STATE CORONER'S COURT

OF NEW SOUTH WALES

Inquest:	Inquest into the death of HB
Hearing dates:	22-23 October 2024 NSW Coroner's Court sitting at Newcastle Court NSW
Date of findings:	4 December 2024
Place of findings:	NSW State Coroner's Court, Lidcombe
Findings of:	**Deputy State Coroner Carmel Forbes**
File number:	2018/00190754
Catchwords:	CORONIAL – death of a twenty-month-old girl from multiple injuries that were inflicted by a known person -two presentations to hospital with suspicious injuries in the two weeks prior to her death-adequacy of systemic response to those hospital presentations prior to her death
Representation:	Mr J Harris Counsel Assisting, instructed by Ms K McKinlay, Department of Communities and Justice, Legal. Ms K Kumar representing Hunter New England Local Health District, instructed by Ms R Cooke, Hicksons Lawyers. Mr I Fraser representing the NSW Department of Communities and Justice, instructed by Ms A Talbot, Crown Solicitor's Office.

	Ms K Bourke representing Commissioner of NSW Police, NSW Police Force instructed by Mr S Robinson, Office of General Counsel NSW Police Force.
Findings:	***Identity*** The person who died was HB. ***Date of death*** HB died on 19 June 2018. ***Place of death*** HB died at John Hunter Hospital, New Lambton Heights, NSW. ***Cause of death*** HB died as a result of multiple injuries. ***Manner of death*** The fatal injuries were inflicted by a known person.
Non-publication orders:	A copy of the non-publication orders can be obtained on application to the Coroners Court Registry.

INTRODUCTION

1. This is an inquest into the tragic death of HB. HB died on 19 June 2018. She was only 20 months old at the time of her death. She died as a result of fatal injuries inflicted by her mother's partner in the family home.

2. HB had presented at hospital with two other sets of injuries in the two weeks prior to her death. Those injuries had come to the attention of Family and Community Services (**FaCS**) and NSW Police.

3. An inquest is a public examination of the circumstances of a death. Section 81 of *Coroners Act 2009* (NSW) (**the Act**) requires a Coroner, at the conclusion of the inquest, to make findings as to:

    a. The identity of the deceased person.
    b. The date and place of the person's death; and
    c. The manner and cause of the person's death.

4. This inquest has been a public examination of the circumstances surrounding HB's two presentations to hospital in the two weeks before her violent death. A thorough and detailed account of the circumstances of her presentations has been provided during the inquest with a particular view as to whether appropriate steps were taken in an attempt to protect HB from further harm.

BACKGROUND

5. HB's mother was 22 years of age at the time of HB's death. She had a background which included trauma and struggles with her mental health, with depression and social anxiety disorder, for which she received treatment.

6. In 2013, aged 17, she formed a relationship with a man and fell pregnant. Her first child was born in 2014. The records suggest that the relationship was violent. They separated in about March 2015.

7. In August 2015, HB's mother formed a relationship with HB's father. HB was born on 24 September 2016.

HB

8. HB's early life was relatively normal. She met developmental milestones and was generally well, other than sleep problems. She was slightly underweight. She had up-to-date immunisations.

9. In January 2018, she commenced attending Family Day Care, on Wednesday each week.

10. In about March 2018, Jessica commenced a new relationship. The new partner moved into her home. He was 25 years of age.

JUNE 2018

First hospital admission

11. On Friday 7 June 2018 HB presented to Maitland Hospital at about 12.30pm with facial injuries. HB's mother and her partner told the medical staff at the hospital that on the evening of Thursday 6 June 2018, their new puppy, a 10-week-old staffy/kelpie, jumped onto HB's bed. They did not say they witnessed this or how it might have caused HB's injury.

12. HB was triaged at 12:40pm. The triage nurse recorded that HB had a facial injury, possibly a fractured nose, and that the parents thought she "*may have been hit by puppy last night.*" HB was admitted to the Emergency Department (ED). HB's mother's partner left the hospital.[1]

13. At 2.13pm, HB was reviewed in the ED Fast Track area by Dr Sheng. HB's mother told the doctor that HB had been unwell for a few days. Dr Sheng noted dried blood on her nostrils, facial swelling, and scratches. HB's mother said HB had been picking her nose recently. Dr Sheng was more concerned about HB's breathing. She commenced

[1] Exhibit 1 Vol 3 Tab 150 p 4.

oral steroids and Ventolin and then transferred HB to the main department for further review.[2]

14. HB was next examined by Dr Wilder, an ED registrar. He obtained a history and examined HB, who had a high temperature and heart rate, and swelling across the bridge of her nose. He was primarily concerned about the unclear mechanism of injury. HB's mother said that she thought the swelling to HB's nose was due to a collision with their puppy the night before. She said the puppy jumped on the bed, and believed there had been a collision, but was unsure if it had been significant, or where or how it happened. Dr Wilder was concerned about that explanation. He said that it was unlikely to account for the injuries. Dr Wilder spoke to his consultant, and they agreed HB was not safe for discharge. He also arranged for review by the ear, nose and throat registrar and the paediatric team.[3]

15. A chest X-ray was obtained, which did not show trauma, but increased density indicating possible pneumonia.

16. At 5.15pm, paediatric registrar Dr Smyth examined HB, together with Dr Laver. HB's mother provided a similar account as before, regarding the puppy. She said the puppy had gone into HB's room and jumped on her bed while she was asleep. HB had cried out, and then settled. In the morning, HB mother's partner had woken and noticed fresh blood under HB's nose and brought her into bed. She said she had first noticed blood in HB's nose two days prior, which she thought was from picking her nose.[4]

17. Dr Smyth called the paediatrician, Dr Mandaliya. They agreed HB had intercurrent pneumonia and should be given penicillin. Dr Mandaliya asked for photos[5] of the injuries, which were obtained with consent. HB was admitted under her care.[6]

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[2] Exhibit 1 Vol 1 Tab 8 [5]; Vol 3 Tab 150 p 4.

[3] Exhibit 1 Vol 1 Tab 9 [4]; Vol 3 Tab 150 p 10.

[4] Exhibit 1 Vol 1 Tab 10 [4]; Vol 3 Tab 150 p 16.

[5] Exhibit 1 Vol 3 Tab 149 p 200.

[6] Exhibit 1 Vol 1 Tab 12 [4-15].

18. Dr Smyth then contacted Dr Webber, who was the on-call child protection paediatrician at John Hunter Children's Hospital (**JHCH**). Dr Webber said it was hard to know the cause of the injury. He said the pattern of injury and history did not fit with a non-accidental injury pattern. He said facial bruising might be explained by an accidental injury, usually from tripping. However, this was not the explanation provided. The explanation was unusual and was not witnessed. He did not recommend any further investigations or treatment. He recommended Dr Smyth should follow the Mandatory Reporting Guide (**MRG**). He was happy to be contacted as necessary, and recommended social work input the following day.[7]

19. The following report was made to the Helpline that evening at 8.52pm:[8]

> *"20 month old female presenting to the emergency department at The Maitland Hospital, with swelling to the bridge of her nose, with crusted dried blood at the base of the nostrils, due to an unclear mechanism of injury. First noticed crusted blood at the nose 2 days prior to presentation; onset of swelling to the nasal bridge on the morning of presentation noted. Mum unable to explain cause of swelling, suggested that the family dog had been up on patient's bed last night and potentially knocked her nose, however not confirmed or directly witnessed."*

20. The FaCS Helpline screened the report as meeting the risk of significant harm (**ROSH**) threshold, as a non-accidental injury which required a Level 1 24-hour response. The caseworker assessing the report initially queried whether the case should be referred to the JIRT Referral Unit (**JRU**), which would commence the process for involving the Joint Investigation Response Team (**JIRT**). However, due to insufficient information, the manager determined it should be referred it to local Maitland Community Service Centre (**Maitland CSC**) to make further enquiries.[9]

21. In the morning of Friday, 8 June 2018 a caseworker from Maitland CSC, was asked to look into the case. The caseworker did not normally work in this role, performing

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[7] Exhibit 1 Vol 1 Tab 10 [15]; Tab 24 [12]; Vol 3 Tab 150 p 22.

[8] Exhibit 1 Vol 4 Tab 153 p 172.

[9] Exhibit 1 Vol 4 Tab 153 p 184.

triage on Helpline reports. She was happy to assist, as a number of staff were engaged in training for the new computer system, ChildStory. She contacted a social worker, from the hospital. She was provided some more detail about HB's injuries and the investigations that were ongoing.

22. The social worker asked for information under Chapter 16A of the *Children and Young Persons (Care and Protection) Act 1998.* Those are provisions which permit and require agencies to share information relating to the safety, welfare, and well-being of children. The social worker was informed about the seven previous reports that had been made to the Helpline, about domestic violence and about HB's mother's parenting.[10]

23. At about 12 noon, the paediatrician Dr Mandaliya reviewed HB with his registrar and the social worker. A full history was taken again from HB's mother. It was broadly consistent with what she said before. The impression was a broken nose. At that time, HB was interacting and looked well, other than the swelling and bruising over the bridge of her nose. Her breathing difficulties had improved.[11]

24. After the review, Dr Mandaliya and the social worker contacted the caseworker at Maitland CSC to provide an update. They noted that the explanation HB's mother gave about HB's injuries had been consistent (i.e. she told the same story) but it remained "*questionable.*" The injury itself was not uncommon.[12]

25. Following this, the caseworker provided an update to her manager. She noted that the hospital did not plan further investigations, and that staff had observed a good attachment between HB, her mother, and her mother's partner.

26. A manager at Maitland CSC determined that the case would be considered at the next Weekly Allocation Meeting (**WAM**), due to be held on 13 June 2018. It does not

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[10] Exhibit 1 Vol 1 Tab 15 [7]; Vol 3 Tab 150 p 27.

[11] Exhibit 1 Vol 1 Tab 12 [8]; Tab 15 [12]; Tab 13 [8]; Vol 3 Tab 150 p 28.

[12] Exhibit 1 Vol 1 Tab 15 [14]; Vol 4 Tab 154 [25].

appear that occurred. That effectively ended FaCS involvement until the following week.

27. Dr Mandaliya reviewed HB again on the ward round the following day, Saturday 9 June 2018. She appeared well, and the swelling had reduced. The plan was to discharge her home and follow up her pneumonia under Hospital in the Home (**HITH**). FaCS were informed about this plan the following day.[13]

28. HB was discharged home at about 1.30pm.[14]

29. The following day, Sunday 10 June 2018, staff from Maitland Hospital tried unsuccessfully to contact HB's mother. They did speak to her on Sunday 11 June 2018, to inform her of blood results, which were normal. HB was discharged from HITH on 12 June 2018, with an appointment to attend for an ENT review on 18 June 2018.[15] That was later cancelled.

Second hospital admission

30. On 12 June 2018, there was a further incident. HB was said to have been cuddling up to her mother, about to go to sleep, when she bumped her nose onto her mother's chest, or shoulder, causing her nose to bleed. Her mother wiped her nose, gave her pain relief, they ate dinner and then went to bed. The next morning HB's mother noticed HB's whole face was swollen and bruised.[16]

31. HB presented to hospital at about midday on 13 June 2018. She was triaged at 11:59am. HB's mother and her partner provided an account that HB had "*banged head off mum's chest last night from cuddling.*" The triage nurse was immediately concerned, later saying she had "*a very high suspicion for non-accidental injury.*"[17]

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[13] Exhibit 1 Vol 1 Tab 12 [11]; Vol 3 Tab 150 p 34.

[14] Exhibit 1 Vol 3 Tab 150 p 24, see also CCTV at timeline 1/1/00008.

[15] Exhibit 1 Vol 1 Tab 13 [10]; Vol 3 Tab 150 p 35.

[16] Exhibit 1 Vol 1 Tab 59 A.

[17] Exhibit 1 Vol 1 Tab 16 [7].

32. Dr Cooper examined HB in the ED at 1pm. Although HB was bright, alert and interacting appropriately, with stable vital signs, she had extensive bruising around her forehead, eyes, and face. He was also concerned about non-accidental injury and contacted the on-call child protection paediatrician at JHCH, Dr Murray.[18]

33. Dr Murray in turn asked the local paediatrician, Dr Santos, to review HB, and asked for photos to be obtained.

34. On reviewing these, and comparing them to the previous week's photos, Dr Murray believed there were clear changes with increased facial swelling. She asked for HB to be transferred to JHCH. She spoke to a maxillo-facial registrar to arrange a review. She contacted Dr Webber, to discuss HB's presentation the previous week. Dr Webber looked at the photos and said that HB had "*clearly been re-injured."*[19] Dr Murray also spoke with the social worker, who told her about the previous Helpline reports that had been made about HB, including about domestic violence.[20]

35. Dr Santos reviewed HB in person. He also asked Dr Mandaliya and the social worker to attend, who confirmed that HB's bruising appeared to be much more pronounced than the previous week. Dr Santos performed a Suspected Child Abuse and Neglect (**SCAN**) protocol, which provides a structured record of the history and injuries. He recorded the account given by HB's mother and her partner. This was largely consistent with the accounts that had been given previously. Dr Santos recorded that HB had swelling to left side of face, especially the cheek, swollen tongue on left, bruises around eyes, swelling to upper side of nose, subconjunctival haemorrhages, split skin between 4/5 toes, small bruise abdomen near umbilicus, and nappy rash. He was concerned HB may have a basal skull fracture. He also observed that HB appeared settled with her mother, but not with the partner. He later faxed the SCAN protocol to JHCH.[21]

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[18] Exhibit 1 Vol 1 Tab 17 [6]; Vol 3 Tab 150 p 1.

[19] Exhibit 1 Vol 1 Tab 24 [17].

[20] Exhibit 1 Vol 1 Tab 20 [6-16]; Vol 3 Tab 151 p 8.

[21] Exhibit 1 Vol 1 Tab 18 [9]; Tab 12 [15]; Tab 15 [20].

36. The hospital made Maitland CSC aware that HB had been presented to hospital again.[22]

37. A second report to the Helpline was made at 3.51pm. This referred to inconsistent explanations being given by the parents:[23]

> *"Clash with her puppy 2 days ago, and that HB also fell forward and hit her mother's shoulder when in her mother's arms; creating the injuries. XXX stated this was an inconsistent story and asked the doctors, who agreed. HB also had increased tongue swelling, but air way and breathing is intact. HB also has a nasal fracture."*

38. The Helpline screened-in the report as a ROSH, a serious non-accidental injury, and referred it to the after-hours team, called the Crisis Response Team (**CRT**). A CRT caseworker contacted the hospital over the course of the evening. She discovered that HB would be remaining overnight for further investigations. She also discovered that HB had a sister, and she made enquiries trying to establish where the sister was, eventually being informed by the staff from JHCH that she was being cared for by her great-grandmother.[24]

39. The CRT caseworker contacted a detective at the NSW Police Child Abuse Squad (**CAS**). The detective in turn contacted Maitland Hospital and found out that HB was to be transferred to JHCHC. A decision was made not to go to the hospital to interview HB's mother and mother's partner that day, but to interview them the next day. This did not occur, as HB remained in hospital; the interview was undertaken on 15 June 2018.[25] At this time, NSW Police were also informed of HB's previous presentation on 8 June 2018. It was the first knowledge the CAS had of the 8 June 208 admission.

40. HB was transferred to JHCH at about 6.20pm.

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[22] Exhibit 1 Vol 1 Tab 15 [24]; Vol 3 Tab 151 p 37.

[23] Exhibit 1 Vol 4 Tab 153 p 198.

[24] Exhibit 1 Vol 1 Tab 21 [16]; Vol 4 Tab 161 [22].

[25] Exhibit 1 Vol 2 Tab 74 [4]; Vol 4 Tab 161 [26]; Vol 5 Tab 217 p 23.

John Hunter Hospital – 13 to 14 June 2018

41. HB was triaged at JHH at 7.15pm on Wednesday 13 June 2018. She was not in any obvious distress and was alert and reactive. The facial injuries were noted.[26]

42. At about 8pm, Dr Quill completed a further SCAN protocol with a social worker. The account given by HB's mother had some minor deviations regarding the timing of the events but was otherwise again consistent with previous accounts. Dr Quill recorded the injuries to be "*likely NAI"* [non-accidental injuries]. HB was to be admitted under the on-call child protection paediatrician, Dr Jadhav. Dr Jadhav advised that CT scans should be obtained, and further photos.[27]

43. At 8.30pm, HB was reviewed by a maxillo-facial registrar, Dr Febbo, with an RMO Dr Wee. He also took a history. HB's mother said HB had been knocked over by the puppy and had her head hit the floor. This was different from previous accounts. She also initially said she did not know the cause of HB's new symptoms, but then referred to hitting her chest. Dr Febbo observed different coloured bruising, which he thought indicated different aged injuries. He thought HB may have a minimally displaced fracture of her right frontal bone, although this was later ruled out. He identified a small degloving injury (a tear near the frenulum between gum and teeth) and a swollen tongue. He did not identify any other fractures.

44. Dr Febbo discussed the case with his consultant, Professor Hoffman, who agreed that the explanation for the injuries sounded "*implausible.*" Professor Hoffman later sent his registrar a text, saying "*it's all very weird."* Professor Hoffman also spoke directly with Dr Quill, to explain that a maxillo-facial admission was not required, but that he was happy to speak to the consultant paediatrician about his concerns. He did not receive a call back.[28]

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[26] Exhibit 1 Vol 3 Tab 149 p 97.

[27] Exhibit 1 Vol 3 Tab 149 pp 80, 119; Vol 1 Tab 21 [9].

[28] Exhibit 1 Vol 1 Tab 22 [5-17]; Vol 3 Tab 149 p 101; Vol 1 Tab 23 [8].

45. Up until this point all hospital staff were concerned that the explanation for the injuries was implausible, and it was suspected that HB's injuries were non-accidental.

46. At about 8.50pm, a CRT caseworker spoke with the JHCH social worker. She was told that HB would remain in hospital overnight for further investigations. The caseworker understood that the explanations were "*consistent.*" Her notes do not appear to reflect the concerns being discussed among health staff.[29]

47. A CT scan of HB's brain was performed at about 10.00pm. It showed subgaleal haematomas [under the skin of the skull] and periorbital haematomas [around the eyes], and a minor displaced nasal bone fracture, but no intracranial haemorrhage.[30]

48. HB was transferred to the ward and was observed to be stable that overnight.

49. At about midnight, the Helpline report was allocated to Maitland CSC, despite the intention to send it to JIRT.[31]

50. The following morning, Thursday 14 June, the report was received at Maitland CSC.

51. The context at Maitland CSC at this time is important to note. There was only one manager on duty at the CSC, who was acting in the role of triage manager. The other managers and many staff were attending training. The triage caseworker who responded to the report was very junior. She had commenced work at DCJ in March and was part-way through her Caseworker Development Course. She may not yet have had training on physical abuse.[32] In addition, there were several urgent Level 1 reports which required a response that day – much more than usual.

52. The caseworker is said to have queried whether the report should have gone to JIRT (as the report itself stated), but the manager said they could respond and make

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[29] Exhibit 1 Vol 4 Tab 161 [31], AF-6; Vol 1 Tab 21 [16]; Vol 5 Tab 217 p 25.

[30] Exhibit 1 Vol 1 Tab 25 [23]; Exhibit 1 Vol 1 Tab 32 [7].

[31] Exhibit 1 Vol 4 Tab 153 p 204.

[32] Exhibit 1 Vol 4 Tab 160 [7].

enquiries, which is what they did. Most of the enquiries were made by the caseworker, who reported back to the manager over the course of the day.

53. A manager from JIRT did in fact become aware of the case during the day. Photos of HB's injuries were left on her desk. She made some enquiries on the computer system to find out what it was about. She also contacted the manager on duty at the CSC, suggesting the hospital be asked to keep HB in hospital for a further night.[33] Nonetheless, the report was not formally sent to JIRT at that stage, and so JIRT was not actively investigating. That process did not commence until the next afternoon.

54. Dr Febbo reviewed HB on a ward round at about 7.00am on 14 June 2018. There was no need for further treatment from maxilla-facial surgeons. He confirmed this plan with Professor Hoffman, who agreed with it. Professor Hoffman also asked "*so, are they pursuing the parents?"* which appears to reflect his thinking at the time.[34]

55. At 10.00am, HB was reviewed by the on-call child protection paediatrician, Dr Vedeler. He had received a handover from the on-call child protection paediatrician from the previous night, Dr Jadhav. Dr Jadhav was still in the hospital, now performing a general paediatrics role. She also reviewed HB later that day.

56. Dr Vedeler again took a history which appeared consistent to earlier reports. However, he did not think the mechanism for the injuries on this occasion appeared possible. Dr Vedeler was not able to complete an oral exam, as HB vomited. He ordered a full skeletal survey, further blood tests, and an ENT review.[35]

57. The skeletal survey did not show any evidence of fracture, and the nasal bone fracture was also not confirmed.[36] The ENT review noted that HB had a septum

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[33] Exhibit 1 Vol 4 Tab 157 [18].

[34] Exhibit 1 Vol 1 Tab 22 [18-22]; Tab 23 [51].

[35] Exhibit 1 Vol 1 Tab 26 [6]; Vol 3 Tab 149 pp 59, 104.

[36] Exhibit 1 Vol 1 Tab 25 [134].

deviation, but she was unlikely to benefit from reduction (surgery).[37] An abdominal ultrasound was also normal.[38]

58. Photos of HB's injuries were available, from the 7 June and 13 June admissions, and these were reviewed, and also sent to the caseworker at Maitland CSC. The acting triage manager, sent those photos onto the regular triage manager, who thought they looked "*really bad.*"[39]

59. A further review by maxilla-facial surgeons was being arranged. At 12.20pm, Dr Vedeler wrote some specific questions for that team in the notes:[40]

> *"- could this have occurred initially with a small puppy stepping on/crashing into face?*
> *- can this be re-injured causing [up] bruising & bleedings by seemingly minor mechanism – head butting chest*
> *- what is an expected mechanism for nasal # on 20 mo old."*

60. At 2pm, Dr Vedeler spoke with the caseworker at Maitland CSC. He explained that the CT scan had showed no serious bony injury, there was a blood clot outside HB's skull, and a degloving injury. He noted these were "*concerning and significant*" and he was unsure if they could fit the proposed mechanism. He noted that, from a medical perspective, HB could go home that afternoon.[41]

61. At 3.45pm, the maxillo-facial surgeon, Professor Kong, reviewed HB. He viewed the imaging and examined HB in person. He noted facial swelling, mild periorbital bruising, but no evidence of septal haematoma or nasal deformity. He recommended conservative treatment. He also recorded in the notes "*Unable to comment on nature/mechanism of injury.*"[42]

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[37] Exhibit 1 Vol 3 Tab 149 p 105.

[38] Exhibit 1 Vol 1 Tab 30 [29].

[39] Exhibit 1 Vol 4 Tab 159 [56], KSG-3.

[40] Exhibit 1 Vol 1 Tab 26 [4], Tab 21 [19]; Tab 25 [36]; Vol 3 Tab 149 p 106.

[41] Exhibit 1 Vol 1 Tab 26 [12]; Vol 4 Tab 160 [47], BW9.

[42] Exhibit 1 Vol 1 Tab 27 [6], Vol 3 Tab 149 p 109.

62. Dr Vedeler and Dr Jadhav then each had discussions with Professor Kong. There are some differences in the recollections as to what was said.

63. Dr Jadhav's progress note, made at the time, recorded that Professor Kong opined that "*the mechanism re puppy & HB -> is plausible.*"[43] Dr Jadhav prepared another note about the conversation, after HB's death, which described the mechanism as "*bizarre and unlikely but possible.*"[44]

64. Dr Vedeler's note recorded Professor Kong as saying, "*bizarre mechanism but is possible regarding force,*" omitting the fact that it was "*unlikely.*" He also recorded the following:[45]

> *"Something like a punch or direct hit would likely cause a bigger injury. A re-bleed could happen much easier, with e.g. mechanism being nose to mum's chest and a small vein could burst into subgaleal space. Swelling is likely to be prominent for 2-3 months. Prof Kong cannot say exactly what would cause the injury."*

65. Professor Kong recalls a conversation with Dr Vedeler, and as far as he can recall Dr Vedeler's account is accurate, although he cannot recall any additional detail.

66. Dr Vedeler and Dr Jadhav then discussed the case. They both remained concerned, but noted Professor Kong's opinion and that, with no outstanding investigations, HB was ready for discharge.

67. Dr Vedeler spoke to the caseworker at Maitland CSC, the social worker and Dr Jadhav. He relayed the result of the investigations, saying that HB had a concerning facial injury with an unclear mechanism, which was "*bizarre but possible.*" Dr Vedeler noted that HB could be discharged. He also recorded, "*from FACS point of view there was no reason why HB could not go home with mum.*"[46]

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[43] Exhibit 1 Vol 1 Tab 25 [44]; Vol 3 Tab 149 p 81.

[44] Exhibit 1 Vol 3 Tab 149 p 100.

[45] Exhibit 1 Vol 1 Tab 26 [13]; Vol 3 Tab 149 p 59.

[46] Exhibit 1 Vol 1 Tab 26 [17].

68. The acting manager emailed the regular triage manager at CSC, stating that the tests had come back "*all clear"* and that the plan was to review the matter at the Weekly Allocation Meeting the following day.[47]

69. A staff member from Maitland CSC, then called the hospital back, asking if HB could be kept in overnight. According to the hospital's notes, the only reason given for this was that there was going to be an allocation meeting the following morning. Dr Vedeler explained that the bed status in hospital was strained, due to the flu season.[48]

70. Dr Jadhav finally reviewed HB at about 5pm and determined that HB could be discharged.[49]

Events following discharge from hospital

71. Following HB's discharge, Maitland CSC's plan was to consider the case in the morning and decide whether to refer to the JRU.

72. The manager from JRU was concerned about the fact that the case had not already been sent to the JRU. She understood police had concerns about the fact that there had not yet been any field assessment. Accordingly, she contacted her manager of client services of JRU.[50] There were a series of emails exchanged about this, on the Thursday night and Friday morning.[51]

73. At 7.34pm a manager of JRU emailed Maitland CSC. She asked that the case be transferred to the JRU in the morning, noting this had been the original intention.[52]

74. The following morning, Friday 15 June 2018, there were further emails between these teams within FaCS. It was noted that the hospital had said the "*injuries were*

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[47] Exhibit 1 Vol 4 Tab 159 [52].

[48] Exhibit 1 Vol 1 Tab 26 [18]; Tab 25 [46]; Tab 37 [30]; Vol 3 Tab 149 p 59; Vol 4 Tab 217 p 32.

[49] Exhibit 1 Vol 1 Tab 25 [48]; Vol 3 Tab 149 p 110.

[50] Exhibit 1 Vol 4 Tab 157 [28]; Tab 158 [21].

[51] Exhibit 1 Vol 4 Tab 156.

[52] Exhibit 1 Vol 4 Tab 158 [24]; Tab 155 [17] JF1.

consistent with the explanation." JRU noted the history of the family and queried whether the injury had been considered in the context of the child protection history. Following this, the matter was transferred to the JRU for consideration.[53]

75. The referral was sent to the JRU at 12.30pm. There was then a process of assessment involving the three agencies, namely NSW Health, NSW Police, and FaCS, sharing information they held about the family. While this was done, it did not at that stage include all of the history held by NSW Health about HB's mother's partner. That history was only identified after HB's death. At about 4pm the JRU determined that the matter should be referred to JIRT, and the case was transferred and accepted at 4.45pm.

76. Meanwhile, the NSW Police CAS had become aware of HB's discharge. Two of the detectives were concerned, and they decided to attend the home to interview HB's mother and her partner. On 15 June 2018 they conducted a walkthrough of the home with HB's mother, who explained where events had taken place. They videoed the interviews.[54]

77. There were clear differences in their accounts. HB's mother's partner said he and HB's mother were outside having a smoke, and the puppy pushed past his leg and went up the hallway. He confirmed no-one had seen anything happen, and said he concluded that, when the puppy jumped from the bed back down, he and HB clashed heads. He said HB's mother had not entered the house, as she had just lit a cigarette. In contrast, HB's mother said she entered the home, and that the dog had licked HB's face, although HB did not wake up.

78. Part of the video was shown that afternoon to the JIRT manager, although there was no sound. She did not observe any dangers in the home. It was planned that the whole video would be made available for review by JIRT, and sent to the child protection team at hospital, to consider the explanation for the injuries.[55]

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[53] Exhibit 1 Vol 4 Tab 158 [26]; Tab 155 [18]; Tab 156 [31] MH6.

[54] Exhibit 1 Vol 2 Tabs 76, 78 and 80.

[55] Exhibit 1 Vol 4 Tab 157 [44].

79. At 2.15pm, there was a report made to the Helpline, regarding HB's presentations to hospital, although this was screened as not involving a risk of significant harm.[56]

Teleconference between the agencies

80. On 15 June 2018 at about 4.00pm, a teleconference was held between staff from the three agencies. The manager from JIRT attended the meeting, although the case had not yet been formally accepted by her team. NSW Police described the inconsistencies given by HB's mother and HB's mothers partner. One of the NSW Police officers present at the meeting provided her opinion that she did not believe the dog was able to inflict the injuries sustained by HB and expressed her concern for the children in the home.[57]

81. A child protection paediatrician from JHCH also attended and confirmed that the injuries were considered possible but very concerning. She had not been involved during HB's admission; she had a handover from other staff. It was agreed that police photos of the dog would be sent to JHCH, and JIRT caseworkers would speak to HB's daycare.[58] NSW Police sent the photos but received no response.

82. At 4.45pm, there was a further briefing between the agencies at JIRT.[59] It was agreed that JIRT would commence an investigation. However, it was noted that, until further information was available, no immediate safety concerns could be identified.

83. At 5.20pm, there was a phone discussion between the managers at JIRT, and the triage manager at Maitland CSC. Staff at CSC stayed back late in case a response was needed that evening. During the phone call, they discussed whether safety planning would assist in safety over the weekend. The JIRT team decided that a visit to the home would not increase HB's safety. Instead, the plan was for there to be a joint response between JIRT and Maitland CSC on Monday. The need for a joint response

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[56] Exhibit 1 Vol 4 Tab 153 pp 276, 287.

[57] Exhibit 1 Vol 2 Tab 74 [17],[18]; Tab 85 [14].

[58] Exhibit 1 Vol 1 Tab 36 'C'; Vol 3 Tab 149 pp 41, 55; Vol 4 Tab 157 ([51], EM17; Vol 5 Tab 217 p 39.

[59] Exhibit 1 Vol 4 Tab 157 p 46 EM18.

was because JIRT would look at HB's safety, and Maitland CSC would consider the safety of HB's sister.[60]

18 June 2018

84. On Monday 18 June 2018 at JIRT the case was allocated to a caseworker. A message was sent to Maitland CSC, to discuss the intended response. That message was never received. As a result, no response was ever planned.[61]

85. The manager client services at JIRT, states that it would have been her expectation that the JIRT response should have included a home visit on the Monday.[62]

86. A further following report was made to the Helpline:[63]

> *"All things considered Detectives are of the opinion a further assessment should be completed by Medical Specialists in relation to the Incident. The injury is severe and appears in the opinion of detectives to be a significant impact and there is no incident that anyone involved can give that is plausible."*

87. The Helpline screened this out as a duplicate.

19 June 2018

88. On 19 June 2018 HB was at home. HB is seen on CCTV footage at about 9.30am, alert and well. She was not seen again on CCTV footage until 12.52pm, after she had sustained fatal injuries.

89. CCTV footage at 12.52pm shows HB's mother's partner carrying HB out of the house, looking limp, and HB's mother looking upset.[64]

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[60] Exhibit 1 Vol 4 Tab 157 [59], EM22; Tab 159 [72]; Tab 158 [41].

[61] Exhibit 1 Vol 4 Tab 158 [46]; Tab 159 [79]; Vol 5 Tab 217 p 46.

[62] Exhibit 1 Vol 4 Tab 158 [43].

[63] Exhibit 1 Vol 4 Tab 153 p 341.

[64] Exhibit 1 Vol 6 Tab 225 1/1/00067.

90. Despite her state, an ambulance was not called until 4.59pm, when HB's mother called 000.

91. Paramedics attended at 5.15pm. The paramedics observed extensive bruising on HB's torso. They continued to resuscitate her until 5.37pm, when she was transported to JHH. However, it was quickly established that there we no signs of cardiac activity. HB was declared deceased at 6.03pm.[65]

AUTOPSY

92. A paediatric autopsy was performed on 21 June 2018 by Dr Allan Cala, at Newcastle.[66] The direct cause of death was recorded as "*multiple injuries,*" including a subdural clot, multiple rib fractures, injuries to the liver and blood in the abdominal cavity. There were no underlying causes.

93. Dr Cala opined that the totality of the injuries could not be explained by accidental infliction, and that the more serious injuries which caused death were occasioned by non-accidental trauma. The injuries were said to be of "*varying ages*" and the facial injuries were "*highly suspicious for a number of assaults.*"

POLICE INVESTIGATION

94. There was an extensive police investigation.

95. The police investigation identified a stain of HB's blood in her bed, and also on the corner of a set of drawers.

96. On 3 August 2018, HB's mother's partner was charged with HB's murder. A week later, HB's mother was charged with manslaughter. In both matters there were guilty verdicts at trial.

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[65] Exhibit 1 Vol 3 Tab 149 p 3; Vol 1 Tab 38.

[66] Exhibit 1 Vol 1 Tab 3.

97. The judge in the related criminal proceedings concluded that the assault had occurred in the bed, and then she was forcefully thrown against the drawers.[67]

EXPERT REVIEW

Bronwen Elliott, Accredited Member of the Australian Association of Social Workers since 1980

98. Bronwen Elliott, Accredited Member of the Australian Association of Social Workers since 1980, provided an independent expert review of the circumstances surrounding HB's death. Her opinions have been accepted by the following three significant parties in this matter: the Department of Communities and Justice, the New England Local Health District, and the NSW Police Force.

99. She is of the opinion that when the matter was referred to the Helpline on 8 June 2018 the matter should have been referred directly to the JIRT with a view to referral to JRU rather than to the Maitland CSC. JIRT would have been better placed, with its specifically trained staff, to respond to the concerns for HB's safety.

100. Ms Elliott explained that what ensued during and after both hospital admissions was that a circular pattern quickly emerged between FaCS and the hospital staff where FaCS staff were waiting for the medical staff to resolve the question of whether HB had suffered a non-accidental injury, and the medical staff were unable to answer the question in the terms that FaCS needed.

101. She pointed out that the issue was not the amount of interaction between the agencies but the nature of the interaction. In particular, FaCS staff accepted information from hospital staff without seeking clarification of contradictions that had previously been noted regarding the explanation of HB's injury with the expectation that medical staff should be able to provide a definitive answer. She pointed out that there appeared to be confusion between plausibility and likelihood of the injury, and that determining that an explanation for HB's injuries was possible did not mean it was reasonable. She felt this was particularly noticeable in the

[67] Exhibit 1 Vol 1 Tab 6 [13].

various recounts of Professor Kong's opinion which was substantially relied upon by Dr Vedeler and Dr Jadhav.

102. In her view, the information exchange between FaCS and NSW Health would have been more effective if the JRU had been involved from the beginning, or at the very latest from the second admission and second report to the Helpline on 14 June 2018. She explained that JRU staff would have been more experienced in evaluating the medical opinions and more experienced in clarifying information rather than passively waiting for the health staff. They would also have been able to access more information both from health records and from directly engaging with the family. Furthermore, JRU staff would have been more familiar with interviewing parents about unusual explanations for injuries and interrogating doctors about the injuries.

103. Ms Elliott noted that the NSW Police CAS were contacted in a timely manner after HB's second hospital admission when the report was processed after hours. The CAS was concerned about HB's two presentations to hospital and her injuries and took the initiative to collect more information. This confirmed their concern that the explanations for the injuries were ill founded. The CAS then communicated their concerns through an interagency meeting to ensure that they could be considered by all the parties. Ms Elliot is of the opinion that it is likely that their experience and training enabled them to focus on HB in a way that the other organisations were not.

104. Ms Elliott concluded that the risk of physical harm to HB was not adequately addressed. She explained that there was a lack of integration of information. She felt that there was a lack of recognition of the importance of likelihood rather than possibility of the injury. She felt that no one except NSW Police appeared to consider what it might mean that HB had appeared twice in a short period with injuries that on both occasions had odd explanations.

105. She confirmed that the FaCS staff lacked the experience of the JIRT team in relation to physical injuries and that FaCS expected the hospital staff to be able to give a definitive answer about whether HB's injuries should worry them. She said these dynamics can be seen in the CSC staff's readiness to accept hospital staff's opinions, especially when these implied no intervention was required, and the limited

challenging of those views. She felt that had the JIRT team begun work with the family earlier and had the limitations of medical opinions on HB's injuries been recognised and challenged, it is possible that a decision could have been made that HB was not safe to go home from hospital. In that event, arrangements might have been made for HB's extended family to care for her and to gain some time to assess the risk.

Ms P Brunner, the former Executive Director of Community Services Statewide Services, Department of Communities and Justice (DCJ)

106. Ms P Brunner, the former Executive Director of Community Services Statewide Services, DCJ, agreed that it would have been appropriate for the matter to have been referred directly to the JRU from the Helpline on HB's first presentation to hospital. That the report met the criteria for a JIRT referral. She informed the Court that since HB's death the guidelines for referral have been revised to provide further guidance on the criteria for referral.[68]

107. She explained that an error was made in the handling of the second report. On 13 June 2018 the whole report only went to Maitland CSC rather than a report of the injuries also going to JRU as intended.

108. At that time the computer system used by FaCS called ChildStory was relatively new, and it would not have been apparent that this error occurred. The Court has been informed that steps have been taken to remedy this fault.

109. That error was recognised on the morning of 14 June 2018, however, the acting triage manager at Maitland CSC decided to make enquiries before the matter was referred to JRU. The CSC made enquiries with the hospital over that day intending to consider referral to the JRU at a meeting the following day.

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[68] Exhibit 1 Vol 5 Tab 179.

110. Unfortunately, the second report was not accepted by JIRT until 4.45pm on 15 June 2018. This delay resulted in a missed opportunity to commence an early coordinated response involving the specialist JRU staff from the three agencies.

111. Ms Brunner is of the opinion that once JIRT accepted the report on the Friday evening, a field assessment should have occurred on the Monday and a home visit should have taken place. This amounted to another missed opportunity to protect HB.

Detective Superintendent Howlett, the Commander of the Child Abuse Squad (CAS), New South Wales Police Force

112. Detective Superintendent Howlett, the Commander of the New South Wales Police Force CAS informed the Court that if the matter had been referred to JRU the police would have been informed of the case at the first hospital presentation and would have likely interviewed HB's parents about their explanation for the injury.

Dr P Craven, Executive Director for the Children, Young People and Families Networks and Streams and Medical Services, Hunter New England Local Health District (HNELHD)

113. Dr P Craven, Executive Director for the Children, Young People and Families Networks and Streams and Medical Services, HNELHD informed the Court that the Local Health District acknowledges that its child protection responsibilities extend beyond reporting and that the Local Health District did not proactively respond to child protection risks as well as it should have.

114. He explained that health staff may have been cautious in providing information to DCJ as there may have been concerns that any information may be used in court. He said that this concern possibly leads to more circumspect communication by health workers to DCJ. The Court has been informed that the three relevant agencies are in the process of improving clarity and timeliness of communication between HNELHD health practitioners, DCJ and NSW Police, and are considering whether communication should be in writing.

115. He also explained that on 14 June 2018 the hospital should have used its best endeavours to comply with the FaCS' request to keep HB in overnight. While she was medically cleared for discharge, the hospital was required pursuant to the *Children and Young Persons (Care and Protection) Act* to use its best endeavours to comply with the FaCS request.

116. Her discharge on 14 June 2018 amounted to another missed opportunity as had HB remained in hospital, JIRT would have become involved prior to her discharge. Dr Craven informed the Court that since HB's death an informal escalation process is in operation whereby decisions about discharge can be escalated to a senior level. A relevant guideline is in the process of being formalised with DCJ.

THE INSTITUATIONAL RESPONSES TO HB'S DEATH

117. The following significant changes have been made within the three agencies since HB's death.

Department of Communities and Justice

118. Following HB's death, the Office of the Senior Practitioner completed an Internal Child Death Review (**ICDR**) into FaCS' involvement in HB's case. Upon completion, the ICDR recommended that:

    a. The Director Community Services, Hunter Valley, Director Joint Child Protection Response (JCPR) Statewide Services and Director Practice Support, Northern collaborate to determine and deliver appropriate training and practice development support for managers and staff at Maitland CSC and Newcastle JIRT, based on the practice issues identified in the review.

    b. To address the identified concerns about practitioners' lack of confidence to prioritise a face-to-face assessment while medical advice was unclear or contradictory:

        i. Development of training for practitioners about physical injuries and how they are assessed.

ii. Development of a workshop targeted for managers casework with a focus on the importance of 'stepping into authority,' with links to the material contained in the Leadership Portal, using HB's review as a case example.

c. HB's review to be presented to the Community Services Operations Forum (with invitations extended to Executive District Directors) in a group supervision session focused on:

i. The leadership required to enable staff to respond with urgency, appropriately challenge decisions that do not appear to be in children's interests, and access support.

ii. Guidance provided in the new Partner Domestic Violence Policy.

d. The Panel recommends that in the audit of the Domestic Violence Kit advice about working with offending and non-offending parents and advice about a work health and safety response for staff be included.

e. For HB's review to be referred to NSW Health Executive Director Strategy and Reform and for the Senior Practitioner OSP to meet with her to share and discuss the findings of the DCJ Serious Case Review and the NSW Health Root Cause Analysis (RCA). The outcome of the meeting to be reported back to the Serious Case Review Panel, and the DCJ Board.

f. That the Executive Director ChildStory develop a permanent solution in ChildStory to enable ROSH reports that have been referred to a business unit in error to be identified and corrected immediately. [69]

119. In addition to these recommendations, the ICDR identified the following steps already taken by FaCS in the time since HB's death:

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[69] Exhibit 1 Vol 5 Tab 217.

a. The JCPR Statement of Intent signed by the three agency heads in September 2018 recommitted the agencies to the fundamental principles underlying the partnership and introduced the concept of an 'agency lead.'

b. A JCPR Program District Engagement Package was endorsed in March 2019 and was being rolled out at the time the ICDR was completed. The package seeks to strengthen and promote joint, collaborative, and positive relationships between JCPR and CSC staff.

c. A specific 'Joint Local Planning & Response' record type was incorporated into ChildStory in June 2018 to capture data relating to information exchange, joint planning, debriefing and 'next steps.'

d. FaCS Newcastle JCPR unit reviewed its rotation and case handover processes to ensure all matters are more closely monitored and managed. Newcastle JCPR have consolidated their supervision practice, and the unit now has regular access to a casework specialist who provides advice on complex matters. [70]

120. Each of the recommendations made in the ICDR have since been completed, and as part of that process significant changes have been made to the Joint Child Protection Response Program (**JCPRP**) practice and procedure.[71]

121. In her oral evidence as part of the institutional conclave, Ms Brunner observed that the JCPRP now adopts a more collegial approach and benefits from greater engagement of health workers at the referral stage. Ms Brunner also highlighted the change in name from JIRT to JCRPR to be culturally significant in emphasising the agencies' shared responsibility for child safety and wellbeing.[72]

[70] Exhibit 1 Vol 5 Tab 217 pp 70-72.

[71] Exhibit 1 Vol 5 Tab 179; Evidence of Pamela Brunner 23 October 2024.

[72] Evidence of Pamela Brunner 23 October 2024.

Hunter New England Local Health District

122. As a result of HB's death, the HNELHD also made changes to practices and procedures regarding child welfare.

123. In particular, the HNELHD has developed a new guideline to formalise escalation procedures between the LHD and DCJ regarding requests for 'safety admissions' in HNELHD facilities. The HNELHD acknowledge that in the context of regular and multiple requests from DCJ for safety admissions, disagreements between the two agencies will occur.[73] The new guideline establishes a documented, proposed pathway for clinicians to escalate concerns to HNELHD and DCJ management if a decision needs to be made at a higher level, or when either agency has a differing opinion as to ongoing management of a specific case.[74]

124. Dr Paul Craven confirmed in evidence that these procedures are already occurring on an informal basis, and the formal procedure is close to being finalised.[75]

125. Further, as a result of HB's death, the Child Protection Team (**CPT**) and the HNELHD's Violence, Abuse and Neglect (**VAN**) service have developed new processes and initiatives to improve communication and escalation procedures regarding child protection matters. The JHCH CPT now assigns a key person upon receipt of referral for a child at possible risk. This person is the central contact for other team members, other hospital staff, and interagency services and clear and documented handover processes have been developed to allow for another team member to take over with all the necessary information of the key person is away or works part time.

126. The JHCH CPT has improved consistency in day rostering of child protection consultant paediatricians, and enhancements from NSW Health have optimised the structure of the CPT at JHCH to be consistent with those in the other two Children's Hospitals in Sydney, based in Westmead and Randwick. The CPT now has two paediatricians, one available for local assessment and District advice every day, and a

[73] Evidence of Dr Paul Craven 23 October 2024.

[74] Exhibit 1 Vol 5 Tab 218 [45], A.

[75] Evidence of Dr Paul Craven 23 October 2024.

second to provide ongoing clinical support, education and local clinical support on a daily basis.[76]

127. Formal processes are now in place for minute-taking in multiagency case conferences with DCJ and JCPRP, which dictate the recording of information to ensure that team documentation is accurate and concise. Note recording is now more accurate, with the treating team recording everything in real time rather than in retrospect. These notes are kept on the NSW Health file.[77] A process has also been established for clinical photography and sharing with DCJ in child protection cases. Senior and executive communication pathways between DCJ and HNELHD staff have also been strengthened.

128. Dr Paul Craven told the inquest that the HNELHD had acted on all recommendations made by the NSW Ombudsman in their review completed in relation to HB's death.[78]

Joint Child Protection Response Program – NSW Police Force

129. Detective Superintendent Howlett observed that significant changes have been implemented as a result of JIRT transitioning to the JCPRP, but concerns remained about delays in receiving report from the DCJ Helpline. The On-Call Response Form was developed in response, and in Detective Superintendent Howlett's evidence partially addresses the concerns of NSWPF staff in this respect. The On-Call Response Form acts to give JCPRP staff advance warning of an incoming referral.[79]

130. In Detective Superintendent Howlett's view the development of the JCPRP Statement of Intent places emphasis on the safety of children and the need to act quickly. Detective Senior Howlett told the inquest she has observed an increase of communication between NSW Health and the NSWPF since the commencement of the JCPRP.[80]

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[76] Exhibit 1 Vol 5 Tab 218 [55]; Evidence of Dr Paul Craven 23 October 2024.

[77] Exhibit 1 Vol 5 Tab 218 [55]; Evidence of Dr Paul Craven 23 October 2024.

[78] Evidence of Dr Paul Craven 23 October 2024.

[79] Evidence of Detective Superintendent Linda Howlett 23 October 2024; Exhibit 3.

[80] Evidence of Detective Superintendent Linda Howlett 23 October 2024.

CONCLUSION

131. On 27 September 2021, a facilitated case discussion involving staff from the NSWPF, DCJ and NSW Health took place. The focus of the discussion was to consider how and what the agencies could have done differently and what lessons could be learnt from HB's case. The recommendations and outcome actions of the discussions were:

    a. JCPRP Statewide Management to consider using HB's deidentified case study in future joint training material, Local Planning Response re-writes and manager level simulations.

    b. JCPRP to implement NSW Ombudsman recommendation about case discussions/tri-agency debriefs on critical matters via Senior Officers Group as required.[81]

132. It is understood these measures have since been adopted.

133. The colocation of staff from DCJ, HNELHD and the NSWPF has been significant and led to greater engagement and improved information sharing, including more efficient sharing of digital information like photos and videos.[82]

134. Senior executives across the three agencies have engaged to discuss a proposal to establish a 'Hunter New England Violence, Abuse and Neglected and Department of Communities and Justice and JCPRP Executive Collaborative.' This Executive Collaborative will comprise a regular schedule of formalised meetings between executive staff from HNELHD, JCPRP (NSW Police) and DCJ, and will focus on collaboration within each organisation.

135. Executives have agreed and terms of reference have been drafted. The first meeting took place on 5 November 2024. At this meeting all three agencies agreed to draft communication strategy for dissemination. A primary purpose of the strategy is to address the use and meaning of words such as "possible" and "likely" in the context

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[81] Exhibit 1 Vol 5 Tab 218 Annexure A.

[82] Evidence of Pamela Brunner, Detective Superintendent Linda Howlett, and Dr Paul Craven 23 October 2024.

of reporting non accidental injury. The meeting also focused on updating the escalation processes within NSW Health, DCJ and JCPRP when concerns arise, agreeing to meet on a three-monthly basis and discussing relevant cases and issues.

136. HB's death is a tragedy that has affected so many people. I acknowledge the commitment of the three agencies involved to learn lessons from the circumstances surrounding HB's death and the commitment by them to try and establish a system that will prevent a similar death in the future. In light of the changes made I do not propose to make any recommendations.

137. I offer my heartfelt condolences to HB's family.

138. I thank Counsel Assisting, Mr J Harris and his instructing solicitor, Ms McKinlay for the work they put into assisting me in this inquest.

139. I close this inquest.

Findings pursuant to s 81 (1) *Coroners Act 2009*

Identity

The person who died was HB.

Date of death

HB died on 19 June 2018.

Place of death

HB died at John Hunter Hospital, New Lambton Heights, NSW.

Cause of death

HB died as a result of multiple injuries.

Manner of death

The fatal injuries were inflicted by a known person.

Magistrate Carmel Forbes

Deputy State Coroner

4 December 2024

NSW State Coroner’s Court Lidcombe