the children and SJ were present together with LS and her previous partner. They noted that she was acting erratically and located a large butchers' knife within LS' reach. Further details regarding this incident, which resulted in a report to FACS appear above at [38].

28 January 2016 – Common assault

86. On 28 January 2016, police attended SJ's residence following a report that she had been assaulted by LS in the presence of CS and DS. SJ reported that LS had grabbed her by the shirt and pushed her backwards. FACS also attended the residence. A corresponding COPS Event records that SJ feared for her safety, the safety of CS and DS and that she found LS behaviour intimidating.

87. A ROSH report was also made which noted that the primary reporting issue was 'DV – Domestic Violence' and referenced LS' history of drug problems and assault offences. The ROSH report records the following:

    a. CS and DS' demeanour as "… the children at the time appeared happy and healthy. The children have been cared for by their grandmother [SJ]. [SJ] is currently in contact with family services at Deniliquin this is due to concerns with [LS's] drug dependencies". However, their responses must be viewed through the prism of a continued exposure to LS' violent behaviour.
    b. That the children reside with LS in a caravan and that SJ is "also seeking assistance via FACS in relation to the children and the current care provided by their mother [LS]. The children although appeared happy have come under notice of FACS".

88. On 3 May 2016, LS was sentenced to a term of imprisonment for the assault and possession charges.

26 January 2016 - ADVO for the protection of SJ

89. In response to the 28 January 2016 assault, an application for a Provisional ADVO was prepared by former Leading Senior Constable Lisa Hyne pursuant to the *Crimes (Domestic and Personal Violence) Act 2007* ("***CDPV Act***"). SJ was the only person listed as a PINOP under the Provisional ADVO. It was issued by Sergeant Phillipe Cookson at 7:20pm on 28 January 2016. In addition to the standard conditions, the terms of the order specified that LS was not to approach SJ within 24 hours of consuming intoxicating liquor or illicit substances.

90. The basis of the ADVO application were the facts of the 28 January 2016 common assault including SJ's fears for her safety and the safety of CS and DS. Notwithstanding SJ's express reference to the fears she held for the children, she was the only person named as a PINOP in the interim, provisional and final ADVO. The NSWPF '*Domestic and Family Violence Standard Operating Procedures 2012*' ("**DV SOPs**") provide as follows regarding children specifically:

> "As stipulated in section 38(2) of the *Crimes (Domestic and Personal Violence) Act 2007* <u>the court must include as a protected person under the order any child with whom the Protected person named in the order has a domestic relationship.</u> However, as stipulated in section 38(3) the court is not required to comply with subsection (2) if satisfied there are good reasons not to.
>
> Police have no such legislated requirement regarding the inclusion of any children however; the court cannot meet its requirement if police do not include the children in the application.
>
> - Accordingly, you <u>should record a child as a protected person if you believe that the child has been or is subject to or affected by direct or indirect violence or threat</u>. If the child/ren is not subject to or affected by direct or indirect violence or threat and you have no fears of such do not record the child/ren as a protected person.
> - In the latter case the child/ren will be protected by the statutory conditions due to their domestic relationship with the protected person.
> - Regardless of whether the child/ren is listed as a protected person each child should be identified in the narrative.
> - You should also provide information that will allow the court or authorised officer to make an informed decision on whether or not to include the child/ren as a protected person This includes your view and any supporting information Ultimately, the decision to include a

child on an AVO lies with the court or authorised officer." (Emphasis added)

91. On 3 May 2016, a final 12-month ADVO was made naming only SJ as the PINOP. It primarily replicated the terms of the interim and provisional ADVO.

92. Had the children been named as PINOPs on the ADVO, this may have had a direct impact on the responses of the NSWPF and Victoria Police officers following SJ's reports on 1 and 2 March 2017. This is particularly so given the speculation around LS' potential use of ice at that time and the operation of the additional condition concerning her consumption of intoxicating liquor or illicit substances.

93. I will now consider the evidence of Ms Hyne and Sergeant Cookson regarding the ADVO application. At the outset, I note that some of that evidence raises appreciable concerns regarding the extent to which NSWPF officers are familiar with procedures specific to children under the DV SOPs and s. 38(2) of the *CDPV Act.* That evidence was outlined in detail by Counsel Assisting in their written submissions (see [102]-[108]):

> *Evidence of former Leading Senior Constable Hyne*
> At the hearing, former Leading Senior Constable Hyne gave evidence that she erroneously considered CS and DS to be captured by the additional conditions in the ADVO by virtue of the fact there was a reference to protected "persons" (plural) rather than a single "person". In her view, the existence of an 's' after person in the ADVO served to afford CS and DS the same protections as SJ under the order. That understanding was erroneous.
>
> During questioning about the events of 28 January 2016, Ms Hyne could not recall where the children were located at the time that LS assaulted SJ. She accepted that, in hindsight, one of the purposes of the ADVO was to protect CS and DS from indirect violence, namely the risk of being exposed to and/or observing LS being violent. However, in 2016 Ms Hyne was not familiar with the term "indirect violence". Nor was she was aware, in January 2016, that the DV SOPS required children to be recorded as PINOPs if they are subject to or affected by "direct or indirect violence or threat". In undertaking her duties, Ms Hyne accepted that she should have looked carefully at any previous COPS entries relating to LS and involving domestic violence, particularly if they occurred in the month preceding the incident. That evidence raised real questions as to the extent of knowledge of officers within the NSWPF as to their role, and as to the operation of an ADVO, when considering and applying for an ADVO.
>
> *Evidence of Sergeant Phillip Cookson*
> At the outset, Sergeant Cookson stated that he had no independent recollection of approving the ADVO in January 2016. He indicated that his written statement

was "based purely" on COPS records and what would otherwise be his usual practice in ADVO matters.

In the context of his role within the ADVO process, Sergeant Cookson accepted that he was under an obligation to include CS and DS as named persons in the order unless there were "good reasons for not doing so". He also accepted that this exercise involved an assessment of risk. In his view, "nothing that [he] read anywhere, nothing that [he] saw anywhere" in relation to the 28 January 2016 incident indicated that CS and DS were at risk of significant harm.

During the course of his oral evidence, Sergeant Cookson stated that he was "purely focussed" on SJ but accepted that CS and DS should have been recorded as PINOPs if they witnessed LS being violent to SJ. Sergeant Cookson contended that the information available to him suggested that the children were "close by" and he did not make further inquiries to clarify this matter.

After being taken to prior incidents involving LS and relevant COPS records, Sergeant Cookson maintained his decision not to list the children as PINOPs and noted that he would "probably still make the same judgment call" if he were "presented with this exact same incident right now". Despite being the approving officer on these facts, he hoped that if he made the wrong judgment call "it would be picked up and any errors corrected" and noted:

> "As - as an accepting officer, I would rarely ring a victim unless I really needed to, to find out further information because I am placing the faith in the constables that are doing their jobs, that what they are presenting to me is an accurate record of what took place."

As with Ms Hyne, Sergeant Cookson stated that, he was under the misapprehension that CS and DS were "automatically also covered under any other points listed in the apprehended violence order." He could not specifically recall receiving any training on the DV SOPS but believed he would have read them "at some point in my career".

94. Regrettably, the evidence of Ms Hyne and Sergeant Cookson raises concerns about the extent of the knowledge of NSWPF officers and their understanding not only regarding the specific ADVO practices relating to children under the DV SOPS but also the role of different officers in the ADVO process and the operation of ADVOs more generally. To their credit, Ms Hyne and Sergeant Cookson accepted during the course of their evidence that this case could offer a valuable learning or training opportunity for officers in the NSWPF. This issue is considered in greater detail below at [477].

1 February 2017 - LS' release to parole

95. After being sentenced in relation to the 2015 aggravated break and enter offence referred to above at [81], LS was ultimately released to parole on 1 February 2017. Notably, due to the backdating of LS' sentence, she was released to parole the day after her sentencing. This presented resultant difficulties, for example in terms of finalising post-release accommodation for LS.

96. LS parole conditions including the following:

> To obey all reasonable directions of her parole office (condition (a)); To reside at an address agreed on by the officer, and to receive visits at that address by the officer at such times as the officer considers necessary (condition (d)): Not to leave New South Wales without permission of the Officer's District Manager (condition (f)); and Not to use prohibited drugs, obtain drugs unlawfully or abuse drugs obtained lawfully (condition (k)).

Scotts Park incident – 4 February 2017

97. Only three days after LS' release to parole, the Scotts Park incident involving CS and DS took place (see above at [64]). Sergeant Roger Campton and Probationary Constable Merten responded to reports of that incident. Sergeant Campton had prior experience with LS, having responded to an earlier domestic violence incident.

98. In his statement, Sergeant Campton recalled asking LS about her mental health, to which she replied that she was receiving treatment and "had an appointment". At the hearing, he gave evidence that he made enquiries as to LS' mental health to "ensure that she was receiving treatment and it wasn't, I suppose an unmanaged issue or condition". Sergeant Campton considered it necessary to "[turn] his mind to" the risk that LS presented "primarily to the children" given her recent release from custody and the nature of her behaviour. He formed the view that she may have mental health issues and more significantly, that there was "certainly potential" that the children were at ROSH.

99. During his oral evidence, Sergeant Campton could not recall receiving specific training on performing risk assessments concerning risk of harm to children. However, he gave evidence that his usual practice involved perusing any previous incidents on the COPS system that were relevant to "decisions that I have to make in relation to risks". He accepted that it would "certainly be beneficial" if police were trained to consider COPS entries as a matter of course when carrying out risk assessments regarding risk of harm or potential risk of harm to children.

100. Sergeant Campton stated that SJ advised that she was struggling since LS' release from gaol but had been allowing LS to spend time with the children. Sergeant Campton advised SJ to contact Probation and Parole to discuss any issues, as they may have been able to organise an alternative.

101. A 'Child/Young Person at Risk' report was made to FACS on 8 February 2017 (as noted also at [65] above). The primary reason for the report was recorded as "risk of psychological harm", and the concerns were that "[the children] are exposed to the erratic behaviour of their mother…the mother has significant history of drug abuse and has been charged with offences involving violence".

102. The ROSH concerns were further particularised as follows:

> "The mother has recently been released from gaol. She has a lengthy history of drug use and possible mental health issues relating to drug use. On this occasion she was reported as yelling at her children and other people in the area could be heard over 100 meters away. The witnesses describe her behaviour as fine for several minutes and she would then just go off for no reason. This behaviour has the potential [to] cause significant harm to her children."

103. Sergeant Campton conceded that he should have been aware of the January 2016 ADVO in making his report and acknowledged that there was "certainly a possibility" that if LS was using drugs, she would be violent. He also gave evidence that had he been aware of the January 2016 ADVO, he would not have sought to have CS and DS added to it. That is because there was "never any intentional harm towards the children" and SJ acted as a protective factor who was "certainly involved in the care of those children".

SJ's recollection of her interaction with FACS in 2016/2017

104. SJ's first police statement is dated 3 March 2017 and was made at a time before CS was discovered. I accept that this was obtained when SJ was in a state of shock and is understandably brief.

105. SJ provided two further statements dated 6 April 2020 and 26 March 2021 respectively, which supplemented her first statement. I accept the submission of Counsel Assisting that, as regards certain matters of significance, the accounts of SJ should be given considerable weight. In particular, I consider that SJ's account of the substance of her communications with FACS, and of her conversations with the NSWPF officers on 2 March 2017 should be favoured given their cogency and consistency with other actions taken by SJ. Notably, SJ's account of her level of anxiety and worry when communicating with NSWPF officers on 2 March 2017 is corroborated by other witnesses including Theresa Clark.

106. I also accept the evidence of SJ in relation to her various attendances at FACS in 2016 where she provided the letter from LS (see above at [105]) and informed them that she was fearful LS would take the children. SJ said that she was advised that court orders were required to obtain custody of CS and DS, and that there was nothing FACS

could do. In early 2017, SJ did in fact take such steps and her evidence is further corroborated by that of Ms Vesty and other FACS documentation.

LS' interactions with Community Corrections and CSNSW

107. On 7 June 2016, SJ was contacted by a Community Corrections Officer ("**CCO**") regarding LS' proposed post-release accommodation. Offender Integrated Management System ("**OIMS**") Notes indicate that SJ reported:

> "… it is way too much for her to cope with as she picking up the pieces of the mess that [LS] left for her to deal with. She will not feel safe with [LS] in the house until she demonstrates stability first and prefers to wait until the expiry of the ADVO before she makes a decision. This will mean that [LS] will have to get her life together during the period of the ADVO i.e. until 22/5/16 before she can reside with the children and her mother. She must demonstrate abstinence."

It appears that LS was notified that SJ was unable/unwilling to have her reside at her home whilst the ADVO was in place and she was caring for the children. However, given the backdating of LS' sentence (see above at [95]), it seems Community Corrections had insufficient time to undertake the necessary pre-release preparations.

108. On 2 February 2017, CCO Maree Wesley was notified that LS had been assigned to her. Ms Wesley also received a call from SJ's lawyer, Ms Paterson, that same day. Ms Paterson confirmed with Ms Wesley that SJ did not want LS residing at her home and notified Ms Wesley of the ADVO.

109. On 8 February 2017, Ms Wesley and LS met for the first time. Ms Wesley did not have LS' complete Community Corrections file at this meeting. LS advised Ms Wesley that she was residing at her mother's home. During this meeting, they specifically discussed matters including the ADVO condition that LS not go near SJ within 24 hours of consuming alcohol/drugs, accommodation with CS and DS, and LS' mental health. LS indicated that she had not used ice for two years and did not have any cravings. Ms Wesley provided LS with a number for AccessLine (a triage service) and directed LS to contact 'intake' that day. This service is for drug and alcohol counselling as well as mental health assessments.

110. Ms Wesley contacted SJ that same day, following her meeting with LS. During the conversation, SJ expressed concerns that LS would leave and take the children as there was no formal order granting custody. The corresponding OIMS case note records that SJ was working on formal custody orders without LS knowing and referenced the Scotts Park incident. Ms Wesley encouraged SJ to contact police if she was concerned for her own safety or the children's safety and to advise Community Corrections.

111. Ms Wesley then contacted LS and directed her to attend St Vincent de Paul's ("**Vinnies**") to obtain assistance in finding suitable accommodation. Ms Wesley

subsequently sought further information from Deniliquin Police Station regarding the Scotts Park incident and the ADVO.

112. On 9 February 2017, SJ told Ms Wesley that she had "no concerns at the moment" but wanted SJ to find separate accommodation and that LS was:

> "having episodes of crying, talking to someone that's not there, like she's psychotic. [SJ] indicated that [LS] was prescribed Seroquel although she is not complying with her dosage at the moment. [SJ] informed [Ms Wesley] that [LS] was up at 3am that morning cleaning the house."

Ms Wesley asked SJ to remind LS to call AccessLine if she had not already, see Dr Magee and attend Vinnies to seek housing support. During this conversation, SJ told Ms Wesley that LS "had agreed to sign the children over to her" and FACS had been notified of this.

113. On 14 February 2017, LS and CS attended the Deniliquin Reporting Centre. Ms Wesley observed that LS' contact with CS was "always appropriate" and that her general demeanour seemed to have improved. LS indicated that she:

a. Had been to Vinnies regarding her housing situation;
b. Agreed to return the following morning;
c. There was no conflict with SJ;
d. Had contacted AccessLine, was referred to the Deniliquin Community MHDA, and was awaiting contact for an appointment;
e. Estimated her mental health as stable;
f. Denied hearing voices or experiencing hallucination;
g. Feels calmer when not taking her medication and that she had been to see her doctor, Dr Magee, the previous day for a medical check-up; and
h. She was looking forward to the future and wanted to attend TAFE with the ambition of becoming a hairdresser.

114. On 16 February 2017, Ms Wesley telephoned SJ, who reported that she had seen LS "crying or presenting as depressed or hearing voices" (as per the last phone call). SJ indicated that she did not feel threatened at that time and would call the police in the event she did. SJ further stated she was not aware of any current mental health diagnosis for LS. SJ noted that LS was aware of legal steps being taken in relation to the formal care arrangements for the children.

115. On 22 February 2017, LS attended an in person meeting with Ms Wesley and referral forms were completed for Anglicare support services. During the appointment, Ms Wesley reports that LS confirmed wanting her own accommodation and spoke about being previously prescribed Seroquel but not liking the side-effects. Ms Wesley referred LS for Cognitive Behavioural Therapy to address her anger management issues, anxiety and depression.

LS' consultation with Dr Magee – 13 February 2017

116. On 13 February 2017, LS attended an appointment with her General Practitioner ("**GP**"), Dr Magee. Dr Magee knew LS well and reports that she first became aware of LS' substance abuse issues when she went to gaol and that over the years, she did not think LS was compliant with referrals to counsellors or prescribed medication.

117. At the hearing, Dr Magee gave evidence that LS presented as calm, coherent and well during the consultation. When asked specifically about her mental health and any prescribed medication, LS told Dr Magee that she "was really good and no she didn't want any medication". Dr Magee accepted this notwithstanding that LS had been untruthful in the past. A follow-up appointment was made for 2 March 2017, as although this was not the usual practice, Dr Magee "liked to keep a close eye" on LS.

118. Dr Magee also gave evidence that she never received a Release Summary and Transfer of Care document dated 1 February 2017 from the Justice Health and Forensic Mental Health Network ("**JHFMHN**"). That summary recorded LS' various prescriptions, including for Seroquel. Dr Magee told the Court that if she had known LS was on Seroquel, she would have spoken to her about it given it is an anti-psychotic medication. Generally speaking, Dr Magee stated that she could not recall ever receiving a discharge summary from JHFMHN in respect of any patient until 2021. Dr Magee gave evidence that she would be assisted by such a summary which would often contain a comprehensive psychiatric assessment. JHFMHN confirmed that Dr Magee was not provided with discharge summary in 2017 but that the Health Centre Release Planning Procedure (which took effect from February 2021) required those to be provided to a nominated general practitioner and the patient.

119. In response to questions from Counsel Assisting regarding mental health services in Deniliquin, Dr Magee gave evidence that "mental health, I think, is in crisis all over the state, all over the country. Understaffed, very difficult for them to see people in a timely fashion, even in crisis."

120. On 23 February 2017, Dr Magee received a telephone call from Ms Wesley. Dr Magee confirmed LS' diagnosis of depression/anxiety/borderline personality disorder. Dr Magee told Ms Wesley that LS' conditions were exacerbated by substance abuse and that "LS is not currently prescribed any medication because in her professional opinion it was not necessary". Ms Wesley raised specific concerns surrounding LS' alleged psychosis but Dr Magee indicated that this was not evident to her when she saw LS on 13 February 2017 and that LS did not appear to be using drugs.

The events of 1 to 2 March 2017

121. Having now considered the involvement of the various agencies with CS, DS, LS and SJ in the years, months and weeks preceding CS' death, I will now turn to examine the events immediately leading up to it. Given the multiple parties that interacted with

SJ and LS between 1 to 2 March 2017, I will deal with each in turn in chronological order.

Wednesday, 1 March 2017

8:45am – 11:30am – School drop-off and subsequent movements

122. SJ stated that in the few days leading up to CS' death, LS had been acting strange and "like unresponsive, she would be staring and could not sit still".

123. At around 8:45am, SJ and LS dropped the children off at school without issue. They then returned home with LS' friend, Robert Cooper before SJ conveyed LS and Mr Cooper to Centrelink and returned home. SJ was aware that LS had an appointment with Ms Wesley later that morning. LS and Mr Cooper took SJ's car to that appointment. SJ observed that LS' mood appeared to have changed following the appointment with Ms Wesley. LS was short in her responses to SJ and seemed upset.

11:30am - Appointment with Ms Wesley, Community Corrections

124. At around 11:30am, LS attended an appointment with Ms Wesley and reported that she did not feel comfortable at home, and that she wanted her own place and for CS and DS to live with her. Ms Wesley contacted Dr Magee and scheduled an appointment for LS for the next day at 3:00pm. Ms Wesley also contacted an administrative officer at Deniliquin Community MHDA and arranged an urgent appointment for LS, explaining that she had been "quite distraught". LS agreed to, upon leaving her appointment with Ms Wesley, attend that office directly.

11:47am - Ms Wesley contacts SJ

125. At 11:47am, Ms Wesley spoke with SJ who was "unsure" how LS was going and confirmed that she wanted LS to find separate accommodation. SJ also indicated to Ms Wesley that LS had been "a bit upset and aggressive at home, not badly though" that day. Following a question from SJ, Ms Wesley confirmed that Community Corrections perform random drug testing. Ms Wesley also recorded that SJ did not attribute LS' presentation to drug use and noted that if she was concerned for her safety or the children's safety, she could contact police. SJ also indicated that steps had been taken through the court in respect of custody arrangements.

11:40am to 1:45pm – LS' attendance at the Deniliquin Community MHDA office

126. At around 11:40am, following her appointment with Ms Wesley, LS attended the Deniliquin Community MHDA office and was assessed by Pieta Marks, an Adult Mental Health Clinician.

127. Given the short time period between Ms Wesley's call and LS' attendance at the office, Ms Marks had limited time to review LS' records and did not contact Dr Magee. During her evidence at the hearing, Ms Marks conceded that, with the benefit of hindsight,

she should have contacted Dr Magee. Ms Marks stated that LS presented to the office "very distressed, sobbing and crying". LS said that she did not want to return to SJ's home, that she and the children were not safe there and that she wanted to seek alternative accommodation. LS also said that she had been out of custody for around one month and that SJ had been caring for the children during her incarceration. LS also indicated that FACS were no longer involved with the children.

128. Ms Marks stated that LS raised other allegations in relation to SJ and said that LS stated that she did not want to return to SJ's home and threatened to set it on fire. Ms Marks gave evidence that she contacted Vinnies for the purpose of enquiring as to emergency accommodation and was informed by Vinnies that the children were under the care and legal guardianship of SJ. Following that call, Ms Marks told LS that the children were ineligible for emergency accommodation but that she was eligible. LS became distressed and said that she would not leave the children. She expressed an interest in relocating with CS and DS to Moama.

129. Ms Marks gave evidence at the hearing that she was confused by the conflicting information that LS and Vinnies had given her. She suggested that LS obtain advice about having the children returned to her care and the possibility of relocating under her existing parole conditions. When asked at the hearing whether she should have thought about the possibility of LS abducting the children, Ms Marks replied, "in hindsight, yes".

130. At some stage during the assessment, Ms Marks conducted a Mental Health Risk Assessment and Mental State Examination ("**MSE**"). She recorded that LS presented with nil symptoms of psychosis, nil evidence of formal thought disorder and did not appear to be under the influence of illicit substances. She further recorded that:

> "[LS] denied any perceptual disturbance and did vocalise that she had experienced 'voices' in the past whilst under the influence of the drug 'ice'. [LS] denied having any thoughts of suicide, self-harm or harm to others. [LS] was oriented to time, place and person. [LS] denied being on any scripted medication. When offered, [LS] declined the offer of presenting to Deniliquin ED saying she did not want any medication. [LS] stated she wished to attend FACS in person as she wished to give them information relating to [SJ] and [REDACTED] as well as the concerns she had around the safety of herself and her children."

131. Of particular note is Ms Marks' oral evidence that LS was glancing away during the assessment which she indicated could be a sign of auditory hallucinations. Ms Marks relevantly noted that LS' speech was at an elevated rate and tone, that her thought form was tangential and she appeared to be glancing away for seconds at a time in the session as if responding to something or someone. However, LS denied hearing any voices at that time but did admit to hearing voices when she was using ice. LS' insight and judgment were recorded as limited.

132. Ms Marks left the room and consulted senior colleagues, Nigel Smith (Acting Team Manager), and Ellen Cross (Mental Health ED Liaison Clinical Nurse Consultant). Ms Marks stated that she reported all of her observations of LS to Mr Smith and Ms Cross, including that LS appeared to be glancing away during the session. However, Ms Marks did not tell them that she considered that LS had limited insight and judgment or possibly suffered from a cognitive impairment. Based on the information she provided, Ms Marks received the following advice:

> "Ms Cross advised me that [LS] would need to seek a variation of her parole in order to relocate and made suggestions as to how [LS] may apply to do this. Mr Smith suggested I accompany [LS] to Deniliquin Emergency Department (ED) and also suggested [LS] make contact with FACS to seek information regarding the process for regaining care of her children and advice regarding her current access arrangements."

133. Ms Marks did not raise the potential scheduling of LS with Mr Smith or Ms Cross as LS' level of distress seemed to have decreased by the time they finished their discussions and Ms Marks had the least restrictive treatment options in mind. She was not sure whether LS would meet the criteria. In oral evidence, Ms Marks made a number of concessions including that:

    a. She did not discuss with the senior clinicians the risk to CS or DS if LS took them;
    b. She incorrectly recorded that there was nil evidence of a thought disorder given LS' presentation;
    c. When LS denied any thoughts of self-harm, suicide or harm to others, she should have assessed any risk of harm to the children;
    d. That she should have recorded in her notes the fact that LS had been de-escalated by the end of their session;
    e. There was a risk to the children which she should have raised with FACS or the police;
    f. She could have sought corroborative evidence from another source; and
    g. She could have contacted SJ.

134. Although she accepted the appropriateness of many of the matters identified above, Ms Marks indicated that she did not have time to action them as she had another appointment after LS. Ms Marks was under the impression that upon leaving Deniliquin Community MHDA, LS would travel directly to FACS. She further conceded that, with the benefit of hindsight, she could have communicated with FACS to notify them of LS' expected attendance at their office.

135. Ms Marks confirmed LS' intention to keep her appointment with Dr Magee on 2 March 2017, and also her appointment with the Drug and Alcohol Clinician from Deniliquin Community MHDA on 7 March 2017. Ms Marks provided LS with an AccessLine card

and told her to contact that number if she ever felt at risk of suicide, self-harm or harm to others. In terms of emergency accommodation, Ms Marks placed the Vinnies number at the back of the AccessLine card in case LS changed her mind.

136. LS left, stating that she would immediately go to the local FACS office. Ms Marks gave evidence that LS was no longer crying or sobbing by this time and appeared "determined to leave and go to FACS". At around 1:45pm, Ms Marks observed LS walk in the direction of the FACS office.

137. When asked how she dealt with the risk of LS taking her kids from SJ, who at the time she understood to have legal guardianship, Ms Marks said that she could not have guessed that she would take the kids from SJ. She accepted, with the benefit of hindsight, that she should have raised with FACS or escalated to police the information LS had given her which suggested that she might take off with CS and DS.

138. In her supplementary statement, Ms Marks indicated that she reviewed electronic records in relation to LS and is now accredited to schedule persons under the *Mental Health Act 2007* (NSW) ("**the MH Act**"). Upon reflecting on her consultation with LS, Ms Marks stated that "it remains my view that I did not have and there were no grounds for me to ask one of my colleagues to schedule her under the *Mental Health Act*".

139. Ms Marks stated that notwithstanding her belief that the children were not at risk of harm from LS (given she had expressed concerns for their welfare and her intention to seek assistance from FACS) she should have completed the Mandatory Report Guide ("**MRG**") on 1 March 2017 and acted upon that result. Completion of the MRG may have led to a FACS report due to LS' comments regarding her home environment. Ms Marks states that, had she conducted the MRG, the results would have directed her to consult with a "professional/service and continue to monitor closely".

140. The evidence establishes that LS did not attend FACS on 1 March 2017 and her whereabouts between leaving Deniliquin Community MHDA and a shoplifting incident which occurred later that day (see [154]) is unknown.

11:40am to 1:45pm - Ms Cross – Clinical Nurse Consultant Mental Health ED Liaison, MLHD

141. Ms Cross also provided statements and gave oral evidence at the hearing. She is a District Clinical Leader within the MLHD and is an experienced registered psychiatric nurse. At the time LS presented to the Deniliquin Community MHDA, in March 2017, Ms Cross was a Clinical Nurse Consultant, Mental Health ED Liaison and accredited to conduct assessments under the *MH Act.*

142. Ms Cross recalled her discussion with Ms Marks and Mr Smith on 1 March 2017 in relation to LS' assessment by Ms Marks. Ms Cross thought that LS was not the legal guardian of CS and DS and had been appraised of Ms Marks' conversation with Vinnies

regarding alternative accommodation. However, it only occurred to Ms Cross in retrospect that LS' proposal to take the children away from who she thought was their legal guardian was concerning. Ms Cross would have looked at the MRG and followed that decision tree had this concern occurred to her at the time.

143. In her oral evidence, Ms Cross agreed that, with the benefit of hindsight, LS' presentation could have raised concerns regarding the stability of LS' mental health. Ms Marks noted that although there were mood fluctuations, LS had settled down and it could not be assumed that LS was suffering from auditory hallucinations by virtue of her glancing away. Counsel Assisting took Ms Cross to the expert evidence of Dr Kerri Eagle as to the possibility that LS was psychotic. Ms Cross gave evidence that from the information provided to her, she did not believe that LS was psychotic but rather upset by her living arrangements. Ms Cross did not consider that LS should have been scheduled.

144. Further, Ms Cross accepted that the plan for LS to see Dr Magee the next day and to see a drug and alcohol clinician on 7 March 2017 did not address the risk to the children. Ms Cross indicated that this was a risk that was not considered.

145. Reflecting on the events of that day, Ms Cross stated that in retrospect, she and Ms Marks should have contacted FACS to see if LS arrived. Additionally, as children were involved, best practice would have been to use the "decision tree" to see if a report to FACS was recommended. Ms Cross could not recall any discussion about making a FACS report.

11:40am to 1:45pm - Evidence of Mr Smith, A/Team Manager, Deniliquin Community MHDA

146. On 2 March 2017, Mr Smith was the A/Team Manager for the Deniliquin Community MHDA. He was called into Ms Cross' discussion with Ms Marks which he recalls was focused on LS' parole conditions. Mr Smith also recalled that Ms Marks had stated that LS wished to take the boys. Although he had little understanding of the children's custody arrangements at that time, nor any prior contact with LS, Mr Smith was generally aware that SJ had custody of the children and that LS was proposing to take them away.

147. Mr Smith advised Ms Marks to support LS by contacting FACS or accompanying her to hospital. He gave evidence that this would not be something which would normally be offered to every person but in certain circumstances it would be appropriate, including where someone presents as distressed and there was knowledge of potential substance use and comorbidities. Mr Smith also gave evidence that "scheduling should always be a thought that crosses your mind in every presentation including LS". There could have been a discussion regarding the scheduling criteria and that question should have been asked.

148. Mr Smith accepted that LS' de-escalation should have been recorded in the clinical notes and that his discussions with Ms Marks would have moved towards the *MH Act* had LS left without de-escalating. He also noted the possibility of asking police to conduct a welfare check on LS had that not occurred. In relation to notifying FACS of LS' presentation, Mr Smith made a concession that there should had been a discussion around the use of the mandatory guide or possible contact with the child wellbeing unit.

149. As to the failure to notify FACS of the interaction with LS, Mr Smith conceded that "there should've been a discussion around the use of mandatory reporter guide, maybe a contact with the child wellbeing unit." Mr Smith accepted that there was no legal impediment to him contacting the Police or FACS to notify them of the interaction.

150. Mr Smith gave candid evidence regarding the conduct of staff members at the Deniliquin Community MHDA since CS' death, noting that they:

> "...talk openly about this particular incident and there's staff that have been on-boarded since 2017 that are aware of this incident and the reason why we are doing the extra things that we need to do and why we ask the mandatory report guide is done routinely while we're engaging with every stakeholder that we can to get collaborative information but also how we can support each other in that, there isn't decisions that are made just with a couple of people involved, that we're wanting the whole team to be aware of difficulty presentations and the joint decisions being made. There's a real desire that there is improvements that come from this event and a hope from myself especially that there's improved communication between the stakeholders when people are involved and for periods of time with other stakeholders and that they're provided care and have information that that should be shared too as part of that - the continuous care of that person. So I guess in this circumstance we're talking about someone that was incarcerated and provided care whilst she was incarcerated and information around that care that was provided while she was incarcerated was not provided as part of her transfer back into community and in fact I didn't see a lot of those documents until now and I think that's a real shame for everyone involved and for everyone in the future if that remains the case."

151. I acknowledge Mr Smith's evidence that accessing JHFMHN records would have been of assistance and that the process for requesting such records is onerous and slow. He noted that Deniliquin Community MHDA would not always request JHFMHN records. Mr Smith could not recall a specific policy applicable to information sharing with police but noted that it occurs on a case by case basis. As regards collaborative information, Mr Smith agreed that it would be helpful for a policy to list potential sources of information that a clinician could consider.

152. Mr Smith considered that a round table discussion between stakeholders regarding information gaps and some sort of inter-agency agreement for information sharing would be "great".

1.28pm – Contact between Ms Wesley and Ms Cross

153. At around 1:28pm, Ms Wesley telephoned Ms Cross and was informed that LS initially presented as upset and crying but was settled following her assessment with Ms Marks. Ms Cross also told Ms Wesley that LS was on her way to the local FACS office. Ms Wesley recalls being told that LS was advised to attend the hospital and ask for medication but had refused to do this.

1:30 to 2:25pm - Shoplifting at Concept Technology and Wired Entertainment, Deniliquin

154. At around 1:30pm and subsequently at 2:25pm, LS and Mr Cooper visited two technology stores in Deniliquin and stole an Asus tablet and power pack. Probationary Constable James Siggee and Senior Constable Rachel Claydon ("**SC Claydon**") responded to the reported thefts and CCTV footage was provided to them.

155. At 6:03pm, after reviewing the CCTV footage Senior Constable Claydon entered a corresponding event into the COPS database, identifying LS and Mr Cooper as persons of interest. Senior Constable Claydon further noted that police had been informed Mr Cooper was residing with LS.

156. In oral evidence, Senior Constable Claydon indicated that she was unaware LS was on parole on 1 March 2017 and could not recall the stealing incident at one of the technology stores.

157. At 2:29pm, Probationary Constable Siggee made a subsequent COPS entry which identified LS and Mr Cooper as persons of interest in both stealing incidents. Probationary Constable Siggee gave evidence that he recalled being informed by someone that LS was one of the persons of interest.

3.10pm - LS collects the children from school

158. At approximately 3:10pm, LS collected CS and DS from school. Their school principal, Ms Bernadette Murphy, observed that the children appeared happy to see LS and willingly followed her to the car.

159. Upon arriving home, CS and DS changed out of their uniforms and put on swimmers. LS indicated to SJ that they were going for a swim and when asked when they would return replied, "I don't know mum we will just be back whenever".

160. At around 4:30pm, LS, CS and DS left the home in SJ's white Holden Cruze.

SJ's subsequent contact with LS and the children

161. SJ stated that she made unsuccessful attempts to contact LS from around 7.30pm on 1 March 2017. The calls went straight to messagebank. Although the Call Charge records indicate that that SJ made a call to LS' phone at 7:52pm that lasted for a period of 307 seconds, I am not satisfied that SJ in fact spoke to LS at this time.

<u>5:20pm – Attendance at Elmore IGA Supermarket</u>

162. At around 5:20pm, LS attended the IGA Supermarket in Elmore in the company of Mr Cooper. An employee of IGA, Ella Spizzica, observed LS walk past the register and into a white Holden Cruze with her hands full of chocolate bars. Neither LS nor Mr Cooper had paid for the chocolates and Ms Spizzica took down the number plate of the vehicle.

<u>6:00pm to 7:00pm - Bendigo Caravan Park</u>

163. At some time around 6:00pm to 7:00pm, LS and the children arrived at Central City Caravan Park in Bendigo. The children went for a swim later that night and witnesses observed that LS appeared "heavily sedated", "like there was no one home", or "really stoned". LS, the children, Mr Cooper, Mr Cooper's sister and Maarten Verhey stayed at the caravan park overnight.

Thursday, 2 March 2017

<u>3:00am – SJ's first report to the NSWPF Constables Bryce and Burnell</u>

164. SJ gave evidence that she became increasingly worried and anxious when LS did not return home with the children. At approximately 3:00am, she flagged down a police patrol car that was driving past her home. In her statement, SJ recalls those events as follows:

> "About 2.00am on Thursday the 3 March 2017, I was still awake because I was worried, I saw a police car drive past my house so I stopped them, it was two male officers. I reported to them that I wanted to report my daughter and grandsons were missing. They took my details and gave me a card. I went back inside and went to bed but I didn't sleep well at all."

165. As noted above, SJ provided a subsequent statement in which she indicated that she was waiting for patrolling police to pass her home and when they did she proceeded onto the middle of the road and said "my daughter has taken the boys". Constables Tyler Bryce and Nicholas Burnell were in the patrol vehicle at the time. SJ states that they asked for the children's details including their age and what they were wearing. SJ also disclosed that LS had recently been released from custody and that the boys were missing. SJ states that the officers said they would report the details and get back to her.

166. Both Constables Bryce and Burnell gave evidence at the inquest. Constable Burnell accepted that as the more senior officer between the two, he occupied a leadership position in respect of any police work they engaged in that evening. Notwithstanding Constable Burnell's evidence, I note that both officers were junior and relatively inexperienced.

167. In his statement, Constable Bryce reported that when he asked SJ why she was worried that the children were with LS, she stated that she was concerned they would miss school in the morning. Constable Bryce states that he conducted a Mobipol device search and saw information and intelligence relating to LS. SJ did not know where LS could be staying with the children but said that LS had driven her vehicle. Constable Bryce further states that he asked whether LS had any mental health issues, to which SJ replied, "No nothing like that" and indicated that she was not sure if LS was on drugs but could be on ice again. SJ also told Constable Bryce that she was in the process of obtaining Family Court orders and that she cared for the children whilst LS was in jail. In his oral evidence, Constable Bryce expressed that he had no concerns for the children as SJ's sole worry was that they would miss school.

168. Counsel Assisting submitted that in reaching this conclusion and conducting a risk assessment, it is not clear that Constable Bryce had any detailed consideration of the relevant factors present. For example, Constable Bryce gave evidence that the fact that LS may have been using ice when she left with the children was not something that to him appeared relevant to her potential risk to the children. Further, Constable Bryce could not explain why he did not reference LS' potential ice use in his email to former Leading Senior Constable Holloway ("**Mr Holloway**"). I accept Counsel Assisting's submission that the risk assessment conducted by Constable Bryce at this time was informal, unstructured and lacked any rigour.

169. In his statement, Constable Burnell indicated that SJ waved down their patrol car and said, "I want to report my two grandchildren are missing". He states that SJ also told officers:

    a. LS had picked up the grandchildren from school;
    b. They had not returned home;
    c. She had called all night but there was no response;
    d. LS was living with her and only recently released from custody;
    e. LS had arrived at her residence unexpectedly;
    f. She was in the process of obtaining custody of the children but there were no formal court orders in place;
    g. She did not know what LS' parole conditions were;
    h. There was talk of going to Pericoota but she did not know where LS might be; and
    i. LS did not have a mental illness but she thought LS may be using ice again.

170. Constable Burnell thought that LS might be suffering from a mental illness due to the erratic and unusual behaviour described in a 'child at risk' incident report he saw on the COPS system from a few weeks earlier. Constable Burnell also noted an address in Echuca from the COPS records. As regards SJ's statement that she thought LS was using ice again, he recalls the following conversation:

> Constable Burnell: "What about drugs? Does she have any drug abuse issues?"
> SJ: "She did have problems with ice which was part of the reason she was in gaol."
> Constable Burnell: "Is she using again?"
> SJ: "I'm not sure"
> Constable Burnell: "Do you suspect she is using again?"
> SJ: "Yeah, I think so."

171. Constable Burnell also recalls asking: 'What concerns do you have regarding the children?" and states that after some delay, SJ responded with "I'm not too sure". Constable Burnell then asked, "Is it because she may be getting back into drugs?", to which SJ replied "Well yeh, I just don't know".

172. In his supplementary statement, Constable Burnell indicated that based on the information SJ supplied he did not hold any concerns that CS and DS were in imminent danger. Rather, he described the main concern as the fact their current whereabouts were unknown and they were unable to be contacted. Constable Burnell gave evidence that with the benefit of hindsight he should have reached the view that there were concerns for safety. However, based on the information presented to him he did not see that risk. He also repeatedly maintained that he did not hold concerns for CS or DS' welfare in the early hours of 2 March 2017.

173. I accept that many aspects of policing involve a judgment call and that reasonable minds may differ in different circumstances. However, in the context of SJ approaching a police car at 3:00am, the information that Constables Bryce and Burnell received from SJ regarding her concerns that the children may not be back in time for school may not have raised immediately safety or welfare concerns, however, that information should not have been taken at face value. Instead, an objective assessment of all the risk factors should have occurred, which would have led the officers to assess the risk posed to the children as higher than simply a concern for the children's whereabouts.

174. In undertaking a risk assessment as regards the safety of the children, Constables Bryce and Burnell could and should have done more to investigate SJ's concerns. The vulnerability of the children was a reason to err on the side of caution in undertaking a risk assessment as to concerns for their welfare or safety.

175. At 3.33am, Constable Bryce created a COPS event and identified that there were no concerns for the children and no court orders in place currently. However, Constable

Bryce did not record LS' possible ice use or that SJ was seeking custody orders through the Family Court.

176. At 3.39am, Constable Bryce sent an email to Mr Holloway who was the incoming supervisor for the day shift. In that email, Constable Bryce indicated that SJ flagged officers down with concerns that LS, CS and DS had not returned home. He provided details of SJ's vehicle and some addresses based on LS' associates. The following was also included in the email:

> "Grandmother does not have any grave concerns just unusual. Can you please task one of the car crews to follow it up and once located contact [SJ] with the result? If not more than happy to call her at 6pm. I've done a quick event E27833994."

177. Constable Burnell gave evidence that he instructed Constable Bryce to send an email to the incoming supervisor to ensure they were made aware of the incident and could "follow it up". Constable Burnell agreed that the follow up was necessary to take steps to locate CS and DS but did not accept that there were concerns for the children's welfare at that time. He described the follow up as an opportunity for Mr Holloway to:

> "…read the report we made that night and to speak with SJ again to see if the circumstances had changed between those few hours and to see where they were at and if they had any more information for us".

178. At the hearing, Constable Burnell was taken to a COPS audit report and asked about Mobipol searches that were conducted in the early hours of 2 March 2017. He gave evidence that he and Constable Bryce conducted searches using his Mobipol profile on 2 March 2017. Constable Burnell could not identify the particular searches that he made or those made by Constable Bryce.

179. Constable Burnell did however recall accessing the COPS event relating to the Scotts Park incident involving LS and the children on 4 February 2017 (see above at [64]). Constable Burnell gave evidence that, after informing himself of that event, he was aware that a child at risk report had been completed and held a concern that LS could have an underlying condition. Constable Burnell could not recall any reference in the COPS event narrative to concerns for the children based on their exposure to LS' behaviour.

180. Notwithstanding the evidence outlined above, Constable Burnell did not accept that the report suggested that CS and DS may be at risk of significant harm when with their mother. Rather, he gave evidence that:

> "That report was about roughly a month prior to 2 March. I did read it and there was nothing, it wasn't clarified that she was suffering any sort of illness. It was, as I think the report said erratic behaviour. That along with our conversation with SJ, along with all the information that we'd been provided

and the questions that we asked and the response we were given led me to believe that there were no immediate concerns."

181. Constable Burnell did not make any inquiries or direct any inquiries to be made as to LS' mental state. He stated that he relied on the information provided by SJ concerning LS' mental health which "led [him] to believe there were no concerns." He relied upon the fact that LS "was their mother and there were no court orders in place to suggest that she cannot be", and assumed the children were safe because there were no custody orders in place. Although he was aware that SJ was seeking custody, Constable Burnell could not recall if he asked her why. He accepted in his evidence that he should have sought to find out why she was seeking custody.

182. In submissions provided on behalf of the NSWPF, much was made of the fact that while SJ was seeking custody, there being no court orders in place at the time, there was nothing to prevent LS from taking the children from SJ's home. While I acknowledge that on its face, this is true, the fact that SJ was actively seeking custody should have suggested a need for further inquiries by Constable Burnell, or at the very least formed part of the matrix of his risk assessment as to the risk of harm with respect to the children.

183. Although Constable Burnell was aware that LS may be using ice, his evidence was that that did not give rise to concerns on his part for the welfare of CS and DS given he had no information to "definitively know that she was using ice or drugs". From his evidence, it appears that Constable Burnell's risk assessment was based on his and Constable Bryce's conversation with SJ as well as the Scotts Park COPS event.

184. As to the adequacy of his inquiries regarding whether the children were at risk, Constable Burnell gave evidence that:

> "I did more than just the one event. There was warnings also on the profile which would have shown that she was on parole and that also would have shown what her latest charge was, which was in relation to a break and enter which is why she was on parole".

185. He conceded that he could have made more inquiries but thought what he did was sufficient to form a clear view as to the risks to CS and DS. Constable Burnell did not accept that SJ's act of flagging down the patrol car was conduct indicative of someone who had anxiety or concerns. He did acknowledge that he did not know her or whether she would be prone to exaggerating or minimising her concerns. He recalled asking SJ what her concerns were and "could see her mind was ticking over for a response and then she just said, 'I'm not too sure'". He indicated that SJ's inability to successfully contact LS did not give rise to a concern on his part for welfare of the children but did raise a concern as to "whereabouts".

186. Constable Burnell made no independent inquiries and did not direct inquiries to be made regarding LS' parole conditions. He accepted that in following up the incident,

LS' parole conditions would be something that police would be able to access. He also accepted that, as the more senior officer, he should have checked the COPS event prepared by Constable Bryce and that a notation as to LS' possible drug use and recent release from custody should have been included.

187. Although he acknowledged that SJ did not know where the children were, Constable Burnell only engaged in an "informal process" of assessing whether they fell within the meaning of a "missing person" under the Missing Person Standard Operating Procedures ("**MP SOPs**"). Although he did not consult the MP SOPs on the morning of 2 March 2017, Constable Burnell gave evidence that he took into account the fact that the whereabouts of the children were unknown but did not consider the situation to be potentially "high risk" because the children were "with their mother so they were not alone".

188. As for his risk assessment, Constable Burnell gave evidence that he assumed the children were safe because LS had retained legal custody. In forming that view, he had regard to the February 2017 ROSH report which he said was not conclusive as there was no definite evidence of LS' mental health issues. He considered it was all speculative but accepted that he should have tried to find out why SJ was seeking custody. In relation to LS' potential drug use, Constable Burnell gave evidence that he had no definitive information about that.

189. When questioned by Counsel Assisting, Constable Burnell did not accept that the following factors represented a potential risk to or raised a concern for welfare in respect of the children:

   a. That SJ flagged down the passing police vehicle at 3:00am;
   b. That the children had been removed from their ordinary place of residence;
   c. That SJ made several attempts to contact LS but had not received a response;
   d. That SJ was in the process of seeking custody, possibly because she was concerned about the welfare of the children when in LS' custody;
   e. That SJ provided information that LS may have been using ice again; and
   f. That there was a ROSH report four weeks earlier.

190. Constable Burnell conceded that, with the benefit of hindsight, he "probably would have called a supervisor nearby just to run them through the situation and get their thoughts on the matter as well."

191. Constable Bryce gave evidence that the above outlined interaction with SJ on 2 March 2017 did not constitute a concern for welfare incident. This was so despite the fact that he recorded the occurrence as a "concern for welfare" in his police notebook. Constable Bryce later accepted that the SJ's act of flagging them down indicated that she was anxious and concerned but he did not factor this in when considering the potential risk to CS and DS. He did not discuss with SJ whether she had consented to taking the children overnight and maintained that his concerns for the children were "for them missing school" and not their welfare.

192. Constable Bryce accepted that he had an independent obligation to conduct a risk assessment considering all possible risk factors. In doing so, he took into account:

> "… missing of school and then asking of the Family Court orders. I think actually Constable Burnell asked that and then I recall that it was just unusual that they're going to miss school and that wasn't known to SJ."

193. Constable Bryce further accepted that his knowledge of LS' possible drug use was a "factor to consider" and "of course is a risk". He did not record this in his police notebook because it was "fresh in his mind". He also did not include it in his email to Mr Holloway because he did not consider it to be factor of concern and did not see why a "sentence including the use of ice would assist in anything further here." Counsel Assisting asked Constable Bryce how else Mr Holloway could have become aware of LS' possible drug use to which he replied, "recorded information on COPS perhaps".

194. Constable Bryce did not accept that the following five factors suggested a potential risk to the children:

    a. That the children had been removed from their ordinary place of residence;
    b. That the children's removal from their ordinary place of residence was unexpected;
    c. That the children's removal from their ordinary place of residence was an unusual occurrence;
    d. That it was not possible to get in touch with the mother of the children on her mobile; and
    e. That a grandmother flagged down a passing police car at 3:00am.

195. In contrast, Constable Bryce was of the view that the children were with a biological parent and that alternative explanations were available for SJ not knowing their whereabouts, such as LS planning a trip away without SJ knowing or potential conflict between SJ and LS.

196. Constable Bryce did not accept that knowledge of the ADVO for the protection of SJ would be relevant in assessing LS' potential risk to the children, even if CS and DS were exposed to indirect violence. Further, he did not accept that knowledge of the 8 January 2016 incident (see above at [38]) would have made him appreciate that there was a real risk of harm to the children. With the benefit of hindsight, Constable Bryce would have liked to have checked the January 2016 COPS events using his Mobipol device.

197. Like Constable Burnell, Constable Bryce was taken in oral evidence to certain COPS entries which he either checked in the patrol vehicle or reviewed upon returning to Deniliquin Police Station. The COPS audit suggests that Constable Bryce accessed the Scotts Park entry on 2 March 2017 but he could not recall reading it at that time.

Constable Bryce accepted that the following factors showed a level of risk to the children and concerns about LS' mental health or drug use:

a. The Scotts Park incident;
b. Information that the children were unexpectedly removed from their usual place of residence; and
c. SJ's belief that LS may have been taking ice.

198. Constable Bryce did not think that SJ seeking court orders for the care of CS and DS was relevant at all to potential risk because "we didn't discuss the grounds of why she was going down those Family Law Court orders". Constable Bryce accepted that he could have conducted further inquiries to obtain additional information about the potential risk of harm to CS and DS. He accepted that without knowing the basis for SJ seeking court orders he could not form a view that this was not a relevant risk factor. But he maintained that this was not a relevant factor, irrespective of the fact that the primary factor he relied upon against a conclusion that there was risk to the children was that they were with their mother.

199. Counsel Assisting asked Constable Bryce about what would have happened if Mr Holloway did not attend his shift and see Constable Bryce's email. Constable Bryce accepted that if Mr Holloway had not attended his shift, the email request for a car crew to "follow up" would not have been seen by anybody else. Despite this, Constable Bryce did not accept that with the benefit of hindsight, it would have been preferable to include those taskings in the COPS system rather than an email.

200. Counsel Assisting also questioned Constable Bryce as to the possibility that by reason of SJ's anxiety she may have found it difficult to articulate all of her concerns. He accepted that it was necessary to form his own view as to any risks to CS and DS that evening. In doing so, he did not give weight to the fact SJ flagged down police in the middle of the night. He also could not recall one way or another whether SJ stated that she wanted to report LS, CS and DS missing.

201. Counsel Assisting put to Constable Bryce, in the context of his email to Mr Holloway, that he was well aware that there were concerns for welfare. Constable Bryce replied that the allocation of resources was directed not to concerns for the welfare of the children, "but concerns for them missing school" so that police could "also inform SJ". He maintained that allocating police resources to make sure CS and DS had attended school was "the only way in Deniliquin… I think that's reasonable".

202. Constable Bryce gave evidence that he did not consider that the children fell within the definition of "missing persons" under the MP SOPs because there were no "fear for the safety or concerns for welfare". To that end, he did not accept that the following factors amounted to at the very least concerns for the welfare of CS and DS:

> "… taken from their usual place of residence, unexpectedly, that was an unusual occurrence. They could not be contacted. The mother was reported to you as someone who may be using ice and you'd seen a report from February

2017 that you've identified showed erratic behaviour and concerns about mental health".

203. I accept the submission of Counsel Assisting that the approach of each of Constables Bryce and Burnell during their evidence displayed an unduly narrow approach to risk assessment given the age of the children and the matters set out above.

7:00am – Commencement of Mr Holloway's shift

204. At 7:00am, Mr Holloway commenced his shift as the Deniliquin Local Area Supervisor and read the email from Constable Bryce. At 8:00am, Constables Abby Crumpler, Ben McGarry and Robert Sheldrick and Melanie Threlfall commenced their shift. Mr Holloway provided them with a printed copy of Constable Bryce's email, and "informed them that [LS] had her two children and to keep a look out for them when they were patrolling".

205. Mr Holloway gave evidence that he could "only go off of what was in the email" and there was "no mention of risk" in the email itself. He accepted that the email did not identify an assessment of factors which might bear upon risk. Mr Holloway's evidence concerning the police response to Constable Bryce's email is considered in further detailed below at [221].

10:50am to 11.21am - LS, CS and DS take a taxi from Bendigo Station to Goornong

206. At approximately 10:50am, LS and the children attended a taxi at Bendigo Railway Station. LS requested to be driven to an address on Pine Grove in Goornong, Victoria, being her aunt's address. Upon arrival, the cab driver described LS as seeming "rattled like she didn't know what to do". LS was then conveyed to the Goornong General Store, arriving at 11:21am.

11:15am - SJ's first attendance at Deniliquin CSC

207. At approximately 11:15am, SJ attended the Deniliquin CSC office and spoke to Ms Clarke. SJ was crying and said that she was concerned as LS had left Deniliquin with the children the previous day and she had not heard from them. Ms Clarke saw on her system that Mr Pearson had previously dealt with SJ's family and sought his assistance.

208. Mr Pearson observed that SJ was "very concerned" as she did not know the whereabouts of CS and DS. He offered to assist her with placing a call to the Helpline. SJ declined and indicated that she would prefer to call herself at home.

209. During his oral evidence, Mr Pearson accepted that he should have taken more time to identify SJ's concerns, including to look back through the FACS file to identify any information of concern. He also accepted that he should have contacted the police.

SJ's call to the Helpline – (timing unclear)

210. After leaving Deniliquin CSC, it seems SJ made a report to the Helpline. It was screened in as ROSH with a risk of neglect with parental risk factors of substance abuse and mental health issues. A response priority of less than 72 hours was recommended and the primary issue was recorded as "drug abuse by the primary carer". SJ indicated that there were no court orders in place granting her custody of the children but she was in the process of seeking those orders. The report recorded the following:

> "*[LS] has taken the children from the care of their grandmother.; There is a history of serious drug use by [LS] and also domestic violence.; This and the previous report indicate that [LS] may be using Ice again and that her mental health is deteriorating.; J & D dated 3/2/16 stated that the children were safe in the care of their grandmother but not safe in the sole care of their mother."

11:30am - LS calls from Goornong General Store

211. At approximately 11:30am, LS used the phone of Philip Nicholas, the owner of the Goornong General Store. LS was walking around the shop and speaking on the phone for approximately 2 minutes. Call charge records show that at around 11:31am there was a 116 second call from Mr Nicholas' to a number registered to LS which it appears must have been left in Deniliquin on 1-2 March 2017. LS then purchased some phone credit.

212. SJ's evidence is that LS called her from an unfamiliar phone number at around 11:30am on 2 March 2017. It seems that during this call, or possibly during a subsequent call at 11:54am, LS asked SJ to collect her and the kids. LS indicated that they were at a milk bar in Goornong, having arrived by taxi and that she had left SJ's car in Bendigo but "didn't know where it was".

213. At around 3:47pm, SJ telephoned Mr Nicholas and he told her what had happened earlier in the day. Mr Nicholas states that he told SJ that LS had been heading back in the direction of Bendigo. SJ's evidence as to when this call occurred in inconsistent. In her statement she suggested that she called Mr Nicholas back after the call from LS from the Goornong Store and before she went to the police. However, in oral evidence she said that she thought it was later in the day, towards the evening.

11:54am - LS' first call with SJ

214. From approximately 11:46am, LS attempted to contact SJ. A 33 second call from LS to SJ's phone is recorded at around 11:53 am, and at around 11:54am, there appears to have been an almost 12 minute call from SJ's phone to LS' phone. This is consistent with Mr Nicholas' recollection that LS was on her own phone making a number of calls.

215. SJ's initial account on 2 March 2017 was that she received one phone call. However, in her subsequent statement she identified that there was one phone call before she went to the police at around midday, and another after that. In her oral evidence, SJ could only recall one call.

12:00pm - SJ's second report to NSWPF

216. At around midday, SJ attended Deniliquin Police Station after making contact with LS and spoke with Mr Holloway.

217. Mr Holloway states that SJ told him LS and the children were just out of Bendigo and that she was going to go get them. He recalls that SJ told him she was in the process of obtaining formal custody orders and thought the children were alright as she could hear them laughing. Mr Holloway stated that he told SJ that she would have to contact Bendigo Police if she had any issues as it was in Victoria. He also made a COPS entry at 3:30pm which recorded that SJ was told as there were no formal court orders or custody arrangements, police could not assist SJ in retrieving the children unless there was an imminent risk to their safety. It further recorded that SJ did not believe there were any risks but still had some concerns so was going to travel there to bring them back.

218. Probationary Constable Siggee was working at Deniliquin Police Station when SJ attended and witnessed some of the conversation between Mr Holloway and SJ. He gave evidence that SJ was in the station for five minutes at the most and that he could not remember whether he searched COPS to learn more about SJ's inquiry after she had left the station. He recalled SJ providing an update about missing children, but said he did not ask for the names of the woman or the children. Probationary Constable Siggee accepted that with the benefit of hindsight, he should have done so. Probationary Constable Siggee also gave evidence that SJ said she was going to collect the children from Bendigo, but he could not remember why. He could only recall that it seemed to him that SJ was more concerned for LS than she was for the children.

219. Despite his involvement with the previous shop-lifting incidents (see [154] above), Probationary Constable Siggee did not raise with Mr Holloway, the possibility of LS' connection with these matters and the missing children because, at that stage, he was not aware that LS was the person involved in the stealing incidents.

220. SJ stated that she went to the police and asked them to call Bendigo Police but was told by the Sergeant that she would have to ring Bendigo Police directly and "it was nothing to do with them". SJ indicated that she was very anxious and kept repeating that LS had taken the kids and "was not in a good way". SJ stated that she was so upset that she went straight to Deniliquin CSC after her conversation with Mr Holloway. SJ's account of her state of mind at around that time is consistent with observations of her by others that morning as being upset and concerned, and with her actions in going straight from the police station to FACS after she spoke with Mr Holloway.

221. Mr Holloway gave evidence of his thought processes upon being told that LS had taken the children. He assumed there was no real risk to the children because he knew LS, knew that this sort of incident had occurred at least once before and that on those occasions the children had been alright. Mr Holloway conceded that he should have

interrogated the COPS system or conducted further inquiries on 2 March 2017 to ascertain the possible risk that LS presented to the children that morning. Mr Holloway acted on his prior knowledge, but he accepted with the benefit of hindsight that he should have conducted a more careful search of COPS to form his own view as to risk. Mr Holloway also accepted that:

a. He never turned his mind to whether or not CS and DS may have been missing persons as defined in the MP SOPs. He attributed this to the fact that SJ had made contact with LS and was aware of her and the children's whereabouts and that as such he did not consider them to be missing;
b. At the time of making the COPS entry, he did not know whether anyone had found the children. He did not know where the children had gone after the phone call between SJ and LS, but said that he believed that SJ did;
c. He was the first senior NSWPF officer to consider Constable Bryce's email but did not consider it incumbent upon him to carefully consider and assess any risk to the children. That was because there were "no concerns that were given in the email";
d. SJ's actions in flagging down a police vehicle at 3:00am and identifying that LS and the children had not returned home suggested some concern about CS and DS' whereabouts. In light of those matters, as a senior NSWPF officer he should have conducted a risk assessment;
e. Given Constable Bryce's email referenced a possible address in Echuca, he could have contacted Victoria Police and asked them to attend that address or take steps to locate CS and DS. However, he did not accept that he "should" have done so because "at the time I had done a risk assessment in my mind and had asked the other car crews to do what I asked them to do";
f. The fact that SJ was the primary carer of CS and DS represented an additional factor in favour of conducting a careful risk assessment on 2 March 2017;
g. Had he been aware of the January 2016 incident involving LS and outlined at [38], that could have suggested a significant risk that LS may behave erratically if using illicit drugs; and
h. Knowledge or awareness of the details of the January 2016 ADVO incident (including SJ's documented fears) would have suggested that there was a real concern for CS and DS in March 2017.

222. As regards Constable Bryce's request for a follow up, Mr Holloway understood that to be based on the fact that SJ "flagged them down and was concerned that [the children] hadn't returned and … couldn't get in contact with her by phone so – and one of the children was sighted". Mr Holloway took it to mean that Constable Bryce wanted the children to at least be sighted so SJ could be informed. Before he tasked a crew and assigned a priority to the job, Mr Holloway performed a risk assessment in his mind based wholly on historic information that he had personally. He accepted that he could have accessed up to date information in the COPS system but did not take this approach to be flawed.

223. When conducting his risk assessment, Mr Holloway was aware of the following matters concerning LS:

a. LS had been charged with offences in the past;
b. LS stayed in Echuca, Victoria for lengthy periods of time;
c. LS probably took the children to Victoria on 2 March 2017;
d. LS was believed to be involved in the illicit drug scene in August 2015 and may have been taking illicit drugs;
e. LS was "known for drug use";
f. LS' children lived with and were primarily cared for by SJ; and
g. LS was involved in a prior incident at Scotts Park.

224. Mr Holloway accepted that, even based on the historical information he had regarding LS on the morning of 2 March 2017, he should have turned his mind to the real possibility that LS may have been abusing drugs. Mr Holloway denied being asked by SJ to contact Bendigo Police and telling her that Deniliquin Police could no longer be involved because the children were interstate. Rather, his evidence is that he told SJ to contact Bendigo Police if "there [were] any issues" but did not provide her with a contact number. Mr Holloway described SJ's appearance at Deniliquin Police Station as "okay to me". PC Siggee also gave evidence that SJ presented as "relatively calm, I guess, a little frantic but still fairly calm".

225. Mr Holloway did not consider that there was anything he could do to help SJ as the children were in Victoria and he considered that there was no imminent risk to their safety. With the benefit of hindsight, Mr Holloway accepted that "there's a lot more" he could have done including carrying out a careful risk assessment, contacting Victoria Police, contacting FACS for relevant information, contacting mental health services for relevant information and contacting Community Corrections regarding parole conditions.

226. I find that Mr Holloway's approach to assessing risk should have included an interrogation of the COPS records for more up to date information. His approach was inadequate in the circumstances.

12:30pm - SJ's second attendance at Deniliquin CSC

227. At 12:30pm, SJ returned to the Deniliquin CSC which is a short walk away from the Police Station. SJ told Ms Clarke that police told her there was nothing they could do at that time and that she needed to attend the community service centre. Ms Clarke states that SJ took a phone call from LS at that time. Ms Clarke recalls that SJ kept saying, "Why are you saying that [LS]". SJ began crying and told Ms Clarke that LS was saying "I am never going to see her or the kids again". SJ remained on the phone and Ms Clarke then went to get Mr Pearson again.

228. Call charge records indicate that at around 12:22pm, SJ had a 22 minute conversation with LS, LS having called her.

229. According to Mr Pearson's account, SJ stated that she made contact with LS earlier, who said she was in Goornong. He states that SJ said she was not sure if LS was taking drugs and that SJ told him that she did not have any worries or concerns about LS' mental health or drug use. Mr Pearson's file note records: "... [Mr Pearson] was very concerned as know[s] that LS has mental health and drug issues" and that SJ had told him that in the first call LS had very slurred speech.

230. As she was speaking with Mr Pearson, SJ received a further call from LS, which Mr Pearson overheard. In that call, LS requested that SJ "come down and pick her and [the] children up". Mr Pearson states that the call then "dropped out", however, LS called back and this time said words to the effect of, "Don't worry about coming and getting us, you will never see me and the kids again". SJ thought LS was slurring her words and that she had been using drugs. Mr Pearson became "very concerned" and called '000' for Victoria Police.

231. Ms Clarke and Mr Pearson sought to obtain information about LS' location, as SJ had said they were "at the Goornong shop where the bus pulls up". Ms Clarke also obtained the registration details of SJ's vehicle.

1:02pm - Mr Pearson's report to '000' (ESTA)

232. At 1.02pm, Mr Pearson called '000'. That call was received by an ESTA 'Police Call-taker' operator. The following is an extract from the transcript of that call:

> V1: Hello caller where do you need to police to come to?
> V2: Um I need them to go to, I know it's a bit weird, um to the Goornong Shopping Centre
> V1: Goorgong, how do you spell that?
> V2: It's G double O….
> V1: Yep….
> V2: R-N-O-N-G
> V1: Okay, um I'm not getting a shopping centre in Goornong. Do you know what the address is or cross street or anything like that?
> V2: (sounds to be talking to someone in the background)
> V1: This isn't Google, there's not a shopping centre coming up
> V2: No, so it's just like I think its like some shops on the road like you know like
> V1: Just on the main road, Midland Highway
> V2: Yeah on the main yeah
> V1: Alright, so I've got Midland Highway in Goornong in Victoria and the shopping centre, what's going on there?
> V2: Um, I work for Child Protection in New South Wales….
> V1: mmm..
> V2: …we've had a mum take off with two kids from New South Wales and um she has just called from that shop down there. She suffers from mental health and she is currently using ice.

V1: Oh okay, so are we, are we to apprehend the children or is this a welfare check?
V2: Um just a welfare check at this stage.
V1: Okay how long ago was the call?
V2: Um probably less than five minutes
V1: Oh okay just bear with me
V2: Um…
V1: Um called someone, Okay and she abducted the children from DHS in New South Wales.
V2: Ah from Family and Community Services. So the kids are currently staying at their grandma's
V1: Yep
V2: and she's gone and taken them
V1: So she took them from the grandmother?
V2: Yes
V1: um bear with me. Do we have custody?
V2: So she is currently going through Family Law Court at the moment…
V1: Who is applying for custody
V2: Yes, that's correct. It's because of mum's mental health and ice use that we are just worried about you know.
V1: Okay, alright now um how many kids are there?
V2: There's two
V1: Do you know which store she is in?
V2: Um she was outside of like an IGA she said like a shopping like a little supermarket so …

233. In addition to the above, the call-taker took a physical description of LS, obtained the car registration, and the names and dates of birth of the children. The call concluded around 1:09pm with the call-taker stating: "Alright so I've put that through for you, Midlands Highway in Goornong give us a call if anything else changes okay."

234. Mr Pearson gave evidence that as of 2 March 2017, he understood a welfare check to involve a police body or other agency going out to determine whether a child is in imminent or immediate danger "based on history or concerns that we have". Mr Pearson accepted that he should have indicated to the call-taker that he felt the children were at urgent and current risk of serious harm were they to remain in LS' care.

235. At 1:05pm, a 'Computer Assisted Dispatch' ("**CAD**") message was created, including the following details:

EVENT CREATED: MIDLAND HWY GOORNONG, Cross Streets= CHUTE ST/ DARLING ST, Name= TIM PEARSON
- CHILD PROTECTION NSW …
Agency= VICPOL, Group= W_O1 , Beat= WGN, Status= P, Priority= 2, ETA= 0,Hold Type= 0,
Current= F, Open= T, Type Code = 573 - P EME-SAR WELFARE CHECK, SubType Code = 2
… SHOPPING CENTRE
WELFARE CHECK ON CHILDREN WITH ICE AFFECTED MOTHER WHO CALLED SOMEONE FROM AA 5

MINS AGO
ABDUCTED CHILDREN FROM THEIR GRANDMOTHER WHO IS APPLYING FOR CUSTODY
MOTHER HAS MENTAL HEALTH ISSUES ALSO 2 CHILDREN
WAS OS IGA OR SIMILAR WHEN CALLED

236. That CAD message is not, itself, dispatched to police.

237. At around 1:13pm, the ESTA police dispatcher contacted Leading Senior Constable Darren Scherger from Victoria Police (WGN208) to convey the job. That exchange was recorded as follows:

> Operator: Apparently there's a shopping centre in Goornong. Or in- WGN208: Yeah, there is.
> Operator: Oh there is?
> WGN208: Uh, in Goornong or Huntly? Operator: Goornong, it's come through.
> WGN208: Ah yeah, there's about four shops yeah.
> Operator: Yeah, near the IGA, does that help?
> WGN208: No, no, there's no IGA in Goornong, it'll be Huntly. Operator: It'll be Huntly, okay cool.
> WGN208: There's an IGA in Huntly.
> Operator: … Thanks. The complaints in New South Wales, I'm assuming they don't really know the local area.
> WGN208: Yeah.
> Operator: Basically it's a check on some children who are with an ice affected mother. The mother's called from outside the IGA. Um, she's taken the children from the grandmother, who's applying for custody for them.

1:05pm - Victoria Police response

238. The ESTA operator initially informed Leading Senior Constable Scherger that "apparently, there is a shopping centre in Goornong." In his experience, Leading Senior Constable Scherger had never known a shopping centre to exist in Goornong and sought confirmation about whether the job related to "Goornong or Huntly". The ESTA operator again confirmed "Goornong, it's come through". Seeking to provide further information, the ESTA operator then referred to the location being "near the IGA, does that help?". Leading Senior Constable Scherger erroneously assumed that the location of LS and the children was Huntly and not Goornong.

239. At the inquest, Counsel Assisting put to Leading Senior Constable Scherger that the information provided to him by the ESTA operator indicated that LS had been sighted in Goornong, and not in Huntly. Further, that at least one possibility arising out of this conversation was that the call related to a shop in Goornong and that if he went to Huntly he would go to the wrong place. Leading Senior Constable Scherger did not accept that possibility and stated, "no it wasn't, it was referred to as a shopping centre and the IGA and that does not exist in Goornong". Leading Senior Constable Scherger maintained that the information supplied to him by ESTA "was relating to a shopping

centre, an IGA in particular, and I stated there is no IGA or shopping centre in Goornong. There's a couple of shops a block apart, that's it."

240. Leading Senior Constable Scherger did not accept that he should have sought clarification from the ESTA operator. He did accept that the information provided by the ESTA operator, namely, that an ice-affected mother with mental health issues had taken children from their grandmother who was applying for custody, suggested the children were potentially at risk of harm and that he knew that at the end of the call.

241. At around 1:14pm, the CAD Chronology was updated to indicate that Leading Senior Constable Scherger in WGN208 was assigned to respond to the job and that a Keep a Look Out For ("**KALOF"**) was to be broadcast. In response to the job, Leading Senior Constable Scherger proceeded to Huntly rather than Goornong. He attended the Huntly IGA supermarket which is located on the Midland Highway and reported "Nil Results". After providing an update to "ESTA/Police communications", Leading Senior Constable Scherger returned to his patrols at approximately 1:23pm.

242. Counsel Assisting suggested to Leading Senior Constable Scherger that instead of disregarding the possibility that LS might have been at Goornong and driving to Huntly, he could have instructed an ESTA operator to direct further enquiries. More specifically, to have an ESTA operator request that a police officer contact Huntly IGA and the "single milk bar" in Goornong to ascertain whether LS had in fact attended, or was at, those locations. Leading Senior Constable Scherger conceded that he could have requested the making of those inquiries "if the resources were available".

243. As to resourcing, Leading Senior Constable Scherger accepted that at the time that he got in touch with the radio operator, at 1:27pm as set out below, he could also have asked for calls to have been made to the shop in Huntly and the shop in Goornong. There is no evidence before me as to whether or not resources could have been made available to conduct those enquiries earlier.

1:25pm – LS returned to Bendigo

244. At around 1:25pm, LS and the children left Goornong General Store in a taxi and returned to Bendigo. This was around 12 minutes after the conversation between Leading Senior Constable Scherger and the ESTA operator.

1:26pm - Victoria Police response continued

245. At around 1:26pm, CAD records the following 'event comment': "WGN 208 – WILL PATROL, KALOF WBI & WCP AREAS". The KALOF did not have any particular level of priority attached to it.

246. The KALOF broadcast was made at around 1.27pm in the following terms (it appears this was made by the ESTA dispatcher):

> "V2: (Indecipherable) channel, switching to Bendigo, Elmore, Rochester kind of areas. Please keep a look out for a Holden Cruze sedan in white, NSW plates [redacted]. Got a female on board, LS, born [redacted]. She's got two young children with her. We've had a job come through from Child Protection NSW saying that LS's taken the two kids from the grandmother's custody. Um, grandmother's currently applying for the custody, so not sure where it is legally at this point. Um, she's called from the IGA in the Huntly kind of area in the Midland highway at around… 1300 hours, so nearly 30 minutes ago. She's called from that area, not sure where she's heading to at this stage. If you could just keep a look out for that white Holden Cruze."

247. The KALOF broadcast was made for the Bendigo unit but up could have been heard by units for the Campaspe, Bendigo and Macedon areas. It did not include any reference to LS being ice affected. On this issue, Leading Senior Constable Scherger's evidence was that "that was relevant, very much so" but that a KALOF is about keeping a look out for a vehicle. As explained by Sergeant McDermott in oral evidence, a KALOF does not involve any actual tasking of a unit or a person to do anything. Rather, it is a general broadcast. As further explained by Mr Dunbar, unless there is a request for a KALOF to be re-broadcast, officers coming onto shift after the broadcast will not be aware of it. Thus, as Mr Dunbar put it, the 2 o'clock shift on 2 March 2017 would not have been aware of the KALOF at 1:27pm unless they actively discussed it.

1:49pm - Mr Pearson's contact with Ms Paterson

248. Mr Pearson's file note records that at 1:49pm, he contacted Ms Paterson about the Family Court orders. Ms Paterson notified him that the paperwork had not been submitted to the court and that there were no orders in place at that time.

1:51pm - LS and children arrive at Bendigo Railway Station

249. At 1.51pm, LS and the children arrived by taxi at Bendigo Railway station, where it appears they met Ada Cooper.

2:00pm - Request for 'Possible Phone Ping'

250. At 2:00pm, the CAD states: 'EVENT COMMENT: 'WBI251 NOTIFIED RE POSSIBLE PHONE PING'.

251. At 2:01pm, Mr Pearson received a call from Leading Senior Constable Scherger, who asked if LS went by any other names. Mr Pearson said no and Leading Senior Constable Scherger said that they were still searching for LS and the car.

252. On Leading Senior Constable Scherger's timing, at around 2:06pm he contacted Mr Pearson directly who, according to Leading Senior Constable Scherger's evidence:

> "… informed me that was in company with calling from mobile phone [redacted], and was in a white Holden Cruze, registered NSW [redacted]. [Mr Pearson] also stated there were no safe custody orders in place, but there was

immediate concerns for the welfare of the children, and the matter was to be treated as a 'matter of urgency'. PEARSON stated has a history of psychiatric illness, but there was no immediate concerns for her safety."

253. It appears that Mr Pearson also told Leading Senior Constable Scherger that the LS may be ice affected and that she had told the grandmother that she would never see them again as this information was relayed to Sergeant McDermott. In a later radio communication to police, Leading Senior Constable Scherger said the job:

> "…related to [LS] suffering mental illness possible suicide calling up saying that she was, you will never see me again to the grandmother in Deniliquin and so on and she's got the two young kids with her".

The fact of that statement having been made by LS was thus clearly known to Leading Senior Constable Scherger. Leading Senior Constable Scherger's statement notes that he explained to Mr Pearson that if there were immediate concerns for the welfare of the children, a safe custody warrant should be obtained as a matter of urgency and that Mr Pearson said that locating the children and parent should be treated as a matter of urgency but that the children did not need immediate protection or safe custody; instead, what was sought was a welfare check.

254. Leading Senior Constable Scherger's Electronic Patrol Duty Return ("**EPDR**") indicates that Leading Senior Constable Scherger recorded that he was told that there were no immediate threats or concerns for LS' safety. However, the EPDR does not include any information or analysis about the existence or extent of any risk to the children.

255. Leading Senior Constable Scherger gave evidence that looking back, his best recollection of what Mr Pearson told him was that "there were immediate concerns for the welfare of the children and the matter was to be treated as a matter of urgency" and that LS had a history of psychiatric illness but there were no immediate concerns for her safety. He accepted that, in light of what Mr Pearson had told him, it was important for him to see what steps could possibly be taken to try to locate LS and her children so that he could respond to the concerns that were being expressed for their welfare. He said, however, that he did not agree that he needed to treat recovery of the children as an urgent matter.

256. Mr Pearson prepared a contemporaneous note of his call with Leading Senior Constable Scherger which is in the following terms:

> "At 1.23pm CW Tim Pearson received a call from Sgt Daniels Goornong Police [LEADING SENIOR CONSTABLE Scherger] who followed up about the 000 call and asked further questions about [LS'] mental state and if there are any orders currently in place. Sgt Daniel stated that if [LS] is found and the children are safe, there is nothing they can do because there are no current orders in place. CW Tim stated that a welfare check will be fine; we just need to know [CS]

and [DS] are safe. Sgt Daniels asked about [LS'] current mental health and CW Tim explained that has previously been diagnosed with Schizophrenia but is no longer taking any medications. Sgt Daniels stated the Police may be able to use the Mental Health Act to arrest. Sgt said he will be back in contact with the CW Tim."

257. Following this call, Leading Senior Constable Scherger contacted Sergeant McDermott about the possibility of phone triangulation to trace LS but was told that there were no grounds for the request. Unfortunately, there is no contemporaneous record of what risk factors were discussed between the two officers to reach this view. Sergeant McDermott states he did not have access to a Mobile Data Terminal ("**MDT**") at the time and all the information he received was communicated orally by Leading Senior Constable Scherger. Sergeant McDermott's contemporaneous notes simply record that there was no safe custody warrant, no threats of self-harm and no threats against the children and also included the entry "DHS concerns for welfare?". In his written statement, Leading Senior Constable Scherger says he informed Sergeant McDermott of the entire facts of the matter that he knew.

258. In relation to a possible triangulation, Sergeant McDermott noted the operation of s. 287 of the *Telecommunications Act 1997* (Cth), and that information can only be accessed where "it will lessen a serious and imminent threat to the life or health of a person". Sergeant McDermott states:

> "Referring to my notes and the ESTA task log, and whilst the complainant from DHS had specific concerns the female may be ice affected, there was no evidence of a threat to the children, there had been no threat of self-ham reported and DHS had not applied for safe custody warrants. In the absence of any other influencing factors, I did not believe at that time, based on the intelligence provided to me, that the criteria for requesting a phone triangulation (serious and imminent threat to the life or safety of a person) had been met."

259. Sergeant McDermott's evidence was that:

   a. He knew the children were under 10 years of age;
   b. He was aware that Mr Pearson had indicated that locating the children and LS should be treated as a matter of urgency; and
   c. He was aware that LS was said to be ice affected.

260. Sergeant McDermott recalled that Leading Senior Constable Scherger "mentioned that he had contacted our local psych services in relation to [LS]" but could not recall being told that SJ was applying for custody of CS and DS. Sergeant McDermott accepted in oral evidence that the information that was provided to him, namely that there was an ice affected mother with mental health issues and that concerns had been expressed by Mr Pearson, indicated that there were concerns for the welfare of the children.

261. Notwithstanding the above, at 2:06pm, the following CAD entry was entered which records:

> 'EVENT COMMENT = S/T WBI251; NIL GROUNDS RE URGENT PHONE TRACE. AWAITING FURTHER FROM NSW DHS. KALOF BROADCAST. GOA [Gone on arrival] UNABLE TO LOCATE IN WGN SUBDISTRICT".

262. At 2:06pm, the CAD refers to WGN208 (that is, Leading Senior Constable Scherger) as the "primary unit" responding to the job, and "Comment = UNABLE TO LOCATE".

263. At 2:06pm, the CAD states: "EVENT CLOSED". Leading Senior Constable Scherger states that he "continued patrolling my response area in an attempt to locate [LS]".

264. At the inquest, Counsel Assisting put to Leading Senior Constable Scherger that the sum of his attempts to locate LS involved:

    a. Driving to the IGA in Huntly, but not exiting his vehicle to speak to the owner;

    b. Arranging the single KALOF at 1:27pm;

    c. Contacting Mr Pearson to obtain more information; and

    d. Contacting Sergeant McDermott to request a phone triangulation.

265. Leading Senior Constable Scherger agreed, save that he added that he also patrolled the area to "sight the vehicle." When asked whether, even with the benefit of hindsight, there was more than he could have done he said there was not.

266. It appears that Sergeant McDermott decided that a 'division wide broadcast' was to be issued to alert all local units of the task. As noted above, a KALOF broadcast had occurred at approximately 1:27pm before Sergeant McDermott's involvement. It appears that no formal KALOF or division wide broadcast was subsequently issued.

267. Sergeant McDermott also advised Leading Senior Constable Scherger to continue to actively patrol his response zone until all locations had been checked or additional information was provided.

268. At 2:26pm, Sergeant McDermott conducted a 'handover' with the afternoon shift patrol and concluded his shift at 3:00pm. He had no further involvement with the matter.

269. In his oral evidence, Sergeant McDermott maintained that the statutory criteria for triangulation was not satisfied, but did accept that an additional KALOF broadcast could have been made. After Sergeant McDermott completed his shift and conducted the handover, he gave evidence that he believed that the afternoon shift Sergeant "would have to take responsibility for whatever action was taken."

270. As to whether the children should have been reported as "missing", Sergeant McDermott accepted that the whereabouts of the children (and LS) were unknown, that there were "concerns for welfare", and that the criteria under the applicable Victoria Police Manual Procedures and Guidelines for Missing Persons Investigation "were met". Sergeant McDermott also accepted that children who meet the criteria for missing persons, and who are under the age of 10, are a particularly vulnerable class of missing person, and that if police become aware of such a situation it "requires an immediate police response".

271. Although the aforementioned policy states that a sergeant should have immediately investigated the report, Sergeant McDermott did not accept that he should immediately have done that. He did not, nor did he instruct Leading Senior Constable Scherger to, complete a missing person's report and risk assessment. His explanation for why he did not accept that this should have been done was that the children were with their mother. Sergeant McDermott also considered that the incident "was probably more along the lines of a welfare check as [it] initially came through as opposed to an official missing persons".

272. Subsequently, Sergeant McDermott gave evidence that, at the time, he did not turn his mind to whether or not a missing person's report should have been made albeit that it was something that should have been considered.

273. Counsel Assisting asked Sergeant McDermott whether or not he considered this an abduction. Sergeant McDermott said that he never considered that possibility at the time, and that there would have had to be some sort of family law order or an intervention order before the taking of children would be considered an abduction. He added, however, that if the children had been named as PINOPs in an ADVO that would have been relevant as to whether or not this was an abduction, but he made no enquiries as to whether this was the case here.

274. As to whether he would have considered the phone triangulation criteria met if he had been aware that, in a phone call that day from Goornong LS had told SJ that she would never see her or the children again, Sergeant McDermott said he would not, as that information did not necessarily suggest an immediate risk to the children. He also said that such information would not have required him to ensure that a number of police vehicles were tasked to try to find LS and the children, as he thought that "that one off – that comment based with the fact that she was ice affected wasn't – wouldn't be enough when you take into account that we didn't know where she was".

2:30pm - Mr Pearson's update to SJ

275. At 2:30pm, Mr Pearson contacted SJ to notify her that the police were looking for LS and the children and he would be in touch with any updates.

3:10pm - SJ's disclosure to Bernadette Murphy, Principal of St Michael's Primary School

276. Bernadette Murphy is the Principal of CS and DS' primary school in Deniliquin.

277. At around 3:10pm, SJ asked to speak with Ms Murphy in private and they went to her office. SJ told Ms Murphy that:

> "[LS] had taken the boys stating an intention to take them for a swim the previous evening. [LS] and the boys had not returned home. [SJ] also indicated that she had spoken with [LS] on the telephone. [LS] had indicated to [SJ] that she was in Bendigo and that they were all fine".

Ms Murphy states that SJ advised her she had let the police, FACS and her lawyers know and that she hoped the police would intercept LS and bring the children home. SJ noted that LS was not to leave NSW according to her parole conditions.

278. Ms Murphy states that she reassured SJ she would try and help locate the boys. Ms Murphy then called former Detective Miles Rogers ("**Mr Rogers**") at around 3:30pm. Ms Murphy states that she contacted Mr Rogers to see if he may have known anyone in the Victoria Police around Bendigo who could fast track the apprehension of LS. She describes being in an anxious state and refers to leaving only a voicemail. Ms Murphy then called FACS to see what they could do, and her calls not being answered, drove down to their office in Deniliquin at 4:50pm and told the receptionist that their phone had been engaged all that time. She was informed that the line was down. She was then told by Mr Pearson that everything was being done that could be done to locate the boys and went home expecting that the boys would be found and reunited with SJ.

279. Mr Rogers confirmed that he saw a missed call from Ms Murphy and that it was not unusual for her to call on a range of matters. He tried to call back at some stage, but was unable to speak with her. Mr Rogers did not have voicemail. It was only the following day, on 3 March 2017, that he found out what had happened to CS.

280. In a supplementary statement, Ms Murphy stated that she did not recall SJ stating words to the effect: "You won't see us anymore". Had SJ said this, Ms Murphy states it would have conveyed the impression their lives were at imminent risk. She would not have forgotten such words.

281. Ms Murphy did not regard the situation as a 'child abduction' as LS was entitled to have her own children in her care and custody, notwithstanding that she was in Victoria in breach of her parole condition. She noted that LS had "returned to the scene" and been actively involved in the school life of the boys – it was not unusual to see her involved in drop-off and collection of the children.

282. Ms Murphy explained that she contacted Mr Rogers rather than '000' because SJ had already phoned police and "hadn't gotten anywhere". She thought Mr Rogers might be able to make inquiries of Victoria Police.

283. Ms Murphy stated that she was well aware of the various school policies, procedures and guidelines operative at the time; she did not believe any particular policy applied to the circumstances on 2 March 2017. Although SJ was "obviously very concerned" that LS had taken the children, and Ms Murphy was also concerned for their welfare, she did not consider the circumstances sufficient to suggest they might have "reasonably been expected to a produce a substantial or demonstrably adverse impact on the children's safety, welfare or wellbeing", or that they were 'at risk of significant harm', such that the Catholic Education Wilcannia-Forbes *'Child Protection Policy: Managing Risk of Significant Harm and Wellbeing Concerns'* did not apply. Nor did the *'Critical Incidents Policy'* apply.

284. With the benefit of hindsight, Ms Murphy states that she should have called '000' herself.

3:45pm - LS attends Elmore BP Service Station

285. At around 3:45pm, LS drove into the BP Service Station at Elmore, Victoria. Ms Spizzica was working at the time, and recognised LS from the Elmore IGA the day prior. Joseph Beer was also in the shop at the time LS was inside, and recognised her from growing up in Deniliquin. Mr Beer had a conversation with "the girl behind the counter" and asked whether the couple had done anything. He stated: "if you're worried, it's [LS] [naming her]. Call the cops if you're worried". The "girl behind the counter" wrote the name down.

286. At 3:47pm, Ms Spizzica called '000' and reported the theft and that LS was at the location in the same vehicle. At the time of the call, Mr Cooper and likely LS were in the shop. The call-taker asked whether they appeared drug or alcohol affected and Ms Spizzica replied, "It's really hard to tell I'm so sorry, I don't know". The call lasted 5.25 minutes, terminating at around 3:53pm. After Ms Spizzica finished with the call, LS and Mr Cooper returned to SJ's car and left the BP Service Station.

287. Elmore BP Service Station is situated on the north-east corner of a "T" intersection on the Midland and Northern Highways. Heading north from the BP, the Northern Highway leads to Rochester and Echuca; to the south, the Midland Highway leads to Goornong and Bendigo; and to the east, the Midland Highway continues to Shepparton. In her statement, Ms Spizzica said that the car had "sped off towards Bendigo".

288. A receipt records the purchase of groceries and fishing and camping equipment, amongst other things at 3:51pm.

289. Mr Pearson received a call from Leading Senior Constable Scherger to say that LS had been sighted in Elmore and that LS was on a "crime spree between Elmore and

Goornong". Leading Senior Constable Scherger also indicated that both Bendigo and Goornong Police were continuing to drive around to find and the children.

3:50pm - Victoria Police response to '000' call

290. At 3:50pm, the ESTA call-taker created the event for 'Margaret St, Elmore @ BP'. The event type was 'PER SUSPECT LOITER' and it was allocated Priority 2. The Event Comment stated:

> "YESTERDAY THEFT OCCURRED AT IGA IN ELMORE; NIL W's WERE INV AT THE TIME; WAS A M AND F INV YESTERDAY … BOTH AT AA NOW WITH THE SAME VEH THEY DECAMPED IN YESTERDAY … COMP ALSO WORKS AT THE IGA – WAS THERE YESTERDAY WHEN THEFT OCCURRED".

291. The call taker noted the vehicle make and model, and also a description of the persons of interest.

292. The Victoria Police units that responded to the job were Rochester 208 (WRC208), Goornong 208 (WGN208), Heathcote 302 (WHC302), Kyabram 302 (WKA302), Bendigo 251 (WBI251), Echuca 251 (WEC251) and Bendigo 616 (WBI616).

293. Specifically, at around 3.53pm, units WRC208 (Leading Senior Constable Goyne), WHC302, and WGN208 (Leading Senior Constable Scherger) were dispatched. WBI251 (Bendigo) and WEC251 (Echuca) were supervisory units who were responsible for monitoring the event, although they do not appear to have been directly involved in responding to the task.

294. Leading Senior Constable Goyne gave evidence that at the time that he received the notification from ESTA, he was approximately four and a half kilometres north of Elmore, travelling in a northerly direction on the Northern Highway towards Rochester. Upon receiving the ESTA notification, he states that he turned around and drove back towards the BP service station in Elmore. Leading Senior Constable Goyne gave evidence that from the time he made the U-turn to the time he arrived at the BP service station, he was looking for a Holden Cruze [the description of LS' vehicle] coming in the other direction and was certain that the vehicle did not pass him.

295. That same time, at 3.53pm, an 'Event Comment' notes: "WGN208 (LEADING SENIOR CONSTABLE Scherger): "COULD BE 'LS – [EE]". This relates to Leading Senior Constable Scherger's broadcast that:

> "The male, I had a job earlier today at the DHS, there's two young kids should be in the car that's been taken. That car has been stolen from Deniliquin it's a is the female and a formerly of a Echuca address. They're the two they were the two I was looking for earlier today in Bendigo."

296. Leading Senior Constable Goyne responded:

"… I just don't know their character so I'm just going to wait till I see if anyone else is in striking distance to assist". In oral evidence, Leading Senior Constable Goyne justified the need for back up by stating, "it is absolute policy when members are working single officer patrols within Victoria Police that if we believe that it's necessary that we ask for backup."

297. Leading Senior Constable Scherger then responded:

> "I'm on the Barnadown Road at Goornong, I'll start heading that way and Heathcote [WHC302] is here with me and we can probably both start heading that way … Just so you're aware the job today related to her suffering mental illness possible suicide calling up saying that she was, you will never see me again to the grandmother in Deniliquin and so on and she's got the two young kids with her."

298. Leading Senior Constable Scherger did not accept that LS' statement to SJ that "you will never see me again" conveyed a possible risk to the children and warranted steps to locate the children as a matter of urgency. Rather, Leading Senior Constable Scherger gave evidence:

> "That comment was made - was relayed to me by Mr Pearson, that he - but there was no direct threats to harm herself or the children, that, 'You won't see me again.' That's all I can really clarify that. That was the comments that was the comments that was made to me by Mr Pearson, that, 'You won't see us again,' and the - my inquiries were with what context was that - there was no direct threats of harm, self-harm or harm to anyone else, just that, 'You won't see me again,' after a dispute of some description where she has picked up her own children."

299. In response to Leading Senior Constable Scherger's radio communication regarding LS' possible suicide, Leading Senior Constable Goyne replied: "Yeah 208 copy, all the more reason I'll hang about and wait for someone to get a bit closer". Leading Senior Constable Scherger then indicated he was "about 10 minutes off" and told Leading Senior Constable Goyne to "watch him with evade police to Gorny that might happen as well."

300. At around 3.54pm, Leading Senior Constable Goyne states: "yeah Rochester 208 I've got no intentions to chase him at all and Rochester to D24 if you can notify my umm 251, I think it's Echuca 251 because I knock off in 5 minutes".

301. Leading Senior Constable Goyne gave evidence that he requested a VKC operator to contact the complainant at the BP service station to seek further information about whether LS was still at the BP service station. The complainant, Ms Spizzica, is recorded as telling the VKC operator, "They - they drove - sorry, we just got on the camera, they turned out - out of the driveway and I'm guessing they head back towards

Echuca?" The VKC operator states, "So they're heading back to Echuca?" and Ms Spizzica replied, "Either Echuca or Bendigo, we're just trying to figure it out now." It appears that this conversation was not broadcast to the responding officers and that Leading Senior Constable Scherger was therefore not aware of this information at the time.

302. At this stage, Leading Senior Constable Goyne communicated that he was situated "off the main street" to see whether "[LS, EE and the children] are going to head north on the Northern". In oral evidence, Leading Senior Constable Goyne elaborated that he was one block north-east of the Elmore BP service station and that he was waiting at that location for further clarification about the direction that LS's car had travelled.

303. VKC then communicated to Leading Senior Constable Goyne that the complainant, Ms Spizzica, was unsure about LS and EE's direction of travel away from the BP service station and that "they have possibly taken off on the Midland [Highway] towards Shepparton."

304. As a result, Leading Senior Constable Goyne indicated that he would attend the BP service station in Elmore to make further enquiries of Ms Spizzica.

305. At 4:02pm, WBI616 (from the south side of Bendigo) offered to look for the vehicle in Bendigo. The Electronic Return for WB1616 has the car patrolling re KALOF for 10 minutes by 16.15 but back at the station at 16.16.

306. Meanwhile, a number of police units appear to have taken up static positions in an attempt to intercept LS's car if it passed in their direction.

307. WGN208 (Leading Senior Constable Scherger) took up a static position on the Midland Highway outside the Goornong Pub (Drovers Arms Hotel). WHC302 remained at the intersection of the Midland Highway and Axedale-Goornong Road, in case the vehicle passed by. The Electronic Return for WHC302 has the car on static observation for A/V at 4:13pm, it is not clear for how long, but despatched on other duties at 16.36.

308. Meanwhile, Leading Senior Constable Goyne's EPDR indicates that at 4:02pm he arrived at the BP service station. Leading Senior Constable Goyne made no contemporaneous record of his attendance at BP Elmore, either in his notebook or by way of his EPDR. In his oral evidence, Leading Senior Constable Goyne stated that, "the EPDR covers verbal conversations between myself and despatch. All the verbal conversation that is noted there was all that was required for that job". Leading Senior Constable Goyne gave evidence that when he spoke with Ms Spizzica at the BP service station, when asked in which direction the vehicle went she pointed to the Midland Highway, and he said to her that that was not towards Shepparton but was towards Bendigo, at which point she nodded. His evidence was that after this he asked her in which direction the car had travelled and she said south. The CAD log, in an entry marked against WRC 208 (Leading Senior Constable Goyne) records at 16.05 (last DOT south on Midland Hwy twds WBI [Bendigo]".

309. Leading Senior Constable Goyne confirmed in his oral evidence that if the car had left travelling towards the Midland Highway it would then have reached a T Junction, at which point it could have turned either towards Echuca or Bendigo.

310. In any event, Leading Senior Constable Goyne communicated to VKC that "they've left the BP and headed south on the Midland Highway towards Goornong." On the basis of this information, the VKC operator informed the police unit from Kyabram, (WKA302), "you can probably disregard now the vehicle's headed south towards Goornong." The Electronic Return for WKA302 has the event closed at 4:00pm.

311. In his oral evidence, Leading Senior Constable Goyne accepted that it was possible that LS may have left the BP service station in a southerly direction but ultimately travelled north via a side street in Elmore. It does not, however, appear that any checks were made of those side streets. Leading Senior Constable Goyne also accepted in oral evidence that LS may well have already travelled north on the Northern Highway, and already passed him by the time he was first notified of the incident. Given these possibilities, Leading Senior Constable Goyne was asked why he didn't countermand the VKC operator's communication to WKA302 that it could "disregard" with words to the effect that "no, we still need to check every direction". Leading Senior Constable Goyne responded that he could have, but that it was not his responsibility to do so. He gave evidence that the responsibility for overseeing jobs lies with his supervisors. When asked whether he might have suggested to his supervisor that it was necessary to check all directions, Leading Senior Constable Goyne stated that "it probably would have been a good suggestion, but it didn't happen" and that he simply didn't turn his mind to it at the time.

312. Counsel Assisting asked Leading Senior Constable Goyne why, if it appeared on the information available to him that the children were unable to be located and there was a concern for their welfare, he did not consider whether or not the children might meet the definition of a missing person under Victoria Police's policies Leading Senior Constable Goyne responded that "at that stage, for my job, for a suspect vehicle, I didn't take that into consideration." Leading Senior Constable Goyne was further asked whether, at the time, he considered he had any responsibility to investigate the circumstances of the children and whether they were at risk. Leading Senior Constable Goyne responded indicating, "No, my job was for a suspect vehicle at a service station." He did not accept that, even in hindsight, this is something he should have done.

313. In his written statement, Leading Senior Constable Goyne said that he subsequently notified Police Communications and supervisors from both the Campaspe Police Service Area and the Bendigo Police Service Area of the vehicle's description and direction of travel. During the course of his oral evidence, Leading Senior Constable Goyne accepted that given he made his statement three years after the incident on 2 March 2017, his memory was "less than perfect". He was asked whether he had any actual recollection of that communication. He stated that, "it would have been over the air…

so a broadcast via the police channel" however he accepted he had no way of knowing if any officers were listening to the channel at the time.

314. In his statement, Leading Senior Constable Goyne also recalls that he requested a KALOF broadcast, noting that two young children were in the rear of the vehicle. However, records provided by ESTA indicate that the only formal KALOF broadcast requested was the one made at 1:27pm. When this was put to Leading Senior Constable Goyne he did not accept that his recollection that he requested a KALOF broadcast was incorrect. However, he conceded that, "if you go word for word then the description is wrong but there was a transmission that gave the name of the vehicle and the description of the vehicle for other vehicles - for other police units to look for."

315. At about 4.04 pm, Leading Senior Constable Goyne took up a static position on the Midland Highway at the southern entrance to the township of Elmore in case the vehicle returned that way. WRC208 notes:

> "WAITING OFF HWY IN WEM – IF THEY COME BACK"

316. Sometime before 4:13pm, Leading Senior Constable Goyne returned to the BP service station to check the CCTV and confirm the description of the vehicle. He gave evidence that the CCTV image that he saw was static and that in that static image the vehicle was pointing in a north-westerly direction. Leading Senior Constable Goyne was asked why he didn't check the CCTV to confirm the direction that the vehicle travelled. Leading Senior Constable Goyne gave evidence that he did not know why he didn't do so, but accepted that it "possibly would have been a good idea".

317. At 4.15pm, an 'Event Comment' for WRC208 notes: "HAVE DONE EXTENSIVE PATROL OF WEM – UTL" [unable to locate].

318. Also, at 4:15pm, an 'Event Comment' for WBI616 states: "PATROLLED BENDL RE KALOF; NOD"; and "Disposition assigned = UTL".

319. At approximately 4:15pm all units were cleared after being unable to locate the vehicle.

320. At 4:30pm, an Event Comment for WGN208 notes: "HAVE PATROLLED AND ALL CAMPING AREAS – UTL [Unable to Locate]".

321. There is no record of any steps being taken to locate LS' car after this.

322. During the course of his oral evidence, Leading Senior Constable Goyne was asked whether, with the benefit of hindsight, there is anything else he now considers could have been done by Victoria Police in response to the notification about LS' sighting at the BP service station that might have resulted in LS' car being located and the welfare of the children being checked. Leading Senior Constable Goyne gave evidence that he did not think anything more could have been done.

323. In response to the questioning from Counsel Assisting about the adequacy of Victoria Police's search for LS' vehicle, Leading Senior Constable Scherger also gave evidence that he "attempted to locate LS and the vehicle and the job was dispatched to other units to assist to attempt to locate and she wasn't located. It wasn't from lack of trying."

5:00pm - Victoria Police's update to Mr Pearson

324. At 4.50pm, a file note relating to Mr Pearson's contact with Leading Senior Constable Scherger records: "Call from Sgt Daniels Goornong Police who stated that they are still searching for and (sic) the children and will call Deniliquin CSC with any further updates".

325. At 5:05pm, Mr Pearson called SJ and notified her that LS and the children had not been found, but that police would continue to search.

5:20pm - LS drives to Woolworths Caltex, Pericoota Road, Moama

326. At around 5:20pm, LS attended a Woolworths Caltex service station on Pericoota Road, Moama NSW. LS and the boys entered the shop and LS purchased drinks and a 'Kinder Surprise' for the children. The shop attendant described her as being in "pilot-mode".

Tragic death of CS

327. An hour or so later, CS was dead.

Findings as to Matters in Issue

328. As noted above at [7]. s. 81(1) of the Act requires me to make statutory findings regarding the following:

a. The person's identity, and
b. The date and place of the person's death, and
c. In the case of an inquest that is being concluded – the manner and cause of the person's death.

329. I find that CS died at approximately 6:15pm on 2 March 2017. CS died in the waters of the Murray River in Moama, NSW. The manner and cause of death was presumed drowning as a consequence of the acts of his mother, LS.

Evidence of SJ

330. Further to my views above at [105], there are some inconsistencies in SJ's evidence regarding, in particular:

a. The content of her conversations with police on 2 March 2017;
b. The identity of officers at FACS with whom she spoke and how many times she spoke to them; and
c. The timing and number of phone calls she had with LS on 2 March 2017 and how long they lasted.

331. In relation to SJ's evidence regarding the timing of her phone calls with LS on 2 March 2017, I accept, that phone records regarding SJ's phone contact with LS over the period 1-2 March 2017 ought to be, and indeed have been, preferred to her recollection regarding the sequence of those calls.

332. In relation to the account set out in SJ's second statement of her conversations with police on 2 March 2017, the NSWPF submitted that to the extent that account is inconsistent with her first statement and the contemporaneous statements of police, it should be approached with caution.

333. The NSWPF further submitted that:

> "As with SJ's interactions with FACS, the *substance* of her evidence with respect to NSWPF – in terms of flagging down the police in the early hours of 2 March 2017 to let them know LS and the children had not returned home and her visit to the police station later that day after hearing from LS – is consistent with other evidence and can be accepted. But where there are "disagreements as to matters of detail", and the Commissioner submits *important matters of detail* that form the basis of criticism of individual police officers and recommendations for systemic change, then that evidence should be approached with caution where it is uncorroborated or inconsistent with other evidence."

334. In response, Counsel Assisting submitted that limited weight should be given to the suggestion that SJ's account of conversations with NSWPF officers on 2 March 2017 "to the extent that account is inconsistent with her First Statement and the contemporaneous statements of police, should be approached with caution" because:

a. SJ's first statement regarding interactions with police contains virtually no details and was provided at a highly stressful time and before the true magnitude of events was known; and
b. In contrast, the statements of police were taken over a month later with full awareness of the tragic outcome, and also the potential for subsequent scrutiny of police involvement.

335. I acknowledge that some inconsistencies exist in SJ's first two statements regarding her interactions with NSWPF on 2 March 2017. These inconsistencies are not raised as a criticism of SJ, who I found to be a credible witness. To the extent that any matter has turned on the evidence in SJ's second statement which is inconsistent with SJ's

first statement, I have balanced the weight of SJ's evidence against the weight of contemporaneous statements and documentation.

Evidence of Mr Miles Rogers

336. In March 2017, Mr Rogers was a Detective Sergeant of Police and also held the position of 'Criminal Investigation Supervisor' at Deniliquin Local Area Command. He served in the NSWPF for around 19 years and received a number of national policing awards.

337. As regards CS' death, Mr Rogers had some limited involvement in what Counsel Assisting describes as 'after the event' criminal investigation in relation to the events of 2 March 2017. He assisted in formally identifying CS.

338. Mr Rogers provided a statement in which he commented on the adequacy of the response of the NSWPF on 2 March 2017 and noted that:

    a. Constables Bryce and Burnell should have identified SJ's report in the early hours of 2 March 2017 as a missing persons incident in accordance with missing persons procedures;
    b. Constables Bryce and Burnell should have recorded a missing persons COPS event rather than an 'Occurrence only' COPS event;
    c. Constable Bryce's email to Mr Holloway was inadequate and was a result of a deficiency in supervision Deniliquin Police Station;
    d. Mr Holloway failed to identify SJ's report as a missing persons incident and as a result failed to make basic inquiries pursuant to missing persons policies to locate the children as a matter of priority; and
    e. NSWPF officers at Deniliquin Police Station should have kept SJ at the station following her second report on 2 March 2017, and engaged directly with Victoria Police on her behalf.

339. Mr Rogers gave oral evidence at the inquest. During his evidence, under cross-examination, Mr Rogers conceded that he had "probably overstated it" when in his written statement he said that Constable Burnell had admitted to him that he and Constable Bryce had "got it wrong". Mr Rogers gave evidence that: "What I should've said is that they, they had concerns about their, their situation." For his part, Constable Burnell denied that the conversation ever took place.

340. Similarly, under cross-examination, Mr Rogers also conceded when asked about the basis of the opinion expressed in his statement that SJ "shouldn't have been turned away by police", that "that language is, in hindsight a bit strong".

341. The NSWPF submitted that Mr Rogers' evidence in this inquest should be regarded with the utmost caution. In relation to Mr Rogers' evidence that NSWPF officers failed to properly identify SJ's two reports on 2 March 2017 as missing persons reports, the NSWPF noted that Mr Rogers opinion was contrary to that of Detective Inspector Glen Browne, the Manager of the Missing Persons Registry (MPR) within the State Crime

Command of the NSWPF. The evidence of Detective Inspector Brown is set out below at [482].

342. Noting that there were inconsistencies in Mr Rogers' evidence, Counsel Assisting submitted that the fundamental point to be drawn from Mr Rogers' evidence is that is demonstrates the intuitive response of a senior police officer with substantial investigative experience – that is, to adopt a proactive and comprehensive approach, consistent with a cautious view of the potential risk posed to two young, vulnerable children. Ultimately, Mr Rogers' contends that more should have been done.

343. I accept that some of Mr Rogers' evidence was the subject of concessions at the hearing or inconsistent. Ultimately, it is not necessary for me to resolve these inconsistencies. The findings I have made are not based on the criticism advanced by Mr Rogers. That being said, Mr Rogers' provided a useful perspective of an experienced police officer with 10 years' experience in the Deniliquin LAC. Mr Rogers was clearly correct that a proactive and cautious approach to the potential risk posed to two vulnerable children should have been adopted by NSWPF, and that ultimately more should have been done to protect them.

CSNSW / Community Corrections

344. The relative involvement of CSNSW and Community Corrections, a sub-division of CSNSW, has been canvassed at [107]-[115], [124]-[125], [153], [356]-[360] above.

345. Having regard to that background, the central matters in the list of issues relating to CSNSW and Community Corrections were as follows:

> [2]. The adequacy of any steps undertaken by CSNSW to ensure a suitable residence was available for LS on and after release under statutory parole.
>
> [3]. The adequacy of any steps taken in respect of LS once released on parole in February 2017, including having regard to the welfare of her children.
>
> [4]. The adequacy of the response of CSNSW to reports made on 1-2 March 2017.
>
> [5]. Whether relevant processes, policies and procedures were followed by Community Corrections on 2 March 2017 in dealing with the situation that presented on 1-2 March 2017.
>
> [6]. The adequacy of those processes, policies and procedures.

346. Jason Hainsworth is the Director of Strategy in Community Corrections, a position he has held since 2013. Mr Hainsworth provided a detailed statement for the inquest which responded to questions and set out the various remedial measures undertaken by CSNSW since CS' death. The statement helpfully annexed policy material in place

at the time of CS' death, as well as a large of amount of policy material that has since been updated by CSNSW. Mr Hainsworth also gave oral evidence at the inquest.

347. Following CS' death, CSNSW undertook, at the direction of the Minister for Corrective Services and the NSW Premier, a Critical Incident Review ("**CIR**"). Mr Hainsworth was involved in an advisory capacity, and subsequently took on a lead role in the CIR. At the inquest, he gave evidence that the purpose of the CIR was not only to identify if anything could have been done to change the course of events and avoid CS' death but to isolate any broader systemic issues relevant to CSNSW and Community Corrections. The resulting report was completed by 21 March 2017, less than three weeks after CS's death.

348. The CIR report contained 10 recommendations, including:

   a. Updating certain policies;
   b. Reviewing protocols between CSNSW and GEO for release arrangements;
   c. Implementing certain compliance systems at Albury Corrections including as to the conduct of pre-release home visits;
   d. Seeking broader legislative reform to assist in managing the transition to parole for backdated sentences;
   e. Reviewing Community Corrections staff training to ensure a focus on risk assessment/management in decision making, and
   f. Reviewing information management within the OIMS system.

349. Mr Hainsworth gave evidence that he has been involved in implementing or seeking to progress those recommendations. In evidence, Mr Hainsworth stated that action had been taken in respect of all 10 recommendations, although at the time of the inquest, certain recommendations still remained "open".

350. CSNSW is to be commended for conducting such a thorough and expeditious review after CS' death. Perhaps even more importantly however, I commend CSNSW for the way in which it has sought to progress and implement the recommendations arising from the review.

The adequacy of steps taken by CSNSW to ensure a suitable residence was available for LS on and after her release to statutory parole

351. As noted at [95] above, LS was sentenced on 31 January 2017. Due to her sentence being backdated, she was released to parole the following day.

352. Mr Hainsworth confirmed that CSNSW identified deficiencies regarding LS' release to SJ's home on 1 February 2017, including that the Junee Parole Unit did not consider whether there were any significant concerns about releasing LS to SJ's address for example by reviewing OIMS records.

353. Mr Hainsworth also gave evidence that the backdating of LS' sentence prevented CSNSW from undertaking the necessary release planning (a process that would usually commence six months prior to the earliest possible release date). In particular, Mr Hainsworth gave evidence that the backdating of LS' sentence meant that:

   a. No "pre-release home visit" was ever conducted in relation to LS' release to SJ's home; and
   b. Had a pre-release visit been undertaken, it was likely that the residence would have been assessed as unsuitable due to the likely confirmation of SJ's view that she was unwilling to have LS at her home.

354. Mr Hainsworth further identified that Community Corrections failed to conduct a home visit within two weeks of LS' release, as was required, given a home visit had not been completed before release. This was because Albury Community Corrections had instigated a local order to cease home visits in Deniliquin, citing reported safety issues and workload. This was not an appropriate response.

355. I find that the concessions made by Mr Hainsworth and by DCJ in submissions were appropriate in the circumstances. The backdating of LS' sentence clearly placed both CSNSW and Community Corrections in a difficult position as regards LS' release planning. Nevertheless, it is regrettable that LS was released to live with SJ in circumstances where SJ had already taken steps to notify CSNSW that she was unwilling to have LS reside at her home with the children. LS' release to SJ's home was one of many preventable acts and omissions that significantly increased the risks presented to CS and DS.

The adequacy of steps taken in respect of LS once she was released to parole in February 2017, including having regard to the welfare of her children

356. As noted at [108], by 2 February 2017, Ms Wesley was aware that SJ did not want LS living with her. As a result, Ms Wesley was assisting LS to find alternative accommodation. The evidence establishes that Ms Wesley took clear steps to progress LS' accommodation issue, including:

   a. Telling LS to attend Vinnies;
   b. Discussing accommodation assistance; and
   c. Assisting LS to complete Anglicare forms for her own accommodation.

357. Ms Wesley was not 'passive' in her receipt of information and she actively undertook collateral inquiries to seek out important information, including from SJ, Deniliquin Police Station and LS' GP. As a result of the three parole visits in February 2017, Ms Wesley ensured LS engaged with local drug and alcohol, and mental health services, and observed LS with CS and noted the contact was 'always appropriate'.

358. As to the adequacy of the steps taken by Ms Wesley, Mr Hainsworth gave evidence that:

a. "In the short period of supervision, it is apparent that [Ms Wesley] focussed on information gathering, accommodation and referrals"; and
b. That she "took reasonable steps to manage a challenging situation, based on the information available at the time", with minor deviations from policy.

359. I accept Mr Hainsworth's analysis of the adequacy of steps taken in respect of LS once she was released to parole in February 2017 and find it to be fair and reasonable.

360. Accordingly, I am satisfied that no criticism should be advanced of Ms Wesley regarding the adequacy of steps taken in respect of LS once she was released to parole in February 2017.

The adequacy of the response of CSNSW to reports made on 1-2 March 2017

361. As noted at [124] at about 11:30am on 1 March 2017, LS had a scheduled appointment with Ms Wesley. At that meeting, Ms Wesley recorded that LS said she didn't feel comfortable at home, that she wanted her own accommodation and wanted her children to live with her. Based on this information, Ms Wesley telephoned the Deniliquin Community MHDA and explained she was sending LS over to them as she had been 'quite distraught' while at the Community Corrections office.

362. Counsel Assisting submitted that, with the benefit of hindsight, Ms Wesley could also have raised concerns with FACS regarding the prospect that LS might take her children from SJ, or to otherwise report LS' concerns that she did not feel safe. Instead, Ms Wesley urgently referred LS to the Deniliquin Community MHDA. I accept that this was a reasonable step in the circumstances.

363. Noting that Ms Wesley:

a. Sought to arrange an urgent GP appointment and then an immediate appointment with Deniliquin Community MHDA and directed LS to attend;
b. Contacted SJ to advise her of LS' presentation, with SJ confirming she would contact the police if she held concerns for herself or the children;
c. Contacted Deniliquin Community MHDA and confirmed LS' attendance, and received advice that LS had been "de-escalated" and was going to attend FACS to discuss the care of her children;

I find that the steps taken by Ms Wesley on 1 March 2017 were appropriate and reasonable in the circumstances.

364. On 2 March 2017, after receiving information from Mr Pearson at FACS about LS leaving with the children, Ms Wesley then spoke with SJ who noted she was very concerned for the safety of the children. A 'Breach of Parole Report' relating to breach of two conditions was not completed until 3 March 2017. Mr Hainsworth addressed

this delay in his evidence, stating that the report was within the 5-day time-frame and that an 'Urgent Breach Report' (used in exceptional circumstances only) was not warranted. I accept Counsel Assisting's submission that no criticism is advanced of Ms Wesley in this regard.

Whether relevant processes, policies and procedures were followed by Community Corrections on 2 March 2017 in dealing with the situation that presented on 1 - 2 March 2017

365. As to whether the applicable processes, policies and procedures were followed by Ms Wesley on 2 March 2017, Mr Hainsworth gave detailed evidence regarding the steps taken by Ms Wesley and concluded that they were in accordance with the operative policy framework.

366. I accept that relevant processes, policies and procedures were followed by Community Corrections on 2 March 2017 in dealing with the situation that presented itself.

The adequacy of those processes, policies and procedures

367. As noted, Community Corrections have made comprehensive policy changes since 2017, notably as follows:

    a. Revisions to the approach to pre-release home visits based on the new process of a 'Risk Mitigation Plan' which involves undertaking a home visit prior to release, but placing greater emphasis on identifying the risks presented by the offender to the general community and any co-residents;
    b. Professional development initiatives implemented by Community Corrections directed towards improving decision making capability of staff and management regarding understanding relevant risks.

368. I find that these changes are appropriate and considered.

369. Against the above evidentiary background, and noting in particular:

    a. The comprehensive and expeditious review undertaken by CSNSW/Community Corrections in the aftermath of CS' death;
    b. The implementation of recommendations arising from the review, to the extent feasible; and
    c. Relatedly, significant CSNSW policy changes since 2017;

    I do not consider it necessary or desirable to make any recommendations in relation to CSNSW or Community Corrections.

FACS / DCJ

370. The relevant involvement of FACS is set out at [29]-[77] above.

371. In the context of these matters, having regard to DCJ's own detailed review of the circumstances surrounding CS' death, the issues relating to FACS/DCJ were the following:

> [7]. The adequacy of any steps taken by FACS in relation to SJ's efforts to obtain legal custody of DS and CS (including the extent to which assumptions were made about her status as the primary carer, when LS in fact had legal custody of the children);
>
> [8]. The adequacy of any steps taken by FACS in response to notifications and information provided to FACS:
>
> a. in the period from release on parole to 1 March 2017; and
>
> b. in the period 1-2 March 2017.
>
> [9]. Whether the relevant processes, policies and procedures were followed by FACS on 2 March 2017 in dealing with the situation that presented.
>
> [10]. The adequacy of those processes, policies and procedures.

The Internal Serious Case Review - April 2017

372. As noted above, following CS' death, FACS conducted an ISCR. The purpose of the ISCR was to assist in identifying any systemic or practice issues and to make recommendations, where appropriate, for organisational improvement, learning and development within FACS.

373. The ISCR noted, in effect, that no one could have predicted that LS would cause serious harm to her children. However as noted in the submissions of Counsel Assisting, the evidence establishes that FACS knew LS had a history of mental illness, was using ice, was violent and that her behaviours were erratic and volatile. FACS also knew that SJ was worried LS might take the children and that LS had voiced an intention to do so on more than one occasion.

374. Ultimately, the ISCR concluded that, "the child protection system did not work well for CS and DS' family and that the lack of ongoing purposeful intervention from FACS ultimately left the boys vulnerable to harm".

375. The specific findings of the ISCR were as follows:

a) Caseworkers lacked curiosity about the family and FACS' responses to reports were not child focused, did not consider the children's experiences in the care of their family and did not recognise the risk of cumulative harm to CS and DS;
b) FACS did not undertake a holistic child protection assessment in response to reports received. FACS did not seek or share information effectively about the family with its interagency partners like NSW Health, NSWPF and CSNSW;
c) The SARA completed in January 2016 was inaccurate and did not capture the high risk that drug use, mental health and violence posed to CS and DS;
d) FACS placed too much responsibility on SJ and did not provide her with support to help her care for CS and DS or to manage LS' harmful behaviours;
e) FACS did not fulfil its statutory responsibilities to protect CS and DS from reported abuse and neglect. FACS needed to use its statutory powers to intervene and seek care orders in the Children's Court to increase safety for CS and DS.

376. The ISCR highlighted that the Deniliquin CSC is a small and isolated office with low staff numbers and a high demand for services. It is a location where FACS find it difficult to fill caseworker positions. Given the size and isolation of the office, it was identified that there was limited opportunity for guidance and support from supervisors and peers. The ISCR also found that remote location of the centre also meant that there were limited service providers in the immediate area to provide assistance to families.

377. In written submissions, the family submitted that the fact of Deniliquin CSC being a small office should not be accepted as an excuse for inaction. It is their view that FACS' failure to fulfil their statutory role and their lack of care and attention, for example by not properly documenting complaints made by SJ in the second half of 2016 and 2017, is profoundly troubling.

378. The ISCR made certain recommendations including that the report be referred to the Serious Case Review Panel to consider the practice and system issues identified.

379. On 31 May 2017, the Serious Case Review Panel considered the Review. The Panel supported the critique and findings of the Review.

Expert Evidence of Professor Judith Irwin

380. Emeritus Professor Judith Irwin is Emeritus Professor Social Work and Social Justice at the University of Sydney. She is a qualified social worker, and has a Bachelor of Social Work, a Master of Arts (Counselling) and a PhD. Professor Irwin has over 45 years of experience in social work and academia. Professor Irwin provided an expert report and supplementary report in the inquest and gave evidence at the hearing.

381. At the commencement of her report, Professor Irwin noted that "work in statutory child protection is fraught with challenges and complex decision making". However, she identified a number of significant criticisms of FACS' response to child protection reports raised in relation to CS and DS. Professor Irwin opines that steps taken by FACS to protect the children were "at times inadequate and inappropriate", mainly because decisions were inappropriately based on the assumption that SJ was the primary carer. In particular, from the period 4 February to 2 March 2017, there were numerous shortcomings in the steps taken by FACS regarding CS and DS – namely:

a. An assumption that the children were safe in the care of their grandmother, despite her not having legal custody. As LS had legal custody, there was always a possibility she could abscond with the children;
b. Although FACS acknowledged that the children would be at 'high risk' of significant harm if in their mother's care, there was no action taken to support SJ in obtaining legal custody;
c. The underlying assumption that the boys were safe in SJ's care, despite her not having legal custody, was evident in "ALL" of the decisions made when ROSH reports were referred from Deniliquin CSC to the Helpline for further assessment (including the decision on 13 February 2017 not to allocate the case to a caseworker);
d. The response to the Helpline call on 8 February 2017 in relation to the Scotts Park incident and SJ's call on 2 March 2017 should have received shorter priority response times;
e. There was no indication the caseworker, Mr Pearson, sought guidance or had supervision in the critical situation that presented on 2 March 2017; and
f. There was no evidence suggesting that the Deniliquin Community MHDA had sought to link the family to relevant services and facilitate interagency collaboration.

382. Professor Irwin also commented on the screening by the Helpline of the various contact reports received between December 2010 and 2 March 2017, identifying a number of errors in the assessment of ROSH (four of which were incorrectly screened out) and also the priority responses (some of which should have received a shorter priority response time).

383. Further, Professor Irwin stated that from the period February to 2 March 2017, there was very little communication between FACS and healthcare professionals responsible for LS, NSWPF and Victoria Police.

384. Finally, Professor Irwin was critical of the response of FACS on 2 March 2017 to the urgent situation that presented. She opined that:

a. When SJ first presented to the Deniliquin Community MHDA around 11:15am on 2 March 2017, the manager or senior staff should have been informed, and

the police contacted urgently, particularly because there was a previous assessment that the ROSH was high when the children were with LS;

b. The Deniliquin Community MHDA seemed to take quite a passive role on 2 March 2017 – it would have been appropriate to take a more active role, including by seeking information about LS' current wellbeing by contacting agencies familiar with her, such as Community Corrections, the Community Mental Health Service and her GP; and
c. Given the gravity of the situation, there should have been "much more persistence in following the situation through with the police in both NSW and Victoria".

385. While Professor Irwin noted that Deniliquin is a small rural town with limited services and resources, she considered that the lack of engagement by FACS with other local services compromised the care and protection of CS and DS.

386. Katherine Alexander, the Senior Practitioner of the Office of the Senior Practitioner, DCJ, is also the Chair of DCJ's Serious Case Review Panel. Ms Alexander has been a social worker in the area of child protection for 28 years; she has worked with DCJ for over 23 years in a variety of roles. Ms Alexander holds a Master of Social Work and certain post graduate qualifications. She is currently undertaking a PhD on decision-making in child protection.

387. Ms Alexander provided a summary of the child protection history of CS and DS.

388. Additionally, Ms Alexander commented upon the difficulties associated with Deniliquin Community CSC as a small, regional office with limited local services to provide assistance to families. She noted that cross-border issues could also impact services. As a remote regional area, the Deniliquin office has experienced challenges in filling caseworker positions. She noted that the small size of the office, coupled with the strong sense of geographic isolation meant there was a lack of opportunity for staff to gain alternative perspectives, and seek support and guidance from supervisors where needed.

389. Ms Alexander's statement, amongst other matters, responded to the criticism of Professor Irwin. Save as to certain limited matters (including comments as to the screening of particular reports), those criticisms were largely accepted. In particular, Ms Alexander agreed that:

a. FACS' actions were inappropriately based on the assumption that SJ was the primary carer and that a more active role should have been taken in monitoring her progress in seeking custody of the children through the Family Court;
b. The report on 8 February 2016 and SJ's call on 2 March 2017 should have been given a shorter response time;

c. Mr Pearson should have sought guidance from senior staff when he was informed LS had absconded with the children (although he did have contact with a range of services and individuals throughout the afternoon);
d. There is no evidence the family was referred to any support services;
e. Caseworkers should have obtained more information from healthcare professionals to inform their assessment of the report on 8 February 2017 leading up to the WAM on 13 February 2017;
f. Caseworkers should have contacted police when SJ first came into Deniliquin Community MHDA at around 11.15am on 2 March 2017 to report that LS had absconded with the children; more time should have been spent with SJ to understand her concerns and ensure police were alerted;
g. FACS should have taken a more active role, and used its statutory powers to intervene and seek care orders in the Children's Court. If the risk assessment in January 2016 correctly identified that the children were at risk, it would not have been sufficient to simply monitor SJ's progress in seeking custody through the Family Court.

390. Ms Alexander stated that in the four years since CS' death in March 2017, DCJ has implemented "a number of significant changes to provide caseworkers with the knowledge, skills and resources to be able to respond effectively to safety and risk issues for children". Those changes and improvements include:

a. Specific resourcing and supervision changes at Deniliquin Community MHDA;
b. Safety, risk assessment and risk reassessment training;
c. The implementation of a 'Supervision Policy' and leadership training;
d. The 'Caseworker Development Program';
e. Changes to Helpline screening; and
f. Improvement to information-sharing with other agencies.

391. Ms Alexander also provided a supplementary statement detailing the manner in which those changes would have operated in the particular circumstances of CS and DS.

392. I accept the criticisms of FACS' response advanced by Professor Irwin, and commend Ms Alexander and DCJ for making the appropriate changes to ensure that similar missteps do not occur in the future.

Expert conclave – Professor Irwin and Ms Alexander

393. At the inquest, an expert conclave was convened in which Professor Irwin and Ms Alexander gave concurrent evidence as to various matters.

394. As noted in Counsel Assisting's submissions, Ms Alexander gave detailed evidence concerning changes to the provision of child protection services which have been implemented by DCJ since CS' death. These changes relate to, amongst other things, safety and risk assessment tools and supervisory structures. Of particular significance

was Ms Alexander's evidence concerning the "culture of critique" within DCJ, which encouraged case workers to "admit where we get it wrong", and the importance of interagency work:

> "I absolutely agree that there has been past and certainly in some of our offices, a culture where we didn't work as closely with other agencies as we should have. My view is that is often to do with the skills and confidence of our people and the more skilled and the more confident and the more we train them, that we achieve safety for children when we work in partnership with everyone who's got something to offer. The more we do that, the more they are open to bringing other agencies in and the more we chip away at a culture that was a bit closed.
>
> So transparent reviews, our practice framework, one of its principles with that embracing a culture of critique, so it's actively encouraging people to admit where we get it wrong, to bring outsiders in, to reflect when we're not sure. So that, trying to shift that culture change, I think it tends to a very real worry that wasn't some parts of our states where we weren't actively working with interagency partners.
>
> …do we need a formal guidance to do more and better interagency work, I believe there's a lot in our system already but solid interagency work where we use our powers to seek information, share information and we bring people to the table genuinely around children, is, it's the heart of good child protection work. It's incredibly essential."

395. Ms Alexander also gave evidence regarding the operation of the Permanency Support Program ("**the PSP**") and emphasised the importance of the "skills, the understanding, the guidance, the professional supervision and support" being instilled in or provided to caseworkers to inform their decision making. Ms Alexander also provided a useful insight into the practical effects on caseworkers of creating myriad policies, rules or guideline documents:

> "…the tricky thing about our work is that when things go wrong it is so tempting - and such horrific things - it is so tempting to create more policies and more rules and more guidance and I saw a child protection system ten years ago that was overburdened by rules and tools and policies and people who didn't know how to think holistically and people who didn't know how to manage risk and they didn't know how to use skills and compassion and put themselves in families' shoes.
>
> We stripped away thousands of pages of policies and created single mandates and those mandates in our practice framework are about working for safety of children and had those mandates been followed and had a world class safety and risk assessment tool been followed with strong relationship skills, I think

there's ample guidance that would have led us to Children's Court. So I'm not - I'm not discounting the idea. I just - I'm confident that we are doing our best to help staff use their statutory powers. It doesn't mean they always will. We've got a huge diverse workforce in hugely diverse settings. I do think the guidance is there though."

396. In relation to formal court orders, Ms Alexander gave evidence that formal orders should have been in place which conferred primary care of CS and DS to SJ. She candidly accepted that this factor, along with the children being named on as PINOPs on the ADVO, "may well have made a difference" to the response from officers of the NSWPF and Victoria Police.

397. Professor Irwin also gave evidence in relation to the changes implemented by DCJ since CS' death. She acknowledged the "cultural change and a movement" concerning certain aspects of the delivery of child protection services which were "an issue in the past". In particular, Professor Irwin indicated that she was "really impressed" with the supervision and group supervision aspect of the "new agency guidelines and the new framework". Professor Irwin largely accepted the oral evidence of Ms Alexander as to those changes.

398. I accept the numerous deficiencies outlined in the ISCR. In particular, I accept that FACS caseworkers lacked curiosity about the family, and their responses to reports were not child focused. Ultimately, FACS did not fulfil its statutory responsibilities to protect CS and DS from reported abuse and neglect. However, I commend the work that DCJ has done to analyse their failures in this matter and their commitment to extracting all potential learnings from the circumstances of CS' death.

399. In their written submissions, Counsel Assisting helpfully identified a number of recommendations made to DCJ including whether they were accepted in full, accepted in part or rejected with reasons. The following recommendations to DCJ were accepted by Ms Alexander as appropriate and potentially offering some utility in practice:

   a. The provision of specific guidance directing caseworkers to critically assess ADVOs of which they are aware and where assessed as inadequately reflecting the risk to children, to seek that they be modified;
   b. The provision of guidance, in consultation between DCJ and NSWPF, regarding terminology used by NSWPF in circumstances where children are reported missing;
   c. The provision of guidance, in consultation between DCJ and NSWPF, regarding what information is relevant to categorisation and prioritisation of police actions in circumstances where children are reported missing;
   d. To include in the 'Missing Children and Young People Casework Practice Guide':
      i. Under the section titled 'Extra information needed to file a missing persons report', guidance on information to be provided, that may give rise to concern as to the welfare of the child;

ii. Specific guidance on interstate child alerts, including relevant procedures and contacts for caseworkers to notify in the event that it is suspected a child has been taken interstate;
iii. A statement to the effect that delay could increase risks to a child in the event it is suspected a child is missing; and
iv. Specific guidance regarding what steps could be taken to obtain more information to identify potential risks to a child in the event it is suspected a child is missing.

400. The following recommendations to DCJ were accepted in part or with certain provisos:

a. Regarding a recommendation to implement a policy requiring a caseworker to liaise with their supervisor proximate to making a '000' call, Ms Alexander accepted that it could be helpful to encourage caseworkers to seek the support of their supervisors in such situations. However, Ms Alexander was cautious about the logistics of implementing and monitoring such a policy, and was concerned that it may send an unintended message that caseworkers are required to seek specific guidance from their supervisors where exercising their own professional judgment. Ms Alexander otherwise accepted that DCJ could take this recommendation on notice. Professor Irwin opined that a policy requiring a supervisor be notified either before or after the 000 call would be helpful, and suggested that it could be embedded into training.
b. Regarding a recommendation to implement measures to encourage interagency collaboration within rural communities, Ms Alexander noted existing guidance on this issue. By way of example, Ms Alexander pointed to advice on the casework practice website and in the casework and development program on the topic of information sharing under s. 16A of the *CYP Act*. However, Ms Alexander accepted that it would be helpful to have a simple and readily accessible fact sheet and related guidance on interagency collaboration and liaison. Professor Irwin agreed that interagency-focused measures would be helpful, and noted (as referenced above) that a cultural shift towards interagency interactions is important and beginning to occur in Deniliquin.

401. Ms Alexander did not support the following recommendations for the reasons detailed below:

a. As to a recommendation for specific guidance encouraging caseworkers to take steps to seek orders in circumstances where a child is assessed as being at risk of harm when in the care of a legal parent, Ms Alexander disagreed on the basis that the there is sufficient existing guidance for caseworkers on when to exercise their statutory powers. As outlined above, she noted that too much specific guidance creates a system overburdened by rules and policies, disempowering caseworkers from thinking "holistically" or being "curious". However, Ms Alexander accepted that simple guidance in circumstances of urgency would be helpful for caseworkers. For her part, Professor Irwin opined

that specific guidance on this topic would be helpful, particularly in light of her concerns that caseworkers may be unduly distracted if there are proceedings in both the Family Court and Children's Court.

b. As to a recommendation regarding specific guidance on the potential consequences of the presence of orders on police responses in the event of a missing child, Ms Alexander reiterated her concern that the creation of factsheets attempting to cover every situation would disempower caseworkers from using their professional training and skills to react to complex situations. Ms Alexander considered caseworkers were adequately trained in this area (regarding the interaction of orders and police responses) through the caseworker development program and local access to care and protection legal officers. Professor Irwin agreed that the complexity of the work makes it difficult to capture everything in a factsheet, and that guidance on the issues is available in the safety and risk assessment.
c. As to the potential for using this matter as an anonymised case study to inform training, Ms Alexander and Professor Irwin both considered the circumstances to be too identifiable. They agreed, however, that there is a benefit to drawing on themes arising from the matter to inform future practice. Ms Alexander raised themes of poor assessment and supervisory processes. Professor Irwin raised themes of interagency responses, safety and risk assessments including those conducted via the Helpline, casework allocations at DCJ Community Services Centres, and the appropriateness of court orders.

402. In written submissions, Counsel Assisting proposed four recommendations aimed at providing training to FACS officers in relation to, broadly:
    a. The significance of custody orders where a child is removed from their usual carer;
    b. The significance of an ADVO naming a child as a PINOP where a child is removed from their usual carer;
    c. The importance of risk assessment in circumstances where it appears a child may be removed from their usual carer; and
    d. Steps that can be taken when a child is removed from their usual place of residence, including how information can be communicated to police.

403. In their written submissions, DCJ resisted each of the four recommendations proposed by Counsel Assisting on the basis that they were either unnecessary in light of the evidence or overtaken by changes to practice at DCJ since 2017.

404. I am conscious of the concerns raised by Ms Alexander about not creating "more policies and more rules and more guidance" when the system goes so wrong, and also, the importance of holistic and curious thinking by caseworkers.

405. However, I am persuaded by the submission of Counsel Assisting that the emphasis in the four proposed recommendations is upon the training of caseworkers, and not on

the creation of additional policy or procedural material that may be overly burdensome on the case workers. Accordingly, I recommend that DCJ:

1. Ensure that DCJ officers and employees receive training as to:
    a. the significance of whether orders in relation to care and custody are in place in the event that a child or children are removed from their usual carer;
    b. the significance of whether an ADVO naming a child or children as a PINOP is in place in the event that a child or children are removed from their usual carer;
    c. the importance of assessing the risk that a child may be removed from their usual carer when information suggesting a possibility of that is received by DCJ.
2. Prepare a simple fact sheet along the lines of that prepared in 2017 in respect of health and education to be used by DCJ employees, and upon which DCJ employees should be trained.
3. Ensure that DCJ officers receive training in relation to steps that can be taken in the event that a child is removed from their usual place of residence, including:
    a. appropriate means of communicating that information, and updating information, to police;
    b. what information is of particular relevance for the purpose of 000 calls and other communications with police;
    c. interstate communication of information;
    d. the need for risk assessment on an ongoing basis in such circumstances, and the appropriate sources of information that should be accessed, including from other agencies;
    e. the need for ongoing communication with police to inform them of any relevant information and any risk assessment.
    f. the range of orders and warrants that are available, and the circumstances in which employees of FACS should seek or should provide input for the purpose of others seeking those orders or warrants.

Victoria Police

406. The relevant involvement of Victoria Police is set out at [78] – [80] and [235] – [247], [250]-[274], [290]-[324].

407. Having regard to that evidentiary background, the matters in the list of issues relating to Victoria Police were:

> [11]. What information was provided to Victoria Police by Tim Pearson during the '000' call at 1.03pm on the afternoon of 2 March 2017 and subsequently to Senior Constable Scherger around 1.45pm and what priority and classification was accorded the matter?

[12]. The adequacy of any communication or information-sharing that occurred as between Victoria Police and the NSW Police Force in relation to LS or the children (noting in particular, the issue re cross-border policing of the Echuca/Moama area).

[13]. The adequacy of any steps taken by Victoria Police in response to the "concern for welfare/child abduction" "000" call. Whom was in charge and what approach was taken?

[14]. Whether applicable processes, policies and procedures were followed.

[15]. The adequacy of those processes, policies and procedures.

Failure of Victoria Police to conduct a remedial review

408. Victoria Police did not conduct any formal debrief regarding its response to the incidents of 2 March 2017.

409. As noted in Counsel's Assisting's written submissions, prior to the inquest, a response on behalf of the Victorian Chief Commissioner of Police advised that:

a. The matter was not reported as an abduction and was not treated as such by the responding units;
b. As to whether the matter was ever considered a "missing persons" investigation, "Victoria Police was never advised that this was a missing person event"; the caller (Mr Pearson) was aware of LS' location at the time of the call. To that end, "A person is not a 'missing person' simply by virtue of police being unable to locate the person at their last known location just minutes before." Victoria Police were not aware of the reports by SJ;
c. As to whether the appropriate level of urgency was attributed to the job, there is no evidence to suggest that Victoria Police's response was delayed in any way;
d. As to cross-border policing arrangements between the NSWPF and Victoria Police, the coronial brief of evidence indicates that at all times when Victoria Police were seeking to locate LS, she was either in Goornong or Elmore, or was in a vehicle travelling south toward Bendigo; there was no information suggesting she was travelling north towards the NSW border, which may have necessitated this information being passed onto police at Moama or elsewhere in NSW. Victoria Police did not have any contact from the NSWPF about LS or her children having been reported as missing, or any other investigations concerning LS; no evidence suggests Victoria Police was ever informed that LS was a missing person.
e. As to whether, with the benefit of hindsight, any additional steps could or should have been taken by Victoria Police to locate LS and her children, "It is not appropriate at this time for the CCP (or their representative) to comment

about whether any additional steps should or could have been taken by attending members in circumstances where no formal review or investigation of the response was undertaken by Victoria Police."

410. I find that Victoria Police's failure to conduct any sort of review or to identify steps that could or should have been taken to locate LS and her children to be troubling.

411. I am satisfied that Victoria Police's failure to undertake a review warrants further consideration by the executive of the Victoria Police Force with a view to considering why such a review did not occur, whether appropriate processes and procedures are now extant to ensure that the situation would not repeat, and to ensure that in appropriate circumstances, reviews are conducted in a timely fashion with a suitable level of rigour.

Submissions on behalf of the Victorian Chief Commissioner regarding hindsight bias and imputed knowledge

412. Written submissions on behalf of the Victorian Chief Commissioner of Police underline the dangers of so-called hindsight bias, that is, the evaluation of the actions or omissions of involved officers through the prism of the known outcome of a case – in this case the tragic death of CS – rather than on the basis of the knowledge that was available to them at the time. In particular, it was submitted that:

    a. "While witnesses were repeatedly asked to concede errors in their own actions with the benefit of hindsight, it was not suggested or acknowledged during the hearing or in submissions by Counsel Assisting that there is any fundamental difference between hindsight knowledge and foresight knowledge"; and that
    b. The Court "should not evaluate the response by Victoria Police through the prism of the tragic outcome in this case as the result is it not only unfairly assesses those who are working without the benefit of hindsight (as is afforded to the Court) but it also prevents any real lessons being learnt, as those personnel at the coalface in future will only ever be armed with foresight, not hindsight."

413. I accept that the appropriateness of steps taken by an individual or agency in an inquest must be assessed against the information available at the time and not based on the known outcome of the case. It is an important distinction to make, and I accept that to do otherwise would, as is submitted by the Victorian Chief Commissioner of Police, unfairly assess the actions of those working without the benefit of hindsight.

414. However, I am satisfied that in this inquest, those assisting have not sought to impute knowledge to Victoria Police that was not known at the time. On the contrary, in examining the Victoria Police witnesses, and in the absence of a contemporaneous review, Counsel Assisting went to great lengths to establish what information was or was not known to involved officers at a particular point in time in order to enable this

Court to assess fairly the adequacy of that officer's response. Where witnesses were asked to concede whether, with the benefit of hindsight, they might have acted differently, the distinction in such a concession is well understood by this Court and has been appropriately taken into account in the making of any finding or recommendation.

415. Clearly, coronial inquests, by their very nature, occur after the event and therefore can give rise to the possibility of hindsight bias. However, as I have already noted, coronial inquests routinely consider whether, armed with the knowledge available to them at the time, a party could have or should have acted differently in the particular circumstance that presented themselves. It is both entirely appropriate to do so and is, in my view, one of the fundamental aspects of the coronial jurisdiction.

416. Against this backdrop, I find the submission of the Victorian Chief Commissioner of Police that the evaluation of Victoria Police's response through the prism of the tragic outcome of this case prevents any real lessons being learnt to be troubling. As has been demonstrated by the proactive remedial reviews undertaken by other agencies in this inquest, it is possible for much to be learned through a rigorous and timely review that appropriately evaluates the acts and omissions of a particular individual against the information known to them at the time. To that end, I find it regrettable that no such review of this matter was conducted by Victorian Police.

Failure of Victoria Police to give proper consideration to the risk of harm to DS and CS

417. I am satisfied that the evidence establishes that following Leading Senior Constable Scherger's conversation with the ESTA operator at 1:13pm on 2 March 2021, Leading Senior Constable Scherger had been informed that:

   a. An ice-affected mother had taken her two children from their grandmother in NSW;
   b. The mother had called from a shopping centre or similar in Goornong,
   c. The mother had mental health issues;
   d. The grandmother had applied for custody of the children through the Family Court; and
   e. Police had been asked to conduct a welfare check in relation to the children.

418. Leading Senior Constable Scherger accepted in oral evidence that the information provided to him by the ESTA operator suggested the children were potentially at risk of harm and that he knew that at the end of the call.

419. As regards Leading Senior Constable Scherger's insistence that LS' call related to Huntly and not Goornong, I accept Counsel Assisting's submission that rather than ruling out the possibility that LS might indeed have been calling from Goornong,

Leading Senior Constable Scherger could have asked for calls to have been made to the shop in Huntly and the "single milk bar" in Goornong to confirm LS' last location.

420. However, having incorrectly assumed that LS had called from the IGA in Huntly, Leading Senior Constable Scherger drove to Huntly where, having not entered the IGA to speak with the owner or make any further inquiries, he reported "Nil Results".

421. In addition to the information provided by the ESTA operator at 1:13pm, I am satisfied that the evidence establishes that following his conversation with Mr Pearson (which likely occurred sometime before 1:23pm in accordance with Mr Pearson's file note), Leading Senior Constable Scherger was made aware that:

    a. It was possible that LS was suicidal;
    b. LS was suffering from a mental illness;
    c. LS had indicated to SJ that "you will never see us again";
    d. Mr Pearson was of the view that:
        i. there were immediate concerns for the welfare of the children; and
        ii. the location of the children was to be treated as a matter of urgency.

422. Despite accepting that he was aware of the above information, during the course of his oral evidence, Leading Senior Constable Scherger did not accept that he needed to treat the recovery of the children as a matter of urgency.

423. I accept the submissions of Counsel Assisting that, given the information available to him, and in circumstances where a case worker has explicitly indicated that the location of the children should be treated as a matter of urgency, it is difficult to understand how Leading Senior Constable Scherger could have come to this view, either at the time, or with the benefit of hindsight.

424. At 2:06pm, less than an hour after having been contacted by the ESTA operator and in relation to a welfare check on CS and DS, Leading Senior Constable Scherger's CAD system records that the event was closed. I am satisfied that, following the closure of the event at 2:06pm, no steps were taken by Victoria Police to formally task any unit with continuing to search for LS and the children (as opposed to the steps taken in relation to the "suspicious vehicle" located at the BP service station at Elmore).

Sergeant McDermott's decision not to order a phone triangulation

425. As outlined at [256], Sergeant McDermott gave evidence that he did not believe at that time, based on the intelligence provided to him, that the criteria for requesting a phone triangulation under s. 287 of the *Telecommunications Act 1997* (serious and imminent threat to the life or safety of a person) had been met.

426. Sergeant McDermott's evidence is that, at the time, he was aware that:

a. The children were under 10 years of age;
b. LS was said to be ice-affected; and
c. Mr Pearson had indicated that locating the children and LS should be treated as a matter of urgency.

427. Sergeant McDermott accepted in oral evidence that, based on the above information, there was a concern for welfare for the children.

428. Sergeant McDermott gave evidence that he was not aware that LS has said to SJ words to the effect of "you will never see us again". He gave evidence that even if he had been aware of that information at the time, he still would not have considered the criteria for a phone triangulation to have been met.

429. The Victorian Chief Commissioner of Police submitted that the threshold for the ordering of a phone triangulation is a very high one, given it involves the use of private information to confirm a person's location and that a concern for welfare alone does not meet the required criteria of the provision. Indeed, it is the submission of the Victorian Chief Commissioner of Police that any request by Victoria Police for a phone triangulation would have been unlawful in the circumstances.

430. Counsel Assisting submitted that, notwithstanding the high threshold, it is simply not possible to know now whether Sergeant McDermott may have taken a different approach if he had been more fully informed, in particular, with regard to LS comment that "you will never see us again".

431. I am satisfied that Sergeant McDermott was aware that LS was ice affected, had mental health issues, and that concerns had been expressed for the welfare of the children. I accept that Sergeant McDermott was not aware that LS had said to SJ words to the effect of "you will never see us again". Based on the evidence of what Sergeant McDermott knew at the time, it was not unreasonable for him not to order a phone triangulation.

The Victoria Police Missing Persons Policy

432. The Victoria Police Missing Persons Policy in force on 2 March 2017, identifies a missing person as any person reported to police:

a. Whose whereabouts are unknown; and
b. There are fears for the safety, or concern for the welfare of, that person.

433. According to this policy, members are required to immediately investigate any report of a missing person, a missing persons report and risk assessment form should be completed, among other forms of reports. Where a missing person is under 10 years of age, the investigating member should start an immediate search, notify the

Divisional Patrol Supervisor, and consider notifying the Police Communications Centre. There are specific procedures where persons may be missing in Victoria.

434. With regard to the relevance of the Missing Persons Policy in this inquest, the Victorian Chief Commissioner of Police submitted that there is no way in which this case could be said to meet the criteria of a missing person under the policy and that any conception that LS or the children were missing persons proceeds on a "factual and legal fallacy".

435. There is no evidence to suggest that at any time on 2 March 2017 Victoria Police received a formal report that LS and the children were missing. However, on the basis of Sergeant McDermott's evidence, I am satisfied that given that he knew there was a concern for the welfare of the children and that their whereabouts was unknown, he could have considered whether the children met the criteria of missing persons and therefore whether the situation required an immediate police response. Sergeant McDermott's evidence was that he did not do so.

436. I acknowledge the difficulty in reaching any definitive conclusion as to the potential outcome in this case had there been active consideration of the application of the Missing Persons Policy. However, I am satisfied that if a missing persons report had been made and an immediate police response required, there is, at the very least, a possibility the tragic course of events may have been altered.

Failure to give proper consideration to the risk of harm to DS and CS following the sighting at the BP in Elmore

437. At 3:53pm on 2 March 2017, Leading Senior Constable Goyne responded to a dispatch report that LS had been sighted at the Elmore BP service station and that police were to keep a look out for a white Holden Cruze (see [292]-[322] above). Following a number of radio communications between Leading Senior Constable Scherger and Leading Senior Constable Goyne, the evidence indicates that shortly after 3:53pm, Leading Senior Constable Goyne was made aware that:

   c. The car also contained two young children;
   d. The mother had taken the children from their grandmother and indicated "you will never see us again";
   e. The mother was suffering from a mental illness; and
   f. The mother was possibly suicidal.

438. Given that Mr Pearson had stressed that there were 'immediate concerns' for the welfare of CS and DS I find it particularly concerning that, having been notified that LS had been sighted in Elmore BP service station at 3:53pm, all responding units were 'cleared' from the event at 4:15pm.

439. The Victorian Chief Commissioner of Police submitted that while no formal KALOF was requested of an ESTA dispatcher after 1:27pm, it is plain from listening to radio transmission between 3:50pm and 4:14pm that the transmission is being heard by police units and is being actively monitored by supervising sergeants in Bendigo and Echuca. The Victorian Chief Commissioner of Police submitted that it is therefore artificial and inaccurate to say that the only KALOF was made at 1:27pm as police units on the road from Echuca to Bendigo and in between and their supervising sergeants were aware to keep a look out for LS and her children/vehicle at all relevant times.

440. Although there were "several announcements for members in the area to keep a look out for LS and her vehicle from the time of the first call", I am satisfied that the evidence is that there was only ever one formal KALOF broadcast on 2 March 2017 in relation to the incident, and that was the one that occurred at 1:27pm. There is no evidence that any Victoria Police officer, beyond Leading Senior Constable Scherger, took any active steps in response to this KALOF broadcast. I am satisfied that the evidence suggests that nothing further was done by way of "active involvement" of any Victoria Police officer after 4:15pm. It is not apparent that Victoria Police sought any further information in relation to LS or her children after the vehicles were 'cleared'. There was no contact with the NSWPF at any time, although it was known that LS resided in NSW with her grandmother and the children.

441. With regard to the adequacy of the response by Victoria Police on 2 March 2017, I am satisfied that the evidence is that by at least 2:06pm on 2 March 2017, Victoria Police were aware of the following information:

   a. An ice-affected mother had taken her two children from their grandmother in NSW;
   b. The mother had called from a shopping centre or similar in Goornong;
   c. The mother had mental health issues;
   d. The mother was possibly suicidal;
   e. The grandmother had applied for custody of the children through the Family Court;
   f. The mother had indicated to the grandmother that "you will never see us again";
   g. Police had been asked to conduct a welfare check in regards to the children;
   h. The FACS officer who made the 000 call was of the view that:
      i. there were immediate concerns for the welfare of the children; and
      ii. the location of the children was to be treated as a matter of urgency.

442. On the basis of the above available information, I find that the incident warranted an urgent and ongoing response from Victoria Police consistent with protecting the welfare of two vulnerable young children and that the response was neither urgent nor ongoing. Victoria Police officers appear to have failed to appreciate the potential risk of harm that LS posed to her children.

443. Accordingly, I make the following recommendation:

That Victorian Chief Commissioner of Police:

1. Improve policies and practices so as to ensure clear guidance as to:
    a. The need for active consideration of the missing persons policy when a child is removed from their usual residence without the consent of their usual carer, including the performance and documentation of a risk assessment to determine whether a missing person's report should be made;
    b. Procedures to ensure all known information that could be relevant to a risk assessment is accessed for the purpose of determining whether a missing persons report should be made; and
    c. The need for a 'cautious' approach where police are called to conduct a welfare check on vulnerable persons (such as children), and associated policy and training as to this aspect.
2. Consider the extent to which the tragic circumstances of CS' death, in de-identified form, might form the basis for 'case studies' emphasizing the importance of a cumulative and holistic consideration of information held by agencies.

NSWPF

444. The relevant involvement of NSWPF is set out at [80]-[103], [164]-[205].

445. Against that evidentiary backdrop, the following matters arise for consideration with respect to the response of the NSWPF:

> [16]. The adequacy of any steps taken by the NSWPF in response to the concern for welfare/missing children reports.
>
> [17]. Whether the NSWPF should have taken steps to have the children added to the ADVO taken out on a provisional/interim basis in January 2016 and on a final basis on 3 May 2016, which listed only [SJ] as the 'person in need of protection'.
>
> [18]. Whether applicable processes, policies and procedures were followed.
>
> [19]. The adequacy of those processes, policies and procedures.

Failure of NSWPF to conduct a remedial review

446. The Court heard evidence regarding the failure of NSWPF to conduct a remedial review. This is addressed in Counsel Assisting's written submissions at [458]-[462].

447. Counsel Assisting has submitted that, given the events that transpired in the 16 hours after SJ notified two NSWPF officers that LS had disappeared with the children, the

failure of the NSWPF to conduct any review or analysis of its potential involvement is troubling. Further, Counsel Assisting submitted that the NSWPF cannot hope to have any real understanding of the extent to which any systemic issues may have contributed to the tragic death of CS.

448. Counsel Assisting submitted that, in stark contrast to the reviews undertaken by both DCJ and the MLHD, the NSWPF did not undertake any review of the circumstances of their involvement in the leadup to CS' death to interrogate the adequacy of the NSWPF response.

449. Counsel Assisting further submitted that, absent thorough and substantive reviews, to properly comprehend the extent to which (if at all) systemic failings or acts or omissions may have contributed to the outcome, it is not possible for agencies to know whether their actions were deficient, how that may have contributed to a tragic outcome, and how they can ensure that mistakes did not happen or can be prevented in the future. In this regard, a commendable "culture of critique" is exemplified by the response of MLHD, CSNSW and DCJ - that is, a genuine desire on the part of those agencies, to understand potential shortcomings and reflect on all possible learnings.

450. In written submissions, the NSWPF contended that it is not accurate to say that they did not conduct *any* review, and refer to a 15 page briefing paper prepared for the Commissioner at the request of the Minister of Police seeking "a comprehensive briefing on the NSWPF involvement in the matter". The NSWPF also noted that significant changes had been made to the Missing Persons Policy since 2017 and further changes to the SOPs are in the process of being approved with a view to incorporating the recommendations proposed in this inquest.

451. Further, the NSWPF noted that CS' death has created several learning opportunities within the Murray River Police District ("**MRPD**") in the area of communication between agencies and the establishment of Safety Action Meetings. Those meetings are designed to facilitate information sharing between service providers. The NSWPF submits that the MRPD has also strengthened relationships and communication with partner agencies.

452. I consider that the 15-page briefing paper prepared on behalf of the Commissioner in fact contained a paucity of actual analysis as to the adequacy of the response of involved officers. By NSWPF's own admission, the briefing paper was prepared to assist in responding to media reports at the time alleging government agency failures contributed to the death of CS. It was not prepared as part of a genuine review of any shortcomings in NSWPF's response. During the completion of the briefing paper, there was no attempt to obtain information from SJ, the person at the centre of NSWPF's response.

453. While changes to the Missing Persons Policy and SOPs and information sharing arrangements in the MRPD are of course welcomed, these changes are not the result of any review, and should not be seen as a substitute for such.

454. I find that the NSWPF's submission that it is not accurate to say that the NSWPF did not conduct any review is lacking in credibility. The steps outlined by the NSWPF in written submissions do not, on any view, constitute a genuine internal review of the adequacy of the NSWPF's response, and to submit that they in some way do displays a disappointing lack of insight on the part of the NSWPF as to what a review of police involvement requires.

455. I am satisfied that the NSWPF's failure to undertake a review warrants further consideration by the executive of the NSWPF with a view to considering why such a review did not occur, whether appropriate processes and procedures are now extant to ensure that the situation would not repeat, and to ensure that in appropriate circumstances, reviews are conducted in a timely fashion with a suitable level of rigour.

Non-inclusion of children as PINOPs in ADVO

456. A central issue relating to the NSWPF concerned the non-inclusion of CS and DS on the ADVO made in 2016, which did not name the children as PINOPs. I considered the relevant factual background underscoring this issue at [89]-[94].

457. As regards the inclusion of the children as PINOPs in 2016, Professor Irwin gave expert evidence that: "If there had been an AVO protecting the children, the police response may have been different on 2 March [2017]". In particular, she opined that given the police incidents where the children were exposed to LS' violent behaviour, "if there had been an AVO protecting the children this may have meant that the police may have been more proactive in trying to locate the children." As noted above, Ms Alexander agreed that this "may well have made a difference" to the response from officers of the NSWPF.

458. Senior Constable Grace Beasant is a Project Officer within the Domestic & Family Violence Team of NSWPF and has been since 2019. The Domestic & Family Violence Team is the "corporate business owner" of the NSWPF DV SOPs. The DV SOPs "outline the expected policy and practices to be used in the NSW Police response to domestic and family violence incidents or reports". In their written submissions, Counsel Assisting helpfully summarised the opinion proffered by Senior Constable Beasant which I have extracted below.

459. In relation to the non-inclusion of CS and DS in the ADVO, Senior Constable Beasant stated that the "relevant provisional and subsequent interim order provided protection to the children by the extended coverage of the mandatory orders as they were in a defined domestic relationship with the listed person in need of protection, SJ. The protection provided by the mandatory orders would speak to the safety concerns raised by SJ and obligations under the DV SOPS".

460. However, Senior Constable Beasant noted that Sergeant Cookson, as the issuing officer at the time of making the provisional order, had an obligation to include the relevant children with whom the primary protected person has a domestic relationship, unless satisfied there were good reasons for not doing so (per 38(3), *CDPV Act*). She also stated that, "Once the provisional order has [been] issued, the legislated onus for compliance with s 38 at the subsequent points of making an interim and then a final order lays with the relevant judicial officer".

461. Senior Constable Beasant went on to state that whilst it was "possible" for Sergeant Cookson to include the children as protected persons so that the additional non-mandatory conditions would apply, "… in my experience the inclusion of children by police and the courts is generally limited to situations where the children are the actual victims of domestic violence". Ultimately, Senior Constable Beasant states that based on the "practical approach" to s. 38 of the CDPV Act, "it cannot be said there was non-compliance from relevant policies, processes and procedures, noting the protection given to the children by the extended application of the mandatory orders".

462. In light of the oral evidence of Ms Hyne and Sergeant Cookson, Chief Inspector Sean McDermott, Manager of the Domestic and Family Violence Team within the NSWPF was called to give evidence at the inquest. I accept Counsel Assisting's characterisation and summary of his evidence which is extracted below.

463. Chief Inspector McDermott gave evidence that, although SJ identified that she was taking steps to get custody of CS and DS, this "fact alone" would not necessarily suggest some risk of harm to the children. However, he agreed that it would suggest that "the grandmother had concern about the safety of the children in relation to them being with the mother or at least be (sic) having the parental custody of the mother". Accordingly, Chief Inspector McDermott said he would have interrogated that fact and asked SJ why she saw this as being an issue. Chief Inspector McDermott have evidence that, in his view, this was the "obvious question".

464. Chief Inspector McDermott also considered the fact that SJ was the primary carer of the children to be a relevant factor.

465. Taking a general approach to ADVO matters, Chief Inspector McDermott accepted that children should be included as named persons unless there are good reasons not to do so. However, this approach is premised on an understanding of s. 38 being applied to generally intimate partner violence relationships. On a literal reading of ss. 38(2) and (3), CI McDermott also accepted that by virtue of their domestic relationship with SJ, the children should have been included as protected persons under the ADVO.

466. On the basis of the above evidence, I am satisfied that, as the "issuing officer" under the interim ADVO, Sergeant Cookson was under an obligation to include CS and DS as named persons unless there were "good reasons not to do so". Chief Inspector

McDermott accepted that under the *CDPV Act*, any reasons for not including the children on the order should have been recorded in writing. When asked whether the DV SOPs should be amended to draw attention to the specific requirement that police officers record their reasons in writing, Chief Inspector McDermott offered an alternative. He suggested that the "better course of action" would be to build into the AVO application system within COPS a mandatory field requiring that any reasons be recorded.

467. Counsel Assisting examined Chief Inspector McDermott regarding aspects of the evidence of Sergeant Cookson and Ms Hyne, particularly regarding their misapprehension that the children were automatically covered by the standard and additional conditions of the ADVO. Chief Inspector McDermott was asked whether it would be beneficial for NSWPF officers to be trained on the extent to which children are automatically covered by ADVO orders. He offered the following response:

> "Well for those two particular officers clearly that evidence they would need training. In terms of widespread training I can say this, that is not an apprehension held by most police officers in the field. Because by the actual reading of the order, it says what it says. The standard orders clearly only say domestic - other parties domestic relationship. So I - I'm not sure I can say there's a widespread benefit of that training to extrapolate the lack of knowledge of those two officers."

468. In terms of ameliorating the risk presented by officers who do not have a great deal of experience in the *CPDV Act* or DV SOPs, Chief Inspector McDermott noted the review mechanism built into the *CPDV Act* where the Court is able to take action themselves.

469. Chief Inspector McDermott was also taken to the evidence of Sergeant Cookson and Ms Hyne regarding the meaning of "indirect violence". When asked whether the COPS system should set out the meaning of indirect violence, Chief Inspector McDermott indicated:

> "I think the - the matter be best dealt with by imposing a - an obligation - sorry, bringing to the attention of the adjudicating officer, the senior police officer, his obligations or her obligations under section 38. And that will prompt further enquiries. And because these supervisors are generally the team leaders of said police, it will become very quickly a habit for them to ensure that they have that material in if it's not already in there, in their application."

470. Chief Inspector McDermott was not aware of whether officers receive any training on the possible consequences of not including children as PINOPs in an ADVO.

471. As submitted by Counsel Assisting, the breach of an ADVO is a criminal offence under s. 14, 'Offence of contravening apprehended violence order' of the *CDPV Act*. The DV SOPS mandate that: "Breach AVO is a criminal offence and MUST be fully investigated".

Further, "Where evidence supports a breach, give strongest consideration to exercising your powers in favour of arrest". Given the information from SJ suggesting that LS may have been ice-affected on 2 March 2017 and in light of the suggestion by Mr Holloway that police had no power to take steps, I am satisfied that action might have been taken or available to police, had the ADVO named CS and DS as PINOPs.

472. Had the children been named in the ADVO, the additional condition as to LS not approaching them within 24 hours of consuming illegal substances would have been operative. Additionally, in accordance with the evidence of Detective Inspector Browne (set out below at [483]), the children would have satisfied the definition of a missing person under the MP SOPs.

473. I am satisfied that, had the children been named as PINOPs on the ADVO, and had the additional condition applied, this may have significantly altered the options available to NSWPF in terms of their response on 2 March 2017.

474. As is noted by both Counsel Assisting and the NSWPF in submissions, the precise nature of the options available to police is necessarily speculative. Clearly however, LS was extremely mentally unwell. A brief review of Mr Cooper's statement shows her volatility and obvious signs of mental health break-down in the week prior to CS' death, including on 1 and 2 March 2017. In those circumstances, it can never be known whether a different outcome may have resulted had LS been intercepted by police (whether by the NSWPF or Victoria Police) at any time. It is not inconceivable that her mental health deterioration would have crystallised upon such interaction, with immediate risks of harm to the children then obvious to attending police.

475. As outlined above at [92], Sergeant Cookson and Ms Hyne erroneously thought that CS and DS were automatically captured by both the mandatory and additional conditions in the ADVO. I am satisfied that both officers clearly failed to appreciate LS' behavioural history and the prior exposure of CS and DS to her violent conduct. Sergeant Cookson's evidence was particularly concerning given his role as approving officer and his disinclination to make additional enquiries of a "victim" unless he "really needed to find out further information". The importance of making an informed decision when approving an ADVO cannot be understated, given the potential consequences.

476. Despite the evidence of Chief Inspector McDermott, in light of the senior positions occupied by Sergeant Cookson and Ms Hyne in January 2016 and the troubling shortfalls in their knowledge regarding the significance of listing children as PINOPs, I find that there is merit in the NSWPF offering additional training on this issue. Such training would safeguard against other officers of the NSWPF proceeding on the misapprehension that children are automatically covered by the totality of conditions in an ADVO by virtue of a "domestic relationship" with the PINOP.

477. As previously noted at [94], both Sergeant Cookson and Ms Hyne accepted that this case could offer a valuable learning or training opportunity for officers in the NSWPF.

478. Further, I accept the submissions of Counsel Assisting that Chief Inspector McDermott's compelling evidence concerning the utility in updating the AVO application system within COPS may offer a further safeguard. The proposed update would involve the addition of:

   a. An alert which identifies to an adjudicating NSWPF officer his or her obligations pursuant to s. 38 of the *CDPV Act*; and
   b. A mandatory field requiring that any reasons required by s. 38 of the *CDPV Act* be recorded in writing.

479. Such an update would serve to clarify the legislative requirements under the *CDPV Act* and ameliorate the capacity for human error, such as was evidenced in the present facts.

480. Having regard to the above evidence, the following recommendations are proposed in relation to NSWPF ADVO policy and training:

   1. The addition of the following features to the AVO application system within COPS:
      a. An alert which identifies to an adjudicating NSWPF officer his or her obligations pursuant to s. 38 of the CDPV Act (including a reference to the potential existence of indirect violence).
      b. A mandatory field requiring that any reasons as required by s. 38 of the CDPV Act be recorded in writing; and
   2. Review of the DV SOPs and associated training to ensure that the significance of listing children as PINOPs is well understood; and
   3. Consideration of the extent to which the tragic circumstances of CS' death, in de-identified form, might form the basis for 'case studies' emphasising the significance of listing children as PINOPs, including as regards the availability of police responses.

481. In this regard, I note that NSWPF has been proactive in taking steps to implement recommendations 1(a) and 1(b). The NSWPF is to be commended.

Missing Person SOPs (2013)

482. At [488] – [491] of Counsel Assisting's written submissions, the evidence in relation to the MP SOPS is set out as follows:

> In March 2017, the NSWPF Missing Persons SOPS were the 2013 version which were reviewed and updated in June 2016 (MP SOPS (2016)). In the opening section, it is noted: "Ultimately, however police response [to a missing persons report] could make the difference between life and death". Further, "Police

must ensure that reports are taken seriously, risks are assessed, investigations commenced and continued, families kept informed and relevant information is cross referenced to resolve MP matters professionally, efficiently and sensitively." The MP SOPS (2016) are said to "establish the minimum standards for NSWPF officers in their day-to-day management of MP matters".

The MP SOPS (2016) define a missing person (relevantly) follows:

> "A missing person is anyone who is reported to police, whose whereabouts are unknown, and there are fears for the safety or concern for the welfare of that person."

Amongst other matters, the MP SOPS (2016) state that:

a. In responding to a missing persons report, the NSWPF will: "Conduct a risk assessment to inform the appropriate level of investigative response";
b. "Investigative actions should be informed by the initial and ongoing risk assessments, as well as by considerations and procedures related to any relevant Special Missing Person Types" (which includes children);
c. The officer taking the missing persons report is deemed the Investigating Officer (or Officer in Charge – OIC) and is responsible for exhausting all avenues of inquiry until the MP is located or the investigating role is otherwise transferred;
d. The Duty Officer is responsible for ensuring and being accountable for the assessment of and initial response to all missing persons incidents;
e. The requirements for the 'Initial Report' – namely, that "if the definition for a missing persons is met, then the report must be taken"; amongst other things, the Investigating Officer must conduct a Risk Assessment and record the result in COPS;
f. The Risk Assessment is a "critical process for all MP matters and it should directly inform the level of response from NSWPF"; further, a "risk assessment must be conducted on receiving a MP report"; the risk rating allocated should be reviewed and re-evaluated throughout the investigation, whilst the person remains missing;
g. "A MP matter can only be finalised when the MP is actually located", which requires that the missing persons is sighted and their identity confirmed by police (or certain other specified persons); further: "Do not accept second hand reports or over the telephone reports"; a 'Located Person' incident is also created on COPS when a missing person is located alive;
h. In section 9, "Special Missing Person Types", if a child goes missing:
    i. Take a report and capture all possible information about likely risk factors;
    ii. Include a 'Child/Young Person at risk' incident in the COPS event;

iii. When conducting the risk assessment, emphasis should be placed on the concern for welfare of the child, and efforts made to determine why the young person is missing;
iv. Various levels of senior police should be involved (i.e. Supervisor/Duty Officer, and the Crime Manager, Investigations Manager or Crime Coordinator);
v. Advice should be obtained from the (then) MPU;

i. In section 9.2d 'Parental Abductions', "Children that are the subject of parental abductions fit the NSWPF definition of a missing person"; further: "Police should take MP reports of these children in all circumstances, irrespective of whether Family Law proceedings have been instituted …";
j. In section 9.2e 'Locating a Missing Child or Young Person', "the child or young person, like other MPs, must be sighted by police or a person in authority on their return";
k. In 'Annexure 2: Missing Person – Risk Assessment', a number of factors are set out, including:
    i. "3. Is this missing person suffering from any serious mental or physical disability";
    ii. "5. Is this missing person under 14 …";
    iii. "13. Does the missing person have a serious drug or alcohol dependency?";
    iv. "19. Are there any other unlisted factors which the officer, family or person wish to note?";
l. In 'Annexure 3: Initial Response Checklist', ("a generic guide for investigating MP cases") - "Search incident records for previous reports relating to the MP".

Missing Persons SOPS (2021)

The 'Missing persons, Unidentified Bodies & Human Remains' (2021) SOPS (MP SOPS (2021)) are significantly more detailed than the MP SOPS (2013) and contain many obvious improvements relative to the version operative at the time of CS' death. Notably:

m. The definition of a 'Missing Person' is essentially the same as that in force in March 2017, save for emphasizing the need for a 'genuine concern' to be held as to the safety or wellbeing of the person. The definition provides:

> "Missing Person: A missing person is anyone who is reported missing to police, whose whereabouts are unknown, and there are fears for the safety or concern for the welfare of that person. This includes anyone missing from any institution, excluding escapees. For missing person reports to be taken, there must

be a genuine concern held for the safety or wellbeing of the person."

n. The 'Missing Persons Checklist' (at Annexure A) is to be used as a guide when obtaining details for a missing person report; Annexure A relevantly includes reference to 'Risk Assessment' questions, including "High Risk 'Red Flag' questions" (see [h] below);
o. The policy sets out 'additional responsibilities' if the missing person is a child;
p. The policy emphasizes the need for ongoing liaison between police and the agency holding case management of the child as "paramount" in locating them and supporting their safety;
q. The policy emphasizes the importance of Chapter 16A of the *Children and Young People (Care and Protection) Act 1988* in relation to exchanging information and the coordination of services between agencies; it states: "In summary, all NSW government agencies are required to exchange information if it will assist with an investigation relating to a missing child or young person";
r. In section 9.2.8, 'Parental Abductions', the policy defines that term as "the hiding, taking or keeping hold of a young person/child by his/her parent while defying the rights of the young person/child's other parent or another member of the family". It is noted: "Police should take missing persons reports of these young people/children in all circumstances, irrespective of whether Family Law Proceedings have been instituted or a Recovery Order exists";
s. Provides clear guidance on the 'Risk Assessment Procedures' (Section 11), which notes:

> "A Risk Assessment is required for each missing person. Conducting an early assessment of a missing person report to determine the urgency of investigative functions is critical. This can be compared to the triage used in assessing casualties and the speed of response needed to save lives. Core to this process is assessment of the level of risk to the missing person and how immediate that risk is. The assessment and categorisation of risk and the circumstances of the case should shape the police response, informing the investigative and search strategies. Risk should also be regularly reviewed to consider new information and evolving circumstances. The first step in the process requires gathering all information that might impact upon the risk assessment."

t. It states: "When taking the initial report of a missing person, police should ask all relevant questions, so that risk can be properly assessed". Further: "Once a response to all questions have been obtained, an

informed decision can be made regarding the risks to the missing person and the appropriate police response required". In this regard:

i. Five "High Risk 'Red Flag' questions" are identified; if the answer is 'yes' to any, "this would indicate the need for an immediate high-level response". Two of the questions are:

   "3. Did the missing person leave with a child in their care?;

   4. Is the missing person particularly vulnerable due to age/disability (eg child, elderly, dementia, autistic)."

ii. Poses questions as to the 'Missing Persons Vulnerabilities', including:

   "2. Does the missing person have a mental health diagnosis? Are they currently unwell and/or taking medication?

   3. Is there a history of addiction: drug/alcohol dependence, gambling? Were they intoxicated when last seen?

   4. Was the missing person recently exhibiting behaviour that is considered out of character?"

iii. Sets out 'Situation/context Questions' (including: "3. Is there a history of serious family conflict/abuse? DV, child or elder abuse, victim or perpetrator), and 'Other Relevant Questions' (including

   "1. What do you think may have happened?

   2. Is there any other reason for the person to go missing or any other information you would like to give?

   3. If we need to, who else could we approach that may be able to provide relevant and recent information about the missing person/ (eg friends, co-workers etc)."

u. For a 'High Risk' rating for a missing person, the following is indicated: "The risk posed is immediate and there are substantial grounds for believing the missing person is in danger. They might include: answers to any of the 'Red Flag' questions indicate a high risk". Further, it is stated:

   "This category requires immediate notification to a Supervisor/Duty Officer/Sector Supervisor. Ensure appropriate crime scene/forensic response if it suspected criminality is

involved. If the missing person is lost, an immediate search and rescue response is required. Immediate consideration should be given to utilising all investigative tools to locate the missing person."

v. It is stated that a 'Missing person must be sighted to be located', and specifies the 'Sighting authorities'; particular procedures apply where the missing person is under the age of 18 years;

w. The policy contains 'Section 18', 'Using Mobile Phones to Urgently Locate Someone at Risk'; reference is made to s 287 of the Telecommunications Act 1997 (Cth), which provides for access to private telecommunications data where a person believes on reasonable grounds that access to that data is reasonably necessary to prevent or lessen a serious and imminent threat to the life or health of a person". Relevantly:

   i. it is specified: "A request for triangulation to locate a missing person should only be made in those instances where there is a reasonable belief that there is a serious and imminent threat to a person's life or health" – the "primary consideration is that the risk is serious and imminent";

   ii. a list sets out some guidance on instances that may justify approval of triangulation, which include where the missing person has a history of self-harm although has not made threats in this instance; and where the missing person is vulnerable (i.e. children);

   iii. it is noted that "imminent' means – "about to happen"; in general, "it means a person is at risk now or in the next few hours"; each request will be assessed on its merits;

   iv. it is noted that "Triangulations assist in locating missing persons in about 20% of occasions"; they will generally only assist in locating a person if there is a known 'link' within the triangulation area, that is, "if there is a known location within the triangulation footprint that the missing person may attend"."

Evidence of Detective Inspector Glen Browne dated 29 March 2021 and 26 May 2021

483. At [492]-[506] of Counsel Assisting's written submissions, the evidence in relation to the evidence of Detective Inspector Glen Browne is set out as follows:

Since August 2019, DI Browne has been the Manager of the Missing Persons Registry ("**MPR**"). The MPR sits within the State Crime Command of the NSWPF. DI Browne provides an overview of significant changes to the MPR

since its commencement as a specialist unit within SCC, including in terms of a greater focus upon" investigation.

Amongst other matters, the MPR is responsible for maintaining the NSWPF policies and procedures for 'Missing Persons, Unidentified Bodies and Human Remains' investigations and reviewing risk assessment processes for all Missing Person COPS Events. Revised Missing Persons SOPS have been prepared in 2020 and 2021; DI Browne stated that although they are "lengthy", they are intended as a "one stop" guide for all police undertaking (relevantly) missing persons investigations. The MP SOPS 2021 contain, amongst other matters – "Clearer guidance regarding what is required when children are reported missing and clearer guidance as to the importance of agencies sharing information to support missing persons investigation;" introduction of new 'Returned Home Interviews' for located children; a new "streamlined application process for the use of the triangulation tool and the "correct" interpretation of s 287 of the Telecommunications Act".

The release of the MP SOPS 2021 has been promoted within NSWPF. DI Browne stated that MPR intends to release a new version of the MP SOPS each year, incorporating recommendations from coronial inquests, improvements to practices and new tools to assist investigating police in the field.

DI Browne was requested to opine on the response of the NSWPF to the two reports from SJ around 3am on 2 March 2017; and later around mid-morning that day. In summary, his evidence was:

a. A key issue is whether LS or her children should have been considered missing people at any time;
b. As LS was legally entitled to custody of her children, the matter could not be classified as an abduction;
c. As to whether Constables Bryce or Burnell should have determined LS and the children to be missing persons, two elements needed to be satisfied to meet the definition of a missing person:
    i. Firstly, the whereabouts of someone needed to be unknown;
    ii. Secondly, there needed to be concern for the safety or wellbeing of a person.
d. As to whether those officers should have formed the view there were genuine concerns for welfare for the safety or wellbeing of any person:
    i. There does not need to be a specific basis for a concern for safety or wellbeing – people are often reported missing when there "are no obvious contributing factors like mental health or drug use";
    ii. Constables Bryce and Burnell apparently formed a view that there were no concerns for the safety and wellbeing of CS and

DS "predominantly based on the fact that [LS] was the children's biological mother and had legal custody of them";

iii. Any concern relating to the safety or wellbeing of the children during this initial report related only to the possibility LS had mental health issues and/or the possibility she was using prohibited drugs;

iv. Whether LS was affected by prohibited drugs to the point that Constables Bryce and Burnell should have a formed a view that it created a "genuine concern for the safety or wellbeing of her children is difficult to judge. Unfortunately, the issue of parents using prohibited drugs, and that impacting their ability to care for their children is not uncommon." Such matters are often reported to FACS and are complex to deal with;

v. It would have been difficult for Constables Bryce and Burnell to form the view that LS was suffering from a mental illness severe enough to cause concerns for the safety or wellbeing of the children (noting that FACS took no issue in response to the 4 February 2017 Scott Park notification);

vi. As Constables Bryce and Burnell apparently formed the view that the circumstances did not meet the definition of a missing person, the relevant SOPS did not apply to their actions, including a mandatory risk assessment;

vii. It is possible that in hindsight a missing person report could have been taken; had this occurred, the police would have followed the relevant MP SOPS (2016) requiring them to gather relevant information, undertake a formal written risk assessment and tasks associated with trying to find the missing persons; no view was proffered as to whether the outcome would have been any different had that occurred;

viii. The nature of Deniliquin Police Station (not a 24-hour police station) should also have been considered.

e. As to the response of Mr Holloway, DI Browne noted the conflicting factual accounts as to what occurred, and the relevant COPS Entry made at 3.02pm on 2 March 2017. His view regarding the steps that ought to have been taken in relation to this report differs as to which account is accepted – whether SJ or Mr Holloway:

i. Based on the account of Mr Holloway and what was recorded in COPS, "the matter would not have required updating with a Missing Person Incident in COPS nor adherence to the MP SOPS (2016)"; and

ii. Based upon SJ's version, "the matter should have been significantly escalated and an urgent police response required"; although to the extent SJ's account suggested the whereabouts

of the children was now known, the matter still may not have met the definition of a missing person. Despite this, according to SJ's version, "there were significant concerns for the safety and wellbeing of [LS] and her children and numerous things should have been done to quickly locate them".

iii. DI Browne did not hold a clear view that the incident should have been reported as a missing person incident when it was first reported (based upon the ANZPAA definition of a missing person).

DI Browne was asked to comment on what risk assessment, including what, if any enquiries, might be expected to be made when an officer is seeking to determine whether or not someone should be characterised as a missing person. DI Browne stated that there is no specific risk assessment tool to "determine whether or not someone should be characterised as a missing person". Further, "to determine if that definition is met, police should use their training, judgement common sense and experience to ask relevant questions, and to interrogate available sources of information available to them in the individual circumstances."

In a supplementary statement, DI Browne identified the following risk factors that might be taken into account when assessing whether a missing persons report should have been taken:

f. Mental Health;
g. Health (drugs and/or alcohol);
h. Care and Protection Orders;
i. Domestic Violence related;
j. Employment/Education issues;
k. Significant family conflict/abuse related; and
l. Unusual behaviour.

DI Browne stated that possible enquiries that might have been undertaken by attending officers to determine an appropriate policing response could have included:

m. Personal knowledge of the people involved;
n. Information provided by the person reporting;
o. Information provided by any other person at the scene or elsewhere;
p. Interrogation of the COPS system, including intelligence reports via MobiPol;
q. Criminal histories; and
r. Other environmental factors.

DI Browne accepted that the current MP SOPS do not require officers to consider the above risk factors and potential enquiries when determining whether someone should be characterised as a missing person, but only once the definition of a missing person has been met. DI Browne ultimately agreed that a future version of the MP SOPS might contain further clarification about the types of risk factors and enquiries that should be considered when determining whether someone should be characterised as a missing person. In particular, he stated:

> "…I can advise that the 2022 SOPs that are currently being drafted will provide further explanation about the definition of a missing person. It does cause me some concern that there has been some confusion. Again, a large part of our training is based on this fact already. There were views held out there that the concern needed to be expressed by the person making the report which isn't the case at all. Quite often we have young people out on the streets of a night where their parents have absolutely no concern for their safety or wellbeing. Police should have that concern even where the person reporting or a family member doesn't. The new SOPs are going to clearly address or are going to provide greater explanation around the definition of a missing person. Of course there's always room in there to accommodate any recommendations in that regard."

DI Browne also accepted there is uncertainty regarding the risk factors to be taken into account in conducting this exercise, stating "that more needs to be done to explain what should occur at this point. I am more than happy to accommodate something in the next version of the SOPs in that regard".

With respect to any proposed amendments to and/or recommendations in respect of the MP SOPS, DI Browne indicated to her Honour that he was happy to engage:

> "…with you or your counsel assisting and our office of general counsel to formulate something that could be included in the next version of the standard operating procedures. I've explained before various inquests that our intention is to bring out a new version of these standard operating procedures on 1 January every year so that we can accommodate coronial recommendations and to improve these SOPs. We - I certainly understand that they are a work in progress and always will be. If you would like to provide me with anything I will happily consider it and get it back to you. I'm happy to engage in that process"

During the course of his oral evidence, DI Browne was also taken to the matrix of information available to Constables Bryce and Burnell in the morning of 2 March 2017, namely that:

s. A grandmother waved down police in the street at 3am to report the fact that her daughter and grandchildren had not returned home as expected;
t. The children were young;
u. It was unusual for the children not to return to the grandmother's house overnight;
v. There had been a recent incident in which LS had displayed erratic and unusual behaviour which suggested that she may have a mental illness;
w. The grandmother indicated that LS has been to gaol for using ice and raised a concern that LS may be using the drug "ice" again; and
x. LS had previously displayed a propensity for violence when affected by illicit drugs.

When pressed, DI Browne did not accept that the above factors, either in isolation or cumulatively, automatically suggested that there were concerns for the welfare of CS and DS.

As to SJ's reference that LS may be using "ice" again, DI Browne conceded that this information would have warranted further enquiries but stated that the information provided to Constables Bryce and Burnell was insufficient to establish a confirmed belief or suspicion that LS was using the drug "ice". DI Browne accepted that if there had been clear evidence that LS was affected by the drug, it would have led to genuine concern for the welfare and safety of the children.

Finally, DI Browne accepted that had the children been listed as being "in need of protection" on the 2016 ADVO, and had it been reported to police that there was a breach of the ADVO and that the whereabouts of LS and the children were unknown, the definition of a missing person would have been met.

The NSWPF response

484. At [510]-[516] of Counsel Assisting's written submissions the evidence with regards to the response of the NSWPF is set out as follows:

Given the circumstances outlined above, the response of the NSWPF to the reports made by SJ must be examined in the context of information that was known to police, or otherwise available to them. The available information included knowledge that:

a. LS had a history of substance abuse and was previously suspected to be involved in "illicit drug scene";
b. LS was missing with her children, both aged under 10;

c. On 8 January 2016 there was a concerning incident involving SJ self-harming, requiring police to remove a butcher's knife from her car and ultimately schedule her; a 'child at risk incident' (ROSH) report was made following this incident;
d. Consequently, it was clear that SJ suffered from mental health issues;
e. In January 2016, an ADVO had been taken out against LS by SJ, which included the children in the statutory orders (made as a final order on 3 May 2016 for a 12-month period);
f. LS had recently been released from custody;
g. On 4 February 2017, a 'ROSH' report had been made with FACS on account of LS' concerning and erratic behaviour at Scotts Park;
h. SJ had raised concerns that LS was using ice again.

As the new MP SOPS (2021) adopt the same 'missing person' definition, it is not apparent that a different approach would ensue today if the same circumstances were to present. To that end, any proposed amendments to the MP SOPS, particularly in respect of factors relevant to an assessment of risk and avenues of enquiry, assume greater importance.

Having regard to DI Browne's comments that clear evidence of LS being ice-affected, or the breach of an ADVO (had the children been listed as PINOPs), would have raised a concern for welfare and safety of the children, the actions taken by officers of the NSWPF to ascertain relevant information and thereby inform their risk assessment carries greater weight. Although SJ indicated to Constables Bryce and Burnell that she was concerned LS was using drugs again, possibly ice, they did not take any steps to ascertain the veracity of that information. Aside from a COPS intelligence report which indicated possible cannabis use, Constable Burnell gave evidence that he had "no information to definitely know that she was using drugs or ice". Instead, Constable Bryce suggested that Mr Holloway could have learned of LS's possible drug use, through "recorded information on COPS perhaps".

Further, SJ's suggestion that LS was possibly using ice again was not referenced in the email to Mr Holloway requesting a follow up, the police notebook entries or otherwise recorded in the COPS system. It is also concerning that the two junior constables chose to inform Mr Holloway of the situation by email. Clearly, had Mr Holloway not attended his shift, there would have been no way for the incoming supervisor to have been aware of SJ's report or the request for a follow up.

Having regard to the totality of Constables Bryce and Burnell's evidence, it appears the overarching factor underpinning their risk assessment was the information conveyed to them by SJ on 2 March 2017. They relied on her evidence as to LS' parole conditions, mental health issues and concern regarding the children "missing school". No further enquiries were made in the police vehicle or upon their return to Deniliquin Police Station on 2 March 2017 to inform themselves of the

potential risks LS presented to the children, aside from perusing LS' COPS intelligence profile and the Scotts Park incident. Contrary to the evidence of DI Browne, it appears that in determining whether the definition of "missing persons" had been met, those officers did not utilise their "training, judgement, common sense and experience to ask relevant questions, and to interrogate available sources of information available to them in the individual circumstances."

The NSWPF also failed to make any enquiries which DI Browne states could have been undertaken by attending officers to determine an appropriate policing response, such as those set out at [483].

In light of the information conveyed by SJ and the evidence of those officers (see from [163] above), it is evident that clear guidance is required in the form proffered by DI Browne. Namely, the MP SOPS should be amended to provide further clarification to officers about the types of risk factors and enquiries that should be considered when determining whether someone should be characterised as a missing person. Given the centrality of a comprehensive risk assessment to the responses available to police, it is conceivable that additional action might have been taken had further enquiries been made as to the risk LS presented to the children. In particular, it may be that a "concern for welfare" would have been established and the MP SOPS (2016) enlivened.

485. Having regard to that evidence and in light of the deficiencies revealed by the approach of police, I make the following recommendations with regard to the NSWPF Missing Persons Policy.

1. Emphasis on 'critical analysis' of reports made to the NSWPF for concern welfare relating to Missing Person reports including:
    a. Making prompt and suitable enquiries to inform any risk assessment for the purpose of determining whether or not a missing person's report is warranted, including consideration of the following avenues of enquiry;
        i. Personal knowledge of the people involved;
        ii. Information provided by the person reporting;
        iii. Information provided by any other person at the scene or elsewhere;
        iv. Interrogation of the COPS system, including intelligence reports via MobiPol;
        v. Criminal histories; and
        vi. Other environmental factors;
    b. Consideration of the following risk factors in assessing whether a missing persons report should be taken:
        i. Mental Health;
        ii. Health (drugs and/or alcohol);

iii. Care and Protection Orders;
iv. Domestic Violence related;
v. Employment/Education issues;
vi. Significant family conflict/abuse related; and
vii. Unusual behaviour

c. Clear guidance as to when the taking of a child from a parent could constitute an abduction and the need to investigate circumstances even where orders have not yet been made;

d. Performing and documenting a risk assessment when a child is removed from their usual residence without the consent of their usual carer, to determine whether a missing person's report should be made;

e. Procedures to ensure all known information that could be relevant to a risk assessment is accessed for this purpose; and

f. Adopting a 'cautious' approach where vulnerable persons (such as children) are involved, and associated policy and training as to this aspect.

486. I acknowledge the proposed draft changes to the 2022 version of the *Missing Persons, Unidentified Bodies and Human Remains SOPS* which were provided as an annexure to the submissions of the NSWPF. The NSWPF is to be commended for this proactive approach. In particular, I acknowledge and endorse Chapter 9.2.10 as to the special considerations applicable when a child is taken from their usual carer by the child's parent or legal. Nevertheless, as the changes remain in draft form at the time of publication of these findings, I maintain the above recommendation with respect to changes to the NSWPF Missing Persons Policy.

487. Finally, in written submissions, Counsel Assisting proposed that I make a recommendation that the NSWPF consider the extent to which the tragic circumstances of CS' death, in de-identified form, might form the basis for 'case studies' emphasizing the importance of a cumulative and holistic consideration of information held by agencies.

488. In response, the NSWPF submitted that the Commissioner does not regard this matter to be a suitable case study in light of its very unique facts. The NSWPF submitted that the Commissioner does however, wholeheartedly support the cumulative and holistic consideration of information held by various agencies and has begun taking steps to achieve that.

489. The Commissioner's view as to the utility of this matter as a case study is regrettable. It is precisely because of the unique facts and on account of the lessons learnt by the Commissioner – as appropriately acknowledged – that a case study would be instructive for police officers on a number of levels. Accordingly, I recommend that NSWPF consider:

1. The extent to which the tragic circumstances of CS' death, in de-identified form, might form the basis for 'case studies' emphasizing the importance of a cumulative and holistic consideration of information held by agencies;

NSWPF and Victoria Police

Cross-border policing arrangements between NSWPF and Victoria Police

490. At [578]-[585] of Counsel Assisting's written submissions, the evidence regarding the cross-border policing arrangements between NSWPF and Victoria Police is set out as follows:

> The evidence before the inquest established that there was no contact between the NSWPF and Victoria Police at any relevant time prior to CS' death. There was an opportunity for Mr Holloway to have made contact with police officers at Bendigo Police Station after SJ attended Deniliquin Police Station around midday on 2 March 2021. In his oral evidence, Mr Holloway agreed there was nothing to stop him from calling Bendigo Police. He did not accept, however, that he should have contacted Bendigo Police to see whether they could go and find the children, on the basis that SJ was going to get them and he "thought that was the better outcome". Beyond that, Mr Holloway could not identify a good reason why he could not pick up the phone and contact Bendigo Police Station himself.
>
> In that context, one issue explored at the inquest was the following:
>
> > [20] The adequacy of any cross-border policing arrangements as exist between NSW Police Force and Victoria Police (specifically, for the Echuca/Moama area if any) as regards missing persons, concerns for welfare and/or child abductions.
>
> The evidence on this was to the following effect.
>
> DI Browne, in his written statement, stated that as to cross-border policing arrangements and missing persons investigations, each State and Territory in Australia has a Missing Persons Unit (Registry in NSW) and that the units work closely together as missing persons investigations often require transfer between jurisdictions. He gave evidence that there is a "highly productive working relationship" with these inter-state units.
>
> Mr Rogers, in his written statement, noted that communication and co-operation between NSWPF and Victoria Police in border areas like Deniliquin tended to be informal and inconsistent. He gave evidence that, "in my time I observed that in some areas and at various times this co-operation was good and in other areas and at other times it was poor." Nevertheless, of Mr

Holloway's failure to contact Victoria Police following SJ's second report on 2 March 2017, he stated:

> "Local Police should have kept SJ at the station and commenced direct engagement with Victoria Police to assist in location the children as soon as possible. In simple terms, SJ should have been taken into the station and Local Police should have got on the phone and started speaking with Victoria Police who could then direct enquiries in Victoria."

Mr Rogers also noted that there is a reciprocal legislative regime for Cross-Border policing which relates to the use of powers in Part 10B (Recognised Law Enforcement Officers) of the *Police Act 1990* (NSW). However, he stated: "my experience was that the interaction between interstate police was for the most part governed by initiative and mutual cooperation between the jurisdictions. In my time I observed that in some areas and at various times this co-operation was good and in other areas and at other times it was poor.

Superintendent Paul Smith, Commander of the Murray River Police District, provided a statement and also gave oral evidence at the Inquest. Superintendent Smith agreed there was a great deal of informal communication between police around the Victorian and NSW border, but less such communication as one moved away from the border. He stated that there was no impediment to police hopping on the phone and contacting any other police force, depending on the circumstances and the particular police officer seeing the necessity to do so; border town officers also had training as recognised law enforcement officers or special constables (for which they receive specific training regarding cross-border arrangements and communications) – so for Moama and Echuca, he would expect such officers to have "daily physical contact".

Superintendent Smith's statement referred to certain memorandums of understanding (MOUs) between the NSWPF and Victoria Police, but noted that he was not aware of any MOUs relevant to issues arising in the Inquest. Nor could he see any necessity for an "overall MOU", noting that there was various legislation conferring powers and arrangements in place for interstate assistance. Superintendent Smith noted that cooperation in the Murray River Police District with Victoria happens on a daily basis; he could not see the need for an MOU if the purpose was to enhance communication. Superintendent Smith told the Inquest that contact with police from other jurisdictions was part of policing general business.

491. It is regrettable that this simple step of contacting police officers at Bendigo Police Station to advise them of the situation relating to SJ and the children, or to seek assistance with their retrieval, was not taken. There was no impediment to this

occurring. This failing was one of initiative and general policing due diligence, given the circumstances that presented.

492. Notwithstanding, given the oral evidence of Superintendent Smith (who has particular expertise in cross-border police commands), it is not apparent that there is a clear necessity for an MOU to formalise cross-border policing communications as between NSWPF and Victoria Police.

493. In the circumstances, no recommendation is proposed.

MLHD

494. The relevant involvement of LS' interaction with the MLHD is set out at [141]-[153] above.

495. Against that backdrop, the following issues are identified with respect to MLHD:

> [22] The adequacy of the assessment of LS conducted by Ms Pieta Marks (of the Deniliquin Community MHDA) on 1 March 2017.
>
> [23] What if any further steps should (or could) have been taken by the Deniliquin Community MHDA following that assessment?

496. The adequacy of the assessment of LS conducted by Ms Marks' on 1 March 2017 was the subject of expert reports from separate psychiatrists, Dr Kerri Eagle and Professor Matthew Large. Given a general level of concurrence in their opinions, Dr Eagle and Professor Large were not called to give evidence at the inquest.

Expert opinions: Dr Kerri Eagle and Professor Matthew Large

Report of Dr Kerri Eagle dated 9 February 2020

497. At [429]-[437] of Counsel Assisting's written submissions, the evidence regarding the expert opinions of Dr Kerri Eagle and Professor Matthew Large are set out as follows:

> Dr Kerri Eagle, Forensic Psychiatrist, provided a detailed overview of the relevant mental health history relating to LS. As to diagnostic formulation, she opined that LS' presentation was "complex", and that her features were consistent with Post Traumatic Stress Disorder; she also notes that LS was diagnosed with a major depressive disorder at 13 years old. Further, LS had a psychotic disorder; her psychotic symptoms could have been substance induced or alternatively part of a chronic psychotic disorder (whether schizophrenia or schizoaffective disorder). She also had a severe substance use disorder and displayed personality traits consistent with borderline personality disorder.

With the benefit of hindsight, Dr Eagle opined as follows regarding the adequacy and appropriateness of Ms Marks' mental health assessment of LS:

a. Aspects of LS' presentation suggested that a psychotic episode should have been considered as a diagnostic possibility (including that LS was "glancing away for seconds at different times in session as if she was responding to something/someone", expressing persecutory ideas regarding her family). The MSE suggested that LS was responding to voices (auditory hallucinations); possibly had persecutory beliefs consistent with delusions, was highly distressed and displayed disordered thoughts. Dr Eagle states: "Psychosis is a potentially severe psychiatric condition with the potential for significant harm and [LS] should have been referred for immediate assessment by a psychiatrist or psychiatry registrar."
b. A risk assessment should form part of any mental health assessment. Ms Marks' assessed LS' risk of violence/aggression as 'medium', although the risk factors considered and the rationale for the assessment was not provided;
c. Even absent a formal risk assessment, LS' presentation strongly suggested the possibility that she would remove her children from SJ's care; information was received during the assessment that the children were known to FACS and under the care of SJ, rather than LS. Dr Eagle states that it could reasonably have been concluded that [LS] intended to remove her sons from her mother's care and that her children were at risk of serious harm in those circumstances;
d. Based on LS' presentation which suggested that she might be experiencing a psychotic episode, her visible level of distress, her impaired judgment and tangential thought form and her indication that she might take steps to remove her children from SJ's care, Dr Eagle opines that LS could have been placed under a mental health schedule (schedule 1 under the Mental Health Act). In particular, LS could have been characterised as a mentally ill person or mentally disordered person and detained or transported to enable a mental health assessment by a psychiatrist or psychiatry registrar. Dr Eagle also states: "Alternatively, [LS'] behaviour was, for the time being, so irrational as to justify a conclusion that she required temporary care, treatment or control for the protection of others from serious physical harm."

In terms of additional steps that might have been taken in LS' assessment, care and management, Dr Eagle stated that:

e. If LS was placed under a mental health schedule and refused to cooperate, police could have been notified and sought to convey LS to

an appropriate emergency department or other declared mental health facility for an urgent assessment;

f. FACS or the Child Protection Helpline should have been immediately notified of the potential for significant risk of harm to the children, given LS' presentation and stated intention to remove them from her mother's care and take them away from Deniliquin;
g. Ms Wesley (as the person referring LS for assessment) should have been contacted, which may have led to important information being provided that could have informed the assessment, including LS' indication that she wanted to leave Deniliquin with her children.

Report of Professor Matthew Large dated 24 April 2021

Professor Large agreed with Dr Eagle to the effect that it was not possible to anticipate that LS would take steps to kill her children; nor would any form of risk assessment have assisted. However, Professor Large agrees that LS taking her children from Deniliquin could have been anticipated – although this was by no means certain, and "that the consequences of this alone might have been severe".

Professor Large states that: "The sudden nature of the unpredictable event of the homicide should temper any criticism of inaction for anything that might have been done later, in the more expected and ordinary course of events".

Professor Large otherwise opined that:

a. Ms Marks performed a timely and professional assessment of LS; she appropriately and contemporaneously consulted others within her service; she could have obtained further information from a number of sources, however, including Probation and Parole [Community Corrections] and SJ;
b. Ms Marks' approach was focussed on assisting LS with her main problem as LS perceived it - that of accommodation; this was consistent a "recovery-focused approach" and was reasonable from the perspective of a social worker; and
c. Ms Marks considered there were uncertainties in the management of LS, and appropriately consulted contemporaneously with Ms Cross and Mr Smith about LS.

Professor Large states that Ms Marks and the Deniliquin Community MHDA gathered sufficient information to consider whether LS might be mentally ill or mentally disordered. In his view, they made an "understandable professional judgment" not to use the *Mental Health Act* on 1 March 2017.

> Professor Large opines that the CMHDA "probably should have informed child protection services and SJ of LS condition on 1 March 2017". He states that whilst Ms Marks was correct to consult with others after "such a complex presentation", she could have "been advised to call the child wellbeing unit (in office hours), used the online mandatory reporting guideline, or called the FACS Helpline directly. While it was somewhat reassuring that LS was intending on going to FACS herself, this did not greatly lessen the responsibility of Deniliquin Community MHDA to contact FACS." Professor Large also states: "Inquiries of FACS (or others) might have resolved the conflicting information that Deniliquin Community MHDA had about who had legal custody of the children."
>
> Moreover, Professor Large states that whilst LS could have been detained under the *Mental Health Act*, "it is less clear to me that she should have been". He opines that: "… a recognisable body of mental health professionals would not have caused LS to be scheduled …". That was particularly so after Ms Marks apparently "deescalated" LS. It was also "quite reasonable" not to conclude LS had a mental illness on 1 March 2017.

Evidence of Robyn Manzie, Director, Mental Health and Drug and Alcohol, Murrumbidgee Local Health District

498. At [438]-[446] of Counsel Assisting's written submissions, the evidence regarding the evidence of Robyn Manzie is set out as follows:

> Ms Manzie provided a detailed statement responding to the matters raised in Dr Eagle's report, and also gave evidence at the inquest. Ms Manzie has been the Director of the Mental Health and Drug and Alcohol Service for the Murrumbidgee Local Health District (MLHD) since 2011. She is a qualified social worker.
>
> Upon hearing of CS' death in March 2017, Ms Manzie commissioned an immediate review of the incident, with a view to identifying issues that may have contributed to the incident, and potential systems improvements. One issue identified by that review was the need to share and obtain corroborative information with other agencies. In oral evidence, Ms Manzie agreed that in relation to the policy for inter-agency sharing of information, "it tended to be on a planned basis. It's not necessarily so easy in an immediate situation." She agreed that NSW Health, DCJ, Justice Health and potentially Police should agree on a process for sharing immediate information and establishing contact points.
>
> Ms Manzie identified that Ms Marks, upon assessing LS, should have contacted Ms Wesley at Community Corrections. Ms Manzie gave evidence that, at the time of CS' death, there were arrangements in place allowing Community Corrections to attend meetings with the MLHD community teams, to enable the

sharing of information regarding consumers. However, she confirmed that there was no formal protocol or document that sets out the need for Community Corrections, for example, to provide background information relating to MLHD's consumers. Ms Manzie agreed that a formal protocol would have assisted with the exchange of information in LS' case. Ms Manzie agreed to review this aspect.

In relation to accessing Justice Health records, Ms Manzie confirmed that the provision of information was variable, and that "[s]ometimes there's a lack of information and we have to ask for it."

Ms Manzie stated that under the 'MLHD 2013_037 Child Protection Training Framework & Guidelines' (requirements for mandatory children protection notification) there should have been a notification to FACS following LS' presentation. The basis for such notification ought to have been the concerns expressed by LS' as to the safety of the children in SJ's house. However, Ms Manzie states there was "no indication in Ms Marks' interaction with [LS] that the children were at risk of harm from LS".

As to whether s 16A of the *CYP Act* should be given more prominence with staff, Ms Manzie said, "I think it would apply to the whole LHD, not just to mental health but certainly a discussion that we can have." She agreed that a fact sheet similar to one used by the Shoalhaven LHD (in response to another inquest) would be of use, undertaking to speak to the director responsible to make that suggestion to her.

In this regard, Ms Manzie confirmed that the MLHD child wellbeing/child protection training material did not explain that health workers were permitted to (proactively) provide information (as opposed to respond to a request) under s 16A. Ms Manzie agreed there was potential for this to aspect to be reviewed', and agreed to raise it within MLHD.

As to whether LS ought to have been placed onto a mental health schedule (including police notification if necessary to assist with arranging an urgent mental health assessment), Ms Manzie gave evidence that that conclusion could only reasonably be reached with the benefit of hindsight.

Ms Manzie's statement confirmed that the MLHD review identified the opportunities for system improvements. She set out the specific recommendations and an explanation as to implementation and progress on that front. Significantly, Ms Manzie stated:

> "The [Deniliquin Community MHDA] were significantly impacted by the tragic circumstances of this case, and to my observation, team members consequently have a heightened awareness of risk in such

presentations. I would expect that in future presentations of high distress, the clinician would seek further background and collateral information."

499. The family submit that it is a matter of regret that LS with such a complex psychological background was attended to by a person with no specialist qualifications when she presented on 1 March 2017 for her mental health assessment. Notwithstanding the evidence of Ms Marks that LS appeared to de-escalate during their conference on 1 March 2017, the family submits that there were sufficient indications that the MLHD should have taken further steps as opined by Dr Eagle.

500. Dr Eagle and Professor Large agreed that it was not possible for the practitioners at the MLHD to anticipate that the events of 2 March 2017 as regards LS would have transpired, nor would any form of risk assessment have assisted. However, I am satisfied that it was foreseeable that LS might seek to take her children from Deniliquin, and that such action was likely to have negative consequences for CS and DS.

501. Before I come to make a finding on the adequacy of the assessment of LS by Ms Marks on 1 March 2017, I make the following comments.

502. Firstly, the practitioners within Deniliquin Community MHDA presented as committed and compassionate, seeking to provide the best mental health and substance abuse support within the constraints of a regional framework. Witnesses gave thoughtful and reflective evidence and made appropriate concessions.

503. Secondly, I wish to note Dr Magee's evidence at the inquest, set out at [119], that mental health services generally, and in particular in regional Australia, are in crisis. I accept that LS' presentation was likely typical for a client at the Deniliquin MHDA and that Ms Marks' assessment of LS should be viewed in that context. In that regard, I accept that it may be impractical and unnecessary for a majority of those clients to be placed under a mental health schedule. However, the facts of this matter should act as a compelling reminder to practitioners to remain attentive to those clients who present with signs of potential psychosis, and to assess any potential risk arising from a client's presentation both to themselves and to any other person at its highest.

504. Thirdly, I wish to note that the MLHD is one of the agencies in this inquest that have undertaken detailed and thorough critical incident reviews, and has already largely actioned a number of arising recommendations. I commend the MLHD and its management for its commitment to extracting all potential learnings from the terrible circumstances of CS' death.

505. Nevertheless, against that background, I find that there were numerous deficiencies with the assessment of LS as outlined above by Dr Eagle. Those shortcomings were that Ms Marks:

a. Did not seek relevant corroborative information (such as from SJ/LS' GP);
b. Did not set out the risk factors/rationale for her risk assessment;
c. Was incorrect to state there was 'nil evidence' of a thought disorder;
d. Did not assess the risk of serious harm to LS' children;
e. Did not raise the potential risk with FACS/Police;
f. Did not consider whether LS ought to have been placed under a mental health schedule;
g. Did not document in clinical notes the important detail of having de-escalated LS (which she conceded she should have); and
h. Did not contact FACS after LS left the service (which she also conceded she should have).

506. As to whether further steps should have been taken by the MLHD and Ms Marks following LS' presentation on 1 March 2017, Dr Eagle identified the following potential steps that were available to Ms Marks:

a. If LS was placed under a mental health schedule and refused to cooperate, police would have been notified and conveyed LS to an appropriate emergency department/mental health facility;
b. That FACS or the Helpline should have been immediately notified of the potential for significant risk of harm to the children; and
c. That Ms Wesley should have been contacted which may have led to important information being provided that could have informed the assessment, including LS' indication that she wanted to leave Deniliquin with her children.

507. Professor Large submitted that the Deniliquin Community MHDA "probably" should have informed child protection services and SJ of LS' condition on 1 March 2017. He also identified that Ms Marks could have called the child wellbeing unit, used the online mandatory reporting guideline or called the Helpline directly.

508. As was conceded by each of the witnesses appearing on behalf of the MLHD, it was clear that the MLHD's 'Child Protection Training Framework & Guidelines' required a notification to FACS following LS' presentation. I find that Ms Marks failed to do so. I also accept Counsel Assisting's submission that Ms Marks should have sought further collaborative information including contacting LS' GP, Dr Magee and her CCO, Ms Wesley; and that she could have made direct contact with FACS to ensure LS had arrived.

509. In written submissions, Counsel Assisting proposed that I make the following recommendations with regard to the MLHD:

1. That the MLHD prepare a written protocol or procedure concerning the transfer of information between Corrective Services and MLHD in relation to persons released from custody;
2. That the MLHD review applicable policies and procedures to ensure that:

a. Emphasis upon the need for practitioners to obtain collaborative/corroborative background information regarding consumers;

b. Relevant sources of such information (for example, general practitioners, family members) are set out;

3. That MLHD introduce a fact sheet regarding the operation of s 16A *CYP Act* and the exchange of information between agencies with responsibility for the safety, welfare or wellbeing or children or young people.

510. With regard to the first proposed recommendation, the MLHD indicated in written submissions in reply that while it accepted the purpose and utility of the recommendation, practical implementation would require the agreement of the two agencies – the Ministry of Health (which was not represented at the Inquest), and Corrective Services NSW directly, to ensure state-wide rather than local implementation.

511. In submissions in reply, Counsel Assisting proposed the follow revised recommendation:

1. That the MLHD prepare a local written protocol or procedure concerning the transfer of information between Corrective Services and MLHD in relation to persons released from custody;
2. That the CSO of the MLHD provide the Ministry of Health with a copy of the:
    a. Submissions of Counsel Assisting dated 17 September 2021;
    b. Submissions of MLHD dated 29 October 2021;

    identifying the issues raised by this inquest concerning a potential protocol or procedure for the transfer of information between Corrective Services and Local Health Districts in relation to persons released from custody, for consideration of the appropriate officer within the Ministry of Health.

512. I accept Counsel Assisting's submission that:

a. The Ministry of Health undoubtedly see benefit in reviewing the circumstances of this tragic matter with a view to considering, at the very least, development and implementation of a state-wide protocol.
b. The proposed recommendation is warranted given that efforts by the MLHD to date have not yet culminated in a local, written protocol or procedure.

513. With regard the to the second proposed recommendation to the MLHD at [610] of Counsel Assisting's written submissions, I do not accept the submissions of the MLHD that existing policies fulfil the underlying purpose of this recommendation. I am persuaded by the submission of Counsel Assisting, that is, that the updated 2018 policy effectively replicates the wording of the police in place in 2016, which was not sufficient to cause Ms Marks or her senior colleagues to comply with the requirement to obtain corroborative information from relevant sources.

514. I am therefore of the view that the recommendation is necessary and I draw the attention of the MLHD to the wording suggested by Counsel Assisting for a requirement to obtain corroborative and additional information, that is:

Requirement to obtain corroborative and additional information

16. It is of critical importance that the Mental Health clinician obtain corroborative and additional information from relevant sources, including:
    a. The consumer's family/carer;
    b. Relevant service providers, such as;
        i. A general practitioner;
        ii. Other mental health clinicians (for example, a psychologists or counsellors);
    c. Government agencies where relevant and subject to appropriate consent where necessary (see [34] of this Policy), including:
        i. Corrective Services (NSW) and/or Community Corrections NSW (where a client is on parole);
        ii. Justice Health;
        iii. Department of Communities and Justice (formerly FACS);
        iv. The NSW Police Force;
        v. Private or public health facilities/hospitals; and
        vi. Schools.

Discuss what sorts of information the consumer is comfortable with sharing (if any) with their support person, friends, family and/or carers.

Where children or young persons are involved, note the powers conferred under *Chapter 16A of the Children and Young Persons (Care and Protection) Act 1998* as to the exchange of information between government agencies and non-government organises: see MLHD Fact Sheet (attached to this Policy); see also [24] of this Policy.

515. With regard to the third proposed recommendation set out at [610] of Counsel Assisting's written submissions, I commend the MLHD for its proactivity in preparing the draft MLHD 'Information Exchange (Chapter 16A) Flow Chart'. I note the submission of Counsel Assisting that the fact sheet reference by the third recommendation contains considerably more information than appears in the draft flow chart.

516. I also note Counsel Assisting submissions that although potentially a helpful format as an annexure to a Fact Sheet, the draft flow chart would benefit from review and amendment, including:
    a. Distinguishing (for example, by using different colours), the different pathways of both requests for information and requesting information;
    b. Distinguishing different pathways in the sequence of the draft flow chart for requests that are considered "inappropriate" vs those that are "appropriate" (otherwise, the sequencing of the arrows is illogical);

c. Providing a 'user-friendly definition' of 'Prescribed Body';
d. Directing practitioners to other available written or online information resources – see Section 8 of the ISHLD Fact Sheet; note also the list of Chapter 16A contacts available at https://www.health.nsw.gov.au/parvan/childprotect/Pages/chapter-16acontacts.aspx#bookmark5; and
e. Including reference or a link to potential pro-forma 'request' correspondence.

517. Accordingly, I make the following recommendations to the MLHD:

1. That the MLHD prepare a local written protocol or procedure concerning the transfer of information between Corrective Services and MLHD in relation to persons released from custody;
2. That the CSO of the MLHD provide the Ministry of Health with a copy of the:
    a. Submissions of Counsel Assisting dated 17 September 2021;
    b. Submissions of MLHD dated 29 October 2021;

    identifying the issues raised by this inquest concerning a potential protocol or procedure for the transfer of information between Corrective Services and Local Health Districts in relation to persons released from custody, for consideration of the appropriate officer within the Ministry of Health.
3. That the MLHD review applicable policies and procedures to ensure:
    a. Emphasis upon the need for practitioners to obtain collaborative/corroborative background information regarding consumers;
    b. Relevant sources of such information (for example, general practitioners, family members) are set out;
4. The MLHD introduce a fact sheet regarding the operation of s 16A, *CYP Act* and the exchange of information between agencies with responsibility for the safety, welfare or wellbeing or children or young people.

Catholic Education Office and Ms Murphy

518. The relevant involvement of Ms Murphy and the Catholic Education Office is set out at [276]-[282] above.

519. Having regard to that background, the matters in the list of issues relating to the Ms Murphy and the Catholic Education Office are as follows:

> [25]. What information was provided to Ms Murphy on 2 March 2017?
>
> [26]. The adequacy of the response of Ms Murphy to the information that was provided to her on 2 March 2017?
>
> [27]. What processes, policies and procedures were in place in respect of such a notification/provision of information?

[28]. The adequacy of those processes, policies and procedures.

520. Ms Murphy was not required for oral evidence, there being no issues in dispute as to her evidence.

521. The evidence of Ms Murphy not being in dispute, it is accepted that on the afternoon of 2 March 2017, SJ did not say words to the effect: "You won't see us anymore"; this would have conveyed to Ms Murphy that the children's lives were at imminent risk. Ms Murphy certainly understood however, that LS had taken the boys and had not returned home; that SJ was sufficiently concerned to have contacted both FACS, her own lawyer and the police; and that LS was in breach of her parole conditions not to leave NSW. The situation was unquestionably worrying, and Ms Murphy stated that she was concerned for the welfare of the children (although not to the point of raising ROSH concerns).

522. In terms of the adequacy of Ms Murphy's response to the information provided to her on 2 March 2017, it is creditable that she took steps to contact FACS, even to the point of driving to their office when she could not make contact by phone.

523. In the circumstances that presented however, I accept Counsel Assisting's submission that it would have been highly desirable for Ms Murphy to contact police directly – instead of, or in addition to, attempting to contact Mr Rogers directly – to reiterate the concerns raised. Ms Murphy, with clear insight into the tragic events, conceded that she should have contacted '000' herself to report her concerns, rather than accepting SJ's account that she had done this and "hadn't gotten anywhere". Had such contact been made, this would be the third report relating to the missing children, and reinforced the concerns raised by SJ.

Remedial response of the Catholic Education Office

524. At [547]-[549] of Counsel Assisting's written submissions, the evidence with regards to the remedial response of the Catholic Education Office is set out as follows:

> A statement was provided by Kathryn Nadin, a Child Protection Officer employed by Catholic Education Wilcannia-Forbes since mid 2018. Ms Nadin agrees with the position set out in Ms Murphy's statement, including that LS' taking of the children was not a 'child abduction" because LS was the parent and had legal custody of them.
>
> Ms Nadin does state that whether the circumstances amounted to a "relevant emergency" is less clear. Ultimately, she states that there was nothing to suggest that LS posed any danger to the children; although the "circumstances represented an escalated degree of concern", they did not amount to an emergency and Ms Murphy's "decisive steps" to locate the boys were an

appropriate response. Ms Nadin also states that "No particular policy applied to the circumstances which confronted Ms Murphy around 3pm on 2 March 2017".

However, Ms Nadin states that with the benefit of hindsight, the circumstances that presented to Ms Murphy may have posed a risk of significant harm, although "this would not have been apparent to Ms Murphy at the time".

525. Having regard to the evidence set out at above, and given Ms Murphy's appropriate and reflective concession with the benefit of hindsight, CEWF proposed a recommendation to the following effect:

> Catholic Education Wilcannia Forbes to review the policy entitled 'Child Protection Policy: Managing Risk of Significant Harm and Wellbeing Concerns' to ensure they stipulate that when a mandatory report is made to the Department of Communities and Justice pursuant to the *Children and Young Persons (Care and Protection) Act 1998* (NSW), the reporter must consider making a subsequent report to NSW Police by calling 000.

526. As noted in the submissions served on behalf of the Catholic Education Office, the Catholic Education Office at Wilcannia Forbes has already amended the Child Protection Policy to bring it in line with the above proposed recommendation. The Catholic Education Office is to be commended for taking such a proactive approach in this regard. I make no recommendation in relation to the Catholic Education Office.

ESTA

527. At [294]-[297] of Counsel Assisting's written submissions, the evidence with regards to ESTA is set out as follows:

> A statement provided by Mr Thomas Dunbar, a 'Quality Improvement Investigator' within ESTA, did not identify any deficiencies in the response of the ESTA call-taker. This position was revised by Mr Dunbar in his oral evidence.
>
> At the inquest, Mr Dunbar provided further details regarding Mr Pearson's call to ESTA. Mr Dunbar explained that the call was properly categorised by ESTA as Priority 2. However, he conceded that, given Mr Pearson said the call concerned a welfare check, the word 'abducted' (as noted by the ESTA call-taker) was "not the most appropriate word to have used … it wasn't being treated as an abduction at that time, based off the information provided during the call" such language was unhelpful and potentially misleading.
>
> Mr Dunbar agreed that the dispatcher was potentially misleading in citing the location as the IGA, stating: "In this instance the dispatcher should've said exactly what was stipulated in the event chronology" – that is, the dispatcher should have noted that the location was outside an IGA or similar. The

dispatcher did not properly convey that it may not have been an IGA. That was important information that should have been conveyed. Mr Dunbar agreed this was a serious error, noting: "It's made a preconceived idea that he's got that he could potentially have gone to the wrong location." Mr Dunbar agreed that the dispatcher should have gone back to the CAD information – given the issue as to the location, whether Huntly or Goornong, to confirm the position given the lack of clarity. The dispatcher should then have reaffirmed the location as accepted by the call taker, namely, Goornong. Mr Dunbar also agreed the CAD reference to a "shopping centre" should have been clarified to "say some shops up the road", as it may could mislead someone to think it was a Westfield or the like.

Finally, in hindsight, Mr Dunbar gave evidence that the "keep a look out for" broadcast should have included other information contained in the CAD, such as the fact that LS was ice-affected and had mental health issues. In this regard, Mr Dunbar also stated that unless police officers actually *hear* a "keep a look out for" broadcast, they do not otherwise know about it. Mr Dunbar said:

> "Keep a, keep a lookout for events are assigned to a specific keep a lookout for unit. There is a keep a lookout for unit for every channel. It is for – it's a unit for the ESTA dispatcher to appropriately manage those events so they don't remain in a pending event list window. They aren't assigned to a police unit, that's the - that's why the 573 event was never taken off the Goornong member and assigned to the keep a lookout for unit, that's the intended to keep a lookout for event. So the - they wouldn't see the keep a lookout for event, but there would be - where it's been cross-referenced, they would see a cross-reference to a specific police event but they wouldn't know what that event is necessarily."

528. I agree with Counsel Assisting that in giving evidence, Mr Dunbar presented as a thoughtful, frank witness. He was readily prepared to accept, explain and analyse errors made by ESTA in their response, necessarily with the benefit of hindsight. I commend Mr Dunbar for the way in which he approached his oral evidence in the inquest.

529. In my view, it is not possible to conclude with any degree of certainty whether, even if the ESTA dispatcher had provided Leading Senior Constable Scherger with the accurate location of LS' call, Leading Senior Constable Scherger would have arrived at the milk bar in Goornong in time to apprehend LS. What is clear however, is that the provision of inaccurate information certainly hindered any attempt to apprehend LS.

530. A critical component of ESTA's role is the accurate dissemination of information. Regrettably, I find that there were significant deficiencies in the way in which the ESTA dispatcher conveyed the job to Leading Senior Constable Scherger in this instance.

531. Accordingly, I recommend that ESTA consider the circumstances of this incident (as appropriately anonymised) as the basis for a training module or case study, highlighting the importance of accurate reference to the content of a CAD event.

532. Written submissions provided on behalf of ESTA indicate that ESTA considers that the circumstances of this matter (as appropriately anonymised) would form the appropriate basis for a training module for call-takers and dispatchers alike.

533. I commend ESTA for accepting this recommendation.

Conclusion

I would once again like to express my sincere condolences to those who knew and loved CS. Throughout these proceedings, CS' grandmother, SJ, displayed enormous dignity and courage. I acknowledge her strength in giving evidence and speaking on behalf of CS.

I also extend my thanks to the Counsel Assisting team, Kristina Stern SC, Emma Sullivan, James Pender, Aleksandra Jez and Claudia Hill. I would also like to extend my thanks to Inspector Trent Swinton, the officer in charge of the investigation, for his assistance.

I also extend my thanks to the legal representatives for all the sufficient interest parties.

I close this inquest.

Teresa O'Sullivan
State Coroner Lidcombe
Date: 15 July 2022

"Appendix 1"

Inquest into the death of CS

Before State Coroner O'Sullivan
17 to 28 May 2021

Final Issues List

(as at 11 May 2021)

Section 81 of the *Coroners Act 2009* (NSW)

1. Determination of the statutory findings required under s. 81 of the *Coroners Act 2009*, including as to manner and cause of death.

Corrective Services NSW (CSNSW)

2. The adequacy of any steps undertaken by CSNSW to ensure a suitable residence was available for LS on and after release under statutory parole.
3. The adequacy of any steps taken in respect of LS once released on parole in February 2017, including having regard to the welfare of her children.
4. The adequacy of the response of CSNSW to reports made on 1-2 March 2017.
5. Whether relevant processes, policies and procedures were followed by Community Corrections on 2 March 2017 in dealing with the situation that presented on 1-2 March 2017.
6. The adequacy of those processes, policies and procedures.

Department of Communities and Justice (formerly known as "Family and Community Services" or "FACS")

7. The adequacy of any steps taken by FACS in relation to SJ's efforts to obtain legal custody of DS and CS (including the extent to which assumptions were made about her status as the primary carer, when LS in fact had legal custody of the children);
8. The adequacy of any steps taken by FACS in response to notifications and information provided to FACS:
    a. in the period from release on parole to 1 March 2017; and
    b. in the period 1-2 March 2017.
9. Whether the relevant processes, policies and procedures were followed by FACS on 2 March 2017 in dealing with the situation that presented.
10. The adequacy of those processes, policies and procedures.

Victoria Police

11. What information was provided to Victoria Police by Tim Pearson during the '000' call at 1.03pm on the afternoon of 2 March 2017 and subsequently to Senior Constable Scherger around 1.45pm and what priority and classification was accorded the matter?

12. The adequacy of any communication or information-sharing that occurred as between Victoria Police and the NSW Police Force in relation to LS or the children (noting in particular, the issue re cross-border policing of the Echuca/Moama area).

13. The adequacy of any steps taken by Victoria Police in response to the "concern for welfare/child abduction" "000" call. Whom was in charge and what approach was taken?

14. Whether applicable processes, policies and procedures were followed.

15. The adequacy of those processes, policies and procedures.

NSW Police Force

16. The adequacy of any steps taken by the NSW Police Force in response to the concern for welfare/missing children reports.

17. Whether the NSW Police Force should have taken steps to have the children added to the ADVO taken out on a provisional/interim basis in January 2016 and on a final basis on 3 May 2016, which listed only SJ as the 'person in need of protection'.

18. Whether applicable processes, policies and procedures were followed.

19. The adequacy of those processes, policies and procedures.

Victoria Police/NSW Police Force – cross-border policing

20. The adequacy of any cross-border policing arrangements as exist between NSW Police Force and Victoria Police (specifically, for the Echuca/Moama area if any) as regards missing persons, concerns for welfare and/or child abductions.

Murrumbidgee Local Health District

21. The adequacy of the assessment of LS conducted by Ms Pieta Marks (of Deniliquin Community Services MHDA) on 1 March 2017.

22. What, if any, steps should (or could) have been taken by MHDA prior to or following that assessment?

23. Whether applicable processes, policies and procedures were followed.

24. The adequacy of those processes, policies and procedures.

Catholic Education Office

25. What information was provided to Ms Murphy on 2 March 2017?

26. The adequacy of any steps taken by Ms Murphy in response to the information that was provided to her on 2 March 2017?

27. What processes, policies and procedures were in place in respect of such a notification/provision of information (including any requirements to contact the NSW Police Force directly)?

28. The adequacy of those processes, policies and procedures.

Recommendations

29. Whether any recommendations are necessary or desirable in relation to any matter connected with CS’ death.