STATE CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Baby Q
Hearing dates:	**18 – 22 December 2023** State Coroners Court, Lidcombe
Date of findings:	**18 April 2024**
Place of findings:	Tamworth Local Court (by AVL to parties located elsewhere)
Findings of:	**Magistrate Harriet Grahame, Deputy State Coroner**
Catchwords:	CORONIAL LAW – manner and cause of death – mental illness – family violence and neglect – family known to the NSW Department of Communities and Justice and the QLD Department of Child Safety, Seniors and Disability Service – neglect – cumulative harm – NSW Police Force – QLD Police Service – cross-border policing – information sharing
File number:	**2018/359588**
Representation:	1. Ms D Ward SC and Ms M Barnett SC, Counsels Assisting the Coroner, instructed by Alexander Jobe and Elizabeth May (Department of Communities and Justice ('**DCJ**')) 2. Mr Jake Harris for DCJ, instructed by Darren Chennell (DCJ) 3. Karen Carmody for the QLD Department of Child Safety, Seniors and Disability Service ('**DCSSDS**'), instructed by Chantal Howland (DCSSDS) 4. Jillian Caldwell for the NSW Police Force ('**NSWPF**') instructed by Jesse Pereira, Wotton + Kearney (NSWPF) 5. Mark O'Brien for the QLD Police Service ('**QPS**') 6. Jaimee-Lee Jessop, Gilshenan & Luton Legal Practice, for QPS Officers Bisa and Barton (limited leave granted)

Non publication order:	Non-publication orders made on 18 December 2023 prohibit the publication of any information that identifies Baby Q LB [redacted] or parents. Non-publication orders made on 18 April 2024 prohibit the publication of the name of a DCJ caseworker. A copy of the orders can be obtained on application to the Coroners Court registry.
Findings:	The *Coroners Act* in s81 (1) requires that when an inquest is held, the coroner must record in writing his or her findings as to various aspects of the death. These are the findings of an inquest into the death of Baby Q [redacted] **Identity** The person who died was Baby Q [redacted] **Date of death** She died on 17 November 2018 **Place of death** She died at Tweed Heads, NSW **Cause of death** The cause of her death is unascertained **Manner of death** Baby Q was a child known to some degree by child protection authorities in three states. Baby Q and her family were also known to Police in Queensland and NSW, and her mother and father were known to mental health services in various states. She was killed by her father who was suffering severe psychosis.

Recommendations:	**To the QLD Director-General, Department of Child Safety, Seniors and Disability Services** 1. In situations where DCSSDS refer a family to a family well-being service in the course of an Investigation and Assessment, consideration be given to requiring the family well-being service (however described) to inform DCSSDS if the family disengages prematurely from the service and the reason for the disengagement. 2. That consideration be given to improving access for DCSSDS caseworkers to expert psychological opinion to help them assess risk to children, when working with a family with complex mental health needs. **To the NSW Secretary, Department of Communities and Justice, and the Commissioner of the NSW Police Force.** 3. That consideration be given to amending ChildStory so that if an Assessment Officer in a Child Wellbeing Unit makes an entry under the CWU tab for a family where there is an open file at a CSC, the CSC is automatically alerted to the entry having been made (for example, recording contact with the family and concerns assessed as non-ROSH). 4. That consideration be given to trialling an information sharing portal that gives DCJ direct access to limited but relevant information on CoPS (such as criminal history and domestic and family violence information) to better inform an assessment of risk and the preparation of Part 16A requests. The Queensland Self Service of Document Retrieval and Unify initiatives provide a useful precedent.

	To the Commissioner of the QLD Police Service, and the Commissioner of the NSW Police Force. 5. That a proposal be taken by QPS and NSWPF to the Australian Criminal Intelligence Commission, which oversees the National Criminal Intelligence System to trial an information sharing portal that would permit state and territory child protection authorities to have direct access to limited but relevant information on NCIS (such as criminal history and domestic and family violence information) to better inform an assessment of risk and the preparation of further lawful requests for information under state or territory law.

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The Coroners Act in s81 (1) requires that when an inquest is held, the coroner must record in writing his or her findings as to various aspects of the death. These are the findings of an inquest into the death of Baby Q

Introduction

1. This inquest concerns the tragic death of a nine-month-old First Nations baby girl, Baby Q (born 2 February 2018). Baby Q was killed by her father, RB on the evening of 17 November 2018. RB was suffering a psychotic episode at the time. Baby Q body was found on Main Beach, Surfers Paradise, Queensland on 19 November 2019. The factual matrix surrounding those events is set out in the decision of Her Honour Justice Wilson in *R v RB* [2020] NSWSC 1552, in which a special verdict of not guilty by reason of mental illness was returned.

2. At the time of her death, Baby Q her parents and her LB were living rough and sleeping in a park. For all of Baby Q short life, the family were transient, living between Geelong, Victoria, the border towns of northern NSW and Queensland and Mackay, Queensland. Both parents suffered from severe mental illness, and RB was also dependent upon alcohol and frequently used cannabis. Multiple government agencies in NSW and QLD, including NSW Department of Communities and Justice (DCJ), Queensland Department of Child Safety, Seniors and Disability Service (DCSSDS), New South Wales Police Force (NSWPF) and Queensland Police Service (QPS) were involved with or had some contact with the family leading up to Baby Q death. The family also had limited contact with non-government support services from time to time.

3. Unfortunately I know very little about Baby Q personality and character. I note photographs of Baby Q contained in the brief show her chubby cheeked and smiling. There is evidence that she was observed as looking happy at various times. Her maternal aunt described her as a “happy healthy baby”.

4. If Baby Q had lived, she would have turned six years old in February of this year and could have been a few months into Year One. In making these findings, I offer Baby Q family my sincere and heartfelt condolences for the profound loss they have suffered.

The role of the coroner and the scope of the inquest

5. The role of the coroner is to make findings as to the identity of the nominated person and in relation to the place and date of their death. The coroner is also to address issues concerning the manner and cause of the person's death.[1] A coroner may make recommendations, arising from the evidence, in relation to matters that have the capacity to improve public health and safety in the future.[2]

6. Pursuant to s 24(1)(b) of the *Coroners Act 2009*, only a senior coroner has jurisdiction to hold an inquest concerning a death or suspected death if it appears to the coroner that the person was (or that there is reasonable cause to suspect that the person was) a child to whom a report was made under Part 2 of Chapter 3 of the *Children and Young Persons (Care and Protection) Act 1998* within the period of three years immediately preceding their death. Baby Q falls into this category. There is a clear public interest in ensuring that the death of a vulnerable child, who has previously been reported to DCJ is fully investigated to ascertain whether the state should have provided greater assistance or whether missed opportunities for care and support can be identified and rectified for future children.

7. It is important to acknowledge at the outset that these proceedings were approached in a cooperative manner by each of the involved parties. The court was also greatly assisted by the provision of internal review reports that were produced by both DCSSDS and DCJ and which indicated their commitment to a full and open review of the circumstances of Baby Q death. It was heartening to hear of improvements that have already been made to systems following these internal reviews.

8. Baby Q family were homeless or in extremely precarious housing in the period leading up to her death. Their life was frequently transient, and they were often difficult to contact. I acknowledge this created particular difficulties for those trying to offer the family support and impacted upon the continuity and quality of the assistance provided. Homelessness and the lack of appropriate

[1] Section 81 *Coroners Act 2009* (NSW).
[2] Section 81 *Coroners Act 2009* (NSW).

accommodation for families in need is an issue of growing concern in our community and one that continues to impact children like Baby Q

9. It is important to acknowledge at the outset that while homelessness was one significant issue the family faced, their difficulties were much more complex. It may be that focus on the family's homelessness at times even contributed to an inadequate appreciation of the real effect of their parents' mental illness on Baby Q and LB Both RB and JM were extremely unwell and were untreated at the time of Baby Q death. RB illness often manifested in aggression and violence, and while agencies regarded JM as a protective influence in the family, she too was unable to provide appropriate care to the children she clearly loved.

10. Baby Q death was impossible to predict. However, an examination of the material before me makes it clear that the risk of some kind of harm occurring to her was entirely predictable, indeed inevitable without significant intervention in the family. While I accept that no single person had all the relevant information indicating the extent of the escalating risk involved, various people who had interacted with the family throughout 2018 should have understood that Baby Q was a child in urgent need of protection. Given the nature of this family's fractured involvement with child protection services and police in various states over the years, the court was particularly keen to understand and assess the systems for information sharing between the relevant agencies.

11. A list of issues was prepared before the proceedings commenced. These issues guided the investigation and focused on the family's involvement with the relevant government agencies in the period leading up to Baby Q death, Baby Q cause and manner of death, information held by the agencies regarding risks posed to the Baby Q and LB whether information was adequately shared across State boundaries, and what changes have been implemented since Baby Q death.

The evidence

12. The court took evidence over four hearing days. The court also received extensive documentary material, estimated at over 50,000 pages. The material included witness statements, government and non-government organisation

records concerning the family, medical records, CCTV and Police body-worn camera footage, various policy and procedures, and a report of an independent expert, Dr Alison O'Neill, Clinical Psychologist.

13. The inquest heard oral evidence from eight witnesses; three of whom met Baby Q and her family in the weeks leading up to her death and on the day she died, four organisational witnesses from the respective child welfare and police agencies, and one independent expert witness, Dr O'Neill.

14. While I am unable to refer specifically to all the available material in detail in my reasons, it has been comprehensively reviewed and assessed. I acknowledge that I had access to a range of material that no individual caseworker would have seen at the time of Baby Q death.

Background and brief chronology

15. Given the significant volume of material, those assisting me drafted a chronological summary of the key events from the available documentary evidence. This summary was tendered and its content was agreed on by the parties, subject to a few minor amendments from DCJ which have now been included. I attach a copy of that document as an annexure to these reasons. I do not intend to repeat all the material contained in it. I regard it as accurate and I adopt its content.

16. For current purposes, I provide the following background and brief chronology.

17. Baby Q was born on 2 February 2018 at Mackay Base Hospital, Mackay, Queensland to RB and JM RB and JM had one other child together, LB who was ten months old when Baby Q was born.

RB

18. RB (aged 47 at the time of Baby Q death) is a Torres Strait Islander man who was raised in Western Australia and Queensland. He is the father of four children: the youngest being Baby Q

19. It appears on the available records that RB was first diagnosed with alcohol induced psychotic disorder in 2000 and schizophrenia in 2001[3]. As recorded in the decision of the Supreme Court, "throughout these years [2002-2013] recurring among the delusions reportedly suffered by RB were hallucinations of being commanded to kill people and to kill a baby, delusions concerning black magic, spirits, and elders and, curiously, the singer Brittney Spears".[4]

20. From 2010[5] until November 2016, RB was "managed" (as the phrase was used within the records) via an Involuntary Treatment Order under the provisions of the *Mental Health Act 2000* (QLD). Despite that order, RB would fail to turn up for his depot medication from time to time, and his compliance varied.

21. Once RB and JM moved to Victoria in mid-2016 (discussed further below), RB started seeing a General Practitioner at the Wathaurong Health Service for his paliperidone (anti-psychotic) injections.[6] Sometime after an appointment on 1 November 2016, RB travelled to Mackay and went into the Community Mental Health service on 11 November 2016 to say hello to his case manager. This ultimately led to the revocation of RB Involuntary Treatment Order.

22. The Medicare records establish that RB did not consult a psychiatrist in the community nor a general practitioner for treatment for his schizophrenia (or anything else) from late November 2016 until the time of Baby Q death. Medical evidence accepted in the Supreme Court proceedings established RB was actively psychotic immediately prior to his arrest on 19 November 2018.[7]

23. RB was also dependent upon alcohol and frequently used cannabis.[8]

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[3] Judgment, Exhibit 1, Tab 8, p.231-232 at [72]-[73].
[4] Judgment, Exhibit 1, Tab 8, p.232 at [75].
[5] Judgment, Exhibit 1, Tab 8, p.223 at [12]. Mackay Health Service Mackay Exhibit 1, Tab 109C, p.1808-73-1808-74.
[6] Wathaurong Health Service Mackay, Exhibit 1, Tab 109B, p.1808-48.
[7] Judgment, Exhibit 1, Tab 8, p.234 at [82]-[85].
[8] Mackay Health Service, Exhibit 1, Tab 109C, p.1808-73.

JM

24. JM (aged 23 at the time of Baby Q death) was born and raised in Victoria with her parents and younger sister. JM had a supportive childhood and did not start showing signs of mental illness until she was 18 or 19 years old. At this time her parents noticed a rapid deterioration in her mental health. JM parents tried very hard to support her, but it was difficult given that she lacked insight into her condition.

25. Like RB JM delusions were sometimes focused on religious or spiritual themes. According to JM father, JM became extremely religious and believed at one point that she was the mother Mary and that she was going to give birth to baby Jesus.[9] She would sometimes go out to baptise people.[10]

26. Around this time (in 2014 or 2015), JM went missing. This was reported to Police by her parents who located JM and took her to hospital where she was involuntarily detained. There followed various admissions to psychiatric in-patient and out-patient facilities[11] and the prescription of anti-psychotic medication.

27. After meeting RB in early 2016 (discussed below), JM mental health deteriorated again, and she was admitted on an involuntary basis to the acute care psychiatric unit of Geelong Hospital from 10 - 27 May 2016. Upon discharge JM was treated as a voluntary patient through Barwon Health's Prevention and Recovery Centre (a sub-acute facility).[12]

28. As at 31 May 2016 JM was being treated for a mental illness consisting of mood disturbance (manic episode) and psychotic symptoms. A medical report prepared for the Victorian Civil and Administrative Tribunal suggested this was most likely Bipolar Affective Disorder Type 1, but confirmation of this diagnosis

[9] Exhibit 1, Tab 105, p.1744 at [21].
[10] Exhibit 1, Tab 105, p.1744 at [23].
[11] Exhibit 1, Tab 105, p.1743-1745; at p. 1743-1745; Exhibit 1, Tab 105A, p.1755-1756; Exhibit 1, Tab 106, p.1758.
[12] Exhibit 1, Tab 106, p.1959 and 1780.

needed further longitudinal assessment. A differential diagnosis included delusional disorder.[13]

29. At a later point in mid-2016 JM was discharged from the Barwon Centre to a community based mental health treatment service in Belmont.[14]

30. Little more is known about JM treatment. There is nothing to suggest she received psychological or psychiatric care following this time, including in the lead up to or following Baby Q birth. In the criminal proceedings after Baby Q death, it was accepted that JM had been suffering from an untreated psychotic condition for several years.[15] It is likely she lacked insight into her condition.

31. There is evidence that JM was subject to violence from RB and that she sustained injuries, such as cigarette burns and other injuries which are likely to have been perpetrated by him. She is reported to have taken a subservient role to him. Both RB and JM had very significant mental health issues and it is difficult to untangle the way in which family violence became incorporated in or interacted with their personal and shared delusions.

32. JM was not a known user of illicit drugs or alcohol. She was intelligent and educated and it appears likely that she became skilled at hiding aspects of her delusions in an attempt to keep her family together. There is evidence that she had a strong bond with her children and tried, as best she could, to protect them.

RB and JM meet and commence a relationship

33. In early February 2016 JM moved to the Gold Coast to study. Shortly thereafter she met RB at Surfers Paradise beach. RB was homeless at the time. Within about two weeks, an intimate relationship developed. JM abandoned her studies and job and travelled to Mackay with RB

34. JM re-established contact with her parents in May 2016 and travelled down to Geelong with RB He was not introduced to her parents, but they

[13] Exhibit 1, Tab 106, p.1959 and 1780.
[14] JM Exhibit 1, Tab 102, p.1710.
[15] Investigators note, Exhibit 1, Tab 9, p.236.

saw him around town and had an idea that he was JM partner. By this time JM was pregnant with LB Her parents did what they could to support JM but she did not always accept their help.

35. After JM and RB met, they drifted up and down the eastern seaboard from Mackay to Geelong and back again, then ultimately moved around the border communities of south eastern Queensland and northern NSW.

36. From late May to about August 2016, JM became a voluntary patient and RB moved back and forth between Mackay and Geelong.[16] In early September 2016, the couple moved into a rented house in Geelong.[17] In December 2016, LB was born. In about September 2017, the family left Victoria for Mackay.[18]

The Family's early involvement with DCSSDS

37. The inquest focused primarily upon events between September and November 2018 being proximate to Baby Q death. However, I will briefly refer to the longer child protection history in Queensland as it usefully indicates the wealth of background material that would have been available to that organisation.

38. One notification was made to DCSSDS in November 2017 (before Baby Q was born) and two further reports were received in May[19] and August 2018.[20] As above, Baby Q was born in February 2018.

39. Reports in November 2017 and May 2018 were prompted by concerns around the family's homelessness. The report in November 2017 was made by a non-government family wellbeing service, , and referred to, among other things, JM and LB looking unclean, the family living out of their car, RB being diagnosed with schizophrenia and being a heavy drinker. A further notification in November 2017 was made by another non-government

[16] Exhibit 1, Tab 106, p.1759 at [15].
[17] JM Exhibit 1, Tab 102, p.1710.
[18] JM Exhibit 1, Tab 102, p.1711 at [22].
[19] QCS documents, Exhibit 5, p.165-171.
[20] QCS documents, Exhibit 5, p.165-171.

organisation, and referred to LB having quite a bit of scabbing all over his body.[21]

40. [redacted] and DCSSDS interviewed JM [redacted] on 7 November 2017, and completed a Safety Assessment on the same day. RB [redacted] was interviewed on 8 November 2017. The Safety Assessment determined that LB was safe because, amongst other things, JM [redacted] was now in emergency accommodation, had applied for housing and had received antenatal care whilst RB [redacted] was said to be engaged with [redacted] for mental health.[22]

41. Between 7 and 23 November 2017 an Investigation and Assessment was conducted by DCSSDS. The Investigation and Assessment was finalised on 21 November 2017, and on 22 November 2017 the Assessment and Outcome was approved with an outcome of 'unsubstantiated' in relation to whether LB was a child in need of protection.[23]

42. The family again came to the attention of DCSSDS in May 2018 when a record of concerns was received on 27 May 2018 from [redacted].[24]

43. [redacted] were alerted to RB [redacted] sleeping rough in a park on the Gold Coast with his two children. Baby Q was three months of age at the time. RB [redacted] was reportedly initially angry with Police as he thought they were going to remove the children, but he settled when [redacted] offered to help him find accommodation.[25]

44. The notification was referred to Nerang SSC and on 28 May 2018, Child Safety Officer Greta Weertman arranged a "home visit" to the Vibe motel where the family were staying. The home visit was conducted between CSO Weertman, CSO Crystal Sanford and Tanya Blackhall from Kalwun[26] with JM [redacted] and [redacted] (RB [redacted] sister) attending.

45. JM [redacted] was seen to have a blood shot eye with a small bruise underneath her eye. She said she got it playing football a few weeks before. [27] At one point

[21] QCS SPRP, Exhibit 1, Tab 43, p. 973.
[22] QCS documents, Exhibit 5, p.46-50.
[23] QCS SPRR, Exhibit 1, Tab 44, p.974.
[24] QCS documents, Exhibit 5, p. 82.
[25] Fing, Exhibit 1, Tab 48A, p.1115.
[26] Kalwun, Exhibit 1, Tab 68, p.1419.
[27] Kalwun, Exhibit 1, Tab 68, p.1482.

during the interview [redacted] stated "You're scared of him" to which JM [redacted] replied "RB [redacted] the head of the family. I can't stand over him."[28]

46. On 29 May 2018 the QPS provided additional information to DCSSDS including extracts from RB [redacted] history and an offer to provide full history on request.[29] On the same day JM [redacted] contacted CSO Weertman again to inform her that the family had secured two nights of accommodation at Montego Motel in Mermaid Beach and that they had also been accepted for a property in Casa De Sol.[30]

47. Another home visit at the Motel occurred that afternoon with CSOs Crystal Sanford and Madeline Kelly. The resulting file note is sparse. DCSSDS concluded that JM [redacted] appeared willing to engage in services and obtain housing. DCSSDS did not see or speak with RB [redacted][31]

48. The next day, 30 May 2018, in response to a section 159N request, DCSSDS received information from the Child Protection Liaison Unit, Gold Coast University Hospital and Health Service, which provided information held with respect to JM [redacted] and RB [redacted] mental health history, as well as RB [redacted] substance abuse, intellectual impairment and of RB [redacted] having three other children (the youngest being in care as at 2016).[32]

49. On 4 June 2018, CSO Weertman and CSO Kristy Wright attended the family home for an unannounced visit. RB [redacted] was not present. The case note for this visit indicates that it focused upon checking physical arrangements for the children (bedding, clothes, food).

50. On 5 June 2018 CSO Weertman had a brief telephone discussion with RB [redacted] Also on 5 June 2018, CSO Weertman discussed the family with Tanya Blackhall from Kalwun who noted that JM [redacted] had been engaging with the family wellbeing service, and RB [redacted] had been "present when engaging with Kalwun".[33]

[28] QCS documents, Exhibit 5, p.145.
[29] QCS documents, Exhibit 5, p.157.
[30] QCS documents, Exhibit 5, p.115.
[31] QCS documents, Exhibit 5, p.118-122.
[32] Brewer, Exhibit 1, Tab 48, p.1088.
[33] QCS documents, Exhibit 5, p.138.

51. On 7 June 2018, the DCSSDS Investigation and Assessment into the May 2018 notification was finalised with an outcome of 'Unsubstantiated - Child not in Need of Protection'.[34] The family risk evaluation neglect risk score was recorded as moderate. It was said that the protective capacities of JM allowed her to provide adequate protection of the children. It was noted that RB consumes "alcohol outside of the home."[35] Various factors were recorded as being strengths and resources, these included that JM had engaged well with Kalwun, she had secured a bond loan, neither RB nor JM were TICA listed, and had a good rental history in Mackay and Victoria and that JM had re-engaged with her parents.[36]

52. I accept counsels assisting's submission that the logic underpinning the assessment was flawed in a number of respects. Of particular concern was the reliance placed on JM contact with Kalwun. The circumstances of this re-engagement was only in its infancy and was essentially untested. As it happens, Kalwun's meeting with JM on 15 June 2018 was her last and the service closed her file. There was no attempt to confirm the level of support JM was actually receiving from her family.

53. It appears, with hindsight, that if DCSSDS had known of the disengagement with Kalwun, proper consideration could have been given to a reassessment. For this reason counsels assisting suggested a recommendation directed to this issue and it is a matter to which I will return.

The issues

54. A draft issues list was served on the parties prior to the inquest. It outlined the following issues which were anticipated to be the focus of proceedings;

    Issue 1: Can the cause of Baby Q death be ascertained? What evidence supports or detracts from a finding that Baby Q died as a result of drowning or as a result of suffocation?

[34] QCS documents, Exhibit 5, p.156.
[35] QCS documents, Exhibit 5, p.159.
[36] QCS documents, Exhibit 5, p.158.

Issue 2: What did Baby Q father do on 17 November 2018 to cause her death and where was Baby Q mother at the time?

Issue 3: What happened to Baby Q and her family on 16 November 2018 after Queensland Police were called to the family then sleeping in a park?

Issue 4: What other involvement did Queensland and/or New South Wales Police have with Baby Q parents in the period September – November 2018 and did this involvement prompt reports to relevant child welfare authorities?

Issue 5: What new information did the Queensland Department of Child Safety, Youth and Women and/or the New South Wales Department of Communities and Justice learn about Baby Q and her family circumstances in the period September – November 2018?

Issue 6: Was information about Baby Q and any risks posed by her family adequately shared across state boundaries and between Police and child welfare authorities? Did state boundaries impact upon the response to Baby Q and her family?

Issue 1: Can the cause of Baby Q death be ascertained? What evidence supports or detracts from a finding that Baby Q died as a result of drowning or as a result of suffocation?

55. Dr Andrzej Kedziora, Forensic Pathologist, conducted a post-mortem examination. The report later produced recorded the cause of death as "undetermined".

56. Notwithstanding this, much of the evidence points to Baby Q having died as a result of drowning when she was thrown into the Tweed River. This evidence does not however exclude the possibility that that Baby Q suffocated in the period leading up to the moment when she was thrown into the river.

57. Dr Kedziora emphasised that certain "positive" findings are typically seen in cases where someone dies as a result of drowning. Such findings "are non-specific," that is, they can be caused by a number of pathological processes or terminal events other than drowning. Nevertheless, Dr Kedziora states that "if

the set is complete and seen in the context of appropriate circumstances and history, they can be regarded as confirmation of drowning".[37]

58. Baby Q displayed some positive findings typical of death as a result of drowning including:

a) "Washer woman's hands" observed on Baby Q hands and to a lesser degree, on her feet.[38]

b) A report of foamy fluid in the airways also recorded in a police photo from the scene. This was of uncertain relevance because Dr Kedziora could not say where the foamy fluid originated from and the Ambulance Service "did not mention froth coming out of the child's mouth or nose during resuscitation.[39] He also referred to the fact that frothy fluid in the airways can be caused by cardiogenic pulmonary oedema.[40]

c) Bilateral pleural effusions in a greater amount than the small amount of physiological fluid that is typically present to lubricate the lung surfaces. The amount was also greater than would be expected as a result of early decomposition. The volume of effusions recorded was considered supportive of drowning.[41]

d) Magnesium was present in pleural and pericardial effusions but its significance was uncertain. Whilst the presence of magnesium was confirmed, "testing for magnesium is not a standard diagnostic method and passive transfer of the electrolyte after death cannot be entirely excluded."[42]

e) Foreign debris (sand and possibly silt) was observed in the airways but its significance was uncertain. Grains of sand in the airways or lung tissue could be "introduced via active respiratory movements during drowning or passively, when the deceased is being washed on a sandy beach by waves tumbling and rolling the body, compressing the chest and abdomen, and filling the mouth and nose with water containing suspended sand particles.

[37] Autopsy report, Exhibit 1, Tab 2, p.17.
[38] Autopsy report, Exhibit 1, Tab 2, p.5 and 17.
[39] Autopsy report, Exhibit 1, Tab 2, p. 17.
[40] Supplementary autopsy, Exhibit 1, Tab 3, p.42.
[41] Autopsy report, Exhibit 1, Tab 2, p.18.
[42] Autopsy report, Exhibit 1, Tab 2, p.18.

> The deeper in the body the sand particles are found, the more probable it is that they have been introduced during drowning…passive transfer of debris into the peripheral airways and alveoli cannot be entirely excluded."[43]

59. In terms of "positive" findings typically seen in drowning deaths but absent in Baby Q case, Dr Kedziora placed some weight on the absence of emphysema aquosum or hyperinflated oedematous lungs. Whilst Baby Q lungs were mottled, congested and slightly oedematous they were not conspicuously hyperexpanded.

60. Dr Kedziora was later provided with additional information from NSWPF including the evidence of by-standers who witnessed RB throw something into the river on the evening of 17 November 2018.

61. In light of this additional information, Dr Kedziora referred to an alternative hypothesis that Baby Q may have been smothered by her father prior to being thrown into the river. Dr Kedziora placed some weight upon the fact that eyewitnesses did not report seeing the objects that were thrown into the river as moving, in circumstances where one might have expected Baby Q would have struggled briefly if she were still alive at that point.[44]

62. Further, Dr Kedziora noted the evidence from by-standers that "the father carried the child covered by a blanket in front of his body while he walked towards the river. The child may have been smothered during that time."[45]

63. Baby Q did not have petechial haemorrhages in the head region which might be present if she had died as a result of smothering, but Dr Kedziora noted that their absence did not rule out smothering.[46]

64. In conclusion, Dr Kedziora did not rule out drowning as a possible cause of death. Many of his findings are consistent with that eventuality. However, he remained of the view that the cause of death was undetermined.

[43] Autopsy report, Exhibit 1, Tab 2, p.18.
[44] Supplementary autopsy, Exhibit 1, Tab 3, p.42.
[45] Supplementary autopsy, Exhibit 1, Tab 3, p.42.
[46] Supplementary autopsy, Exhibit 1, Tab 3, p.42.

65. Having considered all the available evidence I accept counsels assisting's submission that the cause of death should be recorded as unascertained or undetermined. Having said that I note Justice Wilson's analysis in *R* v *RB* [2020] NSWSC 1552.[47] Her Honour states that while the precise mechanism of death remained unclear, Baby Q death was caused by her father "either by drowning (that being the most likely mechanism) or by suffocation when [he] held her in a blanket pressed against him." A coronial finding pursuant to section 81 of *the Coroners Act 2009* (NSW), is usually taken to refer to the precise medical cause of death. In my view recording the cause of death as unascertained or undetermined is appropriate on the evidence before me and is consistent with the approach taken in the Supreme Court.

Issue 2: What did Baby Q father do on 17 November 2018 to cause her death and where was Baby Q mother at the time?

66. At 9:32am (AEDT) on 17 November 2018, CCTV footage records the family boarding a bus at Kingscliff, arriving at Tweed Heads at 10:52am. They spent the day at the Chris Cunningham Park and Jack Evans Boat harbour.[48]

67. About 2:30pm (AEDT), Kirsty Davis, a homeless woman, was approached in Chris Cunningham Park by the family, and there was a discussion about giving Baby Q to Ms Davis. RB asked Ms Davis to take Baby Q permanently, and he persuaded JM to hand her to her. According to Ms Davis, JM was crying and did not want to give Baby Q away, but was eventually persuaded to hand her over. Shortly afterwards, Ms Davis followed the family and returned Baby Q to them and saying that she could not look after the baby when she lived on the streets. About an hour later, the family saw Ms David again, and this time JM tried to give Baby Q to her, but she refused.[49]

68. During the late afternoon/early evening a large storm accompanied by heavy rain impacted the Tweed Heads area and the family took refuge under a multi-level car park located at the Tweed Mall adjacent to Chris Cunningham Park.

[47] R v RB [2020] NSWSC 1552, Exhibit 1, Tab 8 p.228 at [50].
[48] Lovell, Exhibit 1, Tab 6, p.85 at [84]-[85].
[49] Lovell, Exhibit 1, Tab 6, p.85 at [84]-[85].

69. Between 6:34pm and 6:37pm (AEDT), CCTV footage records the family at Tweed Mall. JM was carrying LB and Baby Q was in a shopping trolley.

70. Around this time, a witness, Emily Gregory reported seeing the family in the car park near the Bay Street entrance. Ms Gregory observed RB holding Baby Q to his chest with a red and black blanket wrapped over her. She observed RB who was still holding Baby Q walk away from JM and LB down a ramp leading to Bay Street. CCTV footage confirms that the JM and LB remained in the car park.[50]

71. At 6:47 (AEDT), another witness, Paul Thompson, observed a male matching RB description walk along the Southern footpath of Bay Street. He said the male had a blanket wrapped around his body. The male walked towards the river and climbed over the rocks (shoreline) moving close to the water. He threw an "object" into the river, and then moved back to the grass next to the river and fell onto his knees before lying flat on his stomach. He moved his hands to the side of his head and laid in this position for at least 10 minutes.[51] At least three other witnesses who reside near the Tweed River similarly observed a male lying on his stomach next to the riverbank in the pouring rain for a period of time.[52] [53]

72. In particular, Joanne Newman and John Waterhouse reported seeing a male lying on the ground next to the river, and item(s) floating in the river. Ms Newman described seeing two separate items, "One was white and one was black. The white item looked like a t-shirt or a small towel, it was floating just under the surface.. about the same size as a tea towel or nappy… The black item was rounded on top and seemed to float on top of the water, it was buoyant…".[54] Mr Waterhouse described the object as a "black coloured reasonable sized squarish object in the river. It was a shape more than a blob. I watched the item

[50] Lovell, Exhibit 1, Tab 6, p.87at [90].
[51] Lovell, Exhibit 1, Tab 6, p.88 at [92].
[52] Lovell, Exhibit 1, Tab 6, p.89 at [95].
[53] Lovell, Exhibit 1, Tab 6, p.89 at [96].
[54] Judgment, Exhibit 1, Tab 8, p.226 at [34].

for about 30 seconds as it bobbed up and down through the rough waters of the river towards the sea on the outgoing tide."[55]

73. At about 7:01pm (AEDT), CCTV footage recorded RB returning to the car park at Tweed Mall without Baby Q. Baby Q is not seen again on CCTV footage.[56]

74. Two days later, at about 1:25am (AEDT) on 19 December 2018, a witness, Alexander Owen, was walking along the beach at Surfers Paradise and discovered Baby Q body approximately three to four metres above the waterline. Mr Owen contacted emergency services who attended and attempted to resuscitate Baby Q At 1:51am (AEDT), QLD Ambulance Service pronounced Baby Q life extinct.[57]

75. The Supreme Court proceedings resulted in a finding that RB caused Baby Q death by his deliberate act, although he was at that time labouring under such a defect of reason from a disease of the mind that he did not know what he was doing was wrong in accordance with ordinary standards of right and wrong adopted by reasonable people.[58]

76. Amongst other things, when alone in his cell after being arrested, RB was recorded as saying "She was a bad disease Baby QAt least I have done a good deed…and the Lord say that too, I done the right…job done, job done. I killed my own daughter…She was a bad disease…At least I destroyed the most dangerous thing throughout the entire world…She shouldn't even be called a human being. They are lucky I killed her. She is trouble."[59]

77. RB was later recorded as saying to a cellmate "You know, like when she cries, man, fuckin' terrible…Terrible. When she cries…even, it drains the mother too, and drained me…it makes us fight…You were only supposed to have one child, not two, so, you, you know…Four o'clock, I walked down to river past the elders, she thought I gave the kid to the elders…no, keep going…so I took off the nappy…threw the black and red blanket, and threw that in, and threw her

[55] Lovell, Exhibit 1, Tab 6, p.89 at [95].
[56] Lovell, Exhibit 1, Tab 6, p.91 at [97].
[57] Lovell, Exhibit 1, Tab 6, p.94 at [102].
[58] Judgment, Exhibit 1, Tab 8, p.234, [85].
[59] Lovell, Exhibit 1, Tab 6, p.97 at [110].

in…So I, when I threw her in, well, it was raining at first…it rained. It…pouring on top of her, (sounds like) and something just told me throw her in. And I just laid down, hands behind my back…and cried. And just…I felt bad."[60]

78. There is clear evidence establishing that RB was actively psychotic at the time he took the steps which ultimately resulted in Baby Q death. His delusions over many years had incorporated religious and spiritual themes and frequently focussed on conflicts between good and evil. It appears Baby Q was somehow entangled in his active delusions and came to represent an evil force in his world view. The evidence establishes that RB was alone at the time he took Baby Q to the water.

79. There is clear evidence that JM was also actively unwell at the time of Baby Q death. It should also be remembered that she had been subject to violence and coercive control perpetrated by RB over a number of years. She made statements that indicated she believed he was "the head of the family" and that she could "not stand over him."[61] There are references to her being "mesmerised" by him and appearing fearful of him. Dr O'Neil raised the possibility that RB and JM shared a delusion, sometimes referred to as a Folie à deux.

80. Despite her significant mental health issues, including the fact that some of her recorded delusions appeared to support the idea that she believed RB was God-like or especially spiritually blessed, JM appears to have done her best to protect her children. It is poignant to review her initial reluctance and tears when RB first attempts to give Baby Q to a homeless woman during the afternoon of 17 November 2018. Particularly when later that afternoon it is JM who tries to get the woman to take Baby Q One can only wonder if, even in her own state of ill-health, JM herself felt that the potential danger to Baby Q was increasing.

[60] Lovell, Exhibit 1, Tab 6, p.98 at [113].
[61] QCS documents, Exhibit 5, p.157.

Issue 3: What happened to Baby Q and her family on 16 November 2018 after Queensland Police were called to the family then sleeping in a park?

81. QPS had two interactions with RB during the day on 16 November 2018.

82. The first interaction was at 11:48am (AEDT) when QPS spoke with RB and JM at Broadbeach about welfare concerns. QPS holdings record "Street Check. CAD event for welfare check. Nil Issues. POI did not want to speak with police." The records did not reference either LB or Baby Q[62]

83. The second interaction was at 7:45pm (AEDT) when QPS located RB and other homeless people drinking in a park at Broadbeach. QPS Holdings record "Located drunk/drinking in the park near the soccer club. All moved on without an incident". Neither JM nor the children were referred to in the report.[63]

84. Later that night Senior Constable Zairis and Constable Dorricott were asked to attend Broadbeach Park after it was reported that two children were left alone in the park.[64] At about 12.45am (AEDT) on 17 November 2018 the officers found RB and JM sleeping on the ground with LB and Baby Q in between them.[65] The children were only wearing disposable nappies and the family had limited food and water. RB was described as intoxicated and unwilling to discuss the family's situation. JM said they did not like living in a house because it was "cramped" and declined the officers' offers of assistance. The officers formed the view that "although the children appeared to be healthy and not malnourished from what we could see, we were concerned the parents were not able to care for the children given the very limited food and basic requirements they had in their possession."

85. Assistance was sought from Plain Clothes Senior Constable Adrian Bisa and Plain Clothes Senior Constable Chloe Barton from the Gold Coast District Child Protection & Investigation Unit. This was clearly appropriate in all the circumstances.

[62] Lovell, Exhibit 1, Tab 6, p. 83 at [78], p.127.
[63] Lovell, Exhibit 1, Tab 6, p. 83 at [79].
[64] Zairis, Exhibit 1, Tab 12, p. 266 at [5].
[65] Zairis, Exhibit 1, Tab 12, p.267 at [7]-[10]; Dorricott, Exhibit 1, Tab 15, p.318.

86. At 1:27am (AEDT), body worn camera footage depicts PC S/C Bisa and PC S/C Barton arriving at the scene. In response to the officers informing RB and JM that it was not acceptable to have a nine month old child living on the streets, JM suggested she might be able to arrange travel to Victoria to live with her parents, however RB objected to this and said it was none of their business. The officers determined that the best course of action was to take the family to a 'place of safety'. However they did not know of any emergency accommodation that was available to which they could take a family at night. PC S/C Barton told the court "…I don't know if any resources would have been available [for the family]… other than family, friends, associates… I'm not quite sure what other options we had."[66]

87. Although the afterhours DCSSDS hotline is available to QPS officers out of hours, unfortunately it was not used on this occasion.[67] PC S/C Barton further told the court that she and PC S/C Bisa did not think that the case met the threshold of calling DCSSDS that night, because other than where they were sleeping they did not have information that the children were being neglected or mistreated.[68]

88. JM raised the possibility of staying with Paulette Butterworth in Kingscliff.[69] JM was able to provide enough detail for the officers to be persuaded that the family had a connection to Ms Butterworth. Attempts were made to call Ms Butterworth without success.[70] Similarly, an attempt to have NSW officers attend the Kingscliff address failed. PC S/C Bisa and PC S/C Barton subsequently went to get car seats so that QPS could take the family to the Ms Butterworth's address.

89. When they arrived at Ms Butterworth's address, PC S/C Bisa knocked on her door however there was no response. He then spoke to a neighbour and confirmed that the apartment was where Ms Butterworth lived. After attempts to raise Ms Butterworth, RB entered the unit through an open bathroom

[66] TN 19/12/23 p.6:9-11.
[67] TN 19/12/23 p. 30.1
[68] TN 19/12/23 p.7:37-43.
[69] Bisa, Exhibit 1, Tab 10, p.253-257; Barton, Exhibit 1, Tab 11, p.263 at [13].
[70] Bisa, Exhibit 1, Tab 10C, p.256.

window. RB located paperwork in the unit, which was addressed to Ms Butterworth. At approximately 4:00am (AEDT) the officers left the family at Ms Butterworth's residence. In my view this was a significant missed opportunity.

90. Senior Constable Zairis and Constable Dorricott completed a street check entry for the interaction with the family, knowing that the CPIU officers would complete a child harm report.[71] While I understand why the first responding officers would leave it to the specialised officers to complete the child harm report, unfortunately this meant that some of the useful information the first responding officers were aware of was lost. While PC S/C Bisa and PC S/C Barton left to get the car seats, the other officers had an opportunity to observe the family closely. From viewing the body worn footage and hearing their conversation, it is clear to me that these officers understood, among other things, that both parents had significant mental health issues, that JM appeared to believe RB was the messiah and that JM was incapable of caring for the children or herself. They understood the children were in some danger.[72]

91. Prior to completing his shift, PC S/C Bisa completed a "Report of Suspected Harm – 520 – Report."[73] Such a report needed to be reviewed by a Detective Sergeant prior to being sent to DCSSDS.[74]

92. The Detective Sergeant available to review such reports only worked Monday to Friday between 9am to 5pm. Therefore, this report did not make its way to DCSSDS until after the death of Baby Q[75] Although the afterhours DCSSDS hotline is available to QPS officers out of hours,[76] it was not used on this occasion.

93. The family left Pauline Butterworth's home sometime before 9:30am (AEDT) on 17 November 2018[77], which was approximately six hours after arriving.

[71] Dorricott, Exhibit 1, Tab 15, p.320 at [27].
[72] Body Worn footage, Exhibit 1, Tab 15B.
[73] Bisa, Exhibit 1, Tab 10, pp.259-261.
[74] TN 18/12/23, p.72:31-36, p.78:8-19; TN 19/12/23, p.13:5-22.
[75] TN 18/12/23, p.72:31-36, p.78:8-19; TN 19/12/23, p.13:5-22.
[76] TN 19/12/23, p.30.1.
[77] JM Exhibit 1, Tab 102, p.1715-1716.

94. The court heard evidence from PC S/C Bisa and PC S/C Barton regarding their decisions that night. Both said that this was an unusual call out and neither of them had previously been called to attend a similar situation involving a homeless baby or infant. Further, neither of them had been involved in a similar call out in the years since Baby Q death.[78] In his evidence, Denzil Clark, A/Detective Chief Superintendent of Crime within the Crime and Intelligence Command of QPS, also stated that he could not recall attending an occurrence involving a "family unit" living rough.

95. The officers said they were focused upon dealing with the immediate problem at hand. The decision was therefore made that the family could not remain in the park overnight, given the risk to the children.[79] PC S/C Bisa said that he anticipated that the family would remain in the unit for a few nights, although he conceded that there was nothing to stop the family from leaving again.[80]

96. QPS and the officers themselves submit that all decisions made on 17 November 2018 in relation to the family were made in good faith and with the welfare of the children as their paramount concern, and that all decisions made were reasonable and informed by the information available to them at the time.[81]

97. In my view, attending police were clearly motivated to assist the family, but they lacked the resources and skills needed in the situation. I accept that the officers had no knowledge of available supported accommodation where they could take the family unit. Nevertheless, it should have been clear, even on the limited contact they had, that the issue was not a simple issue of "homelessness."

98. It was appropriate to call for first responding officers to make immediate contact with officers from the Child Protection Investigative Unit (CPIU) and ask them to attend.

99. It is acknowledged that the family were not easy to assist and were reluctant to fully engage with police. However, in my view given the clear parental mental health issues it would have been appropriate for officers of CPIU to take the

[78] TN 18/12/23, p. 66:31-35; TN 19/12/23,t p.4:5-12.
[79] Bisa, Exhibit 1, Tab 10, p.261; Zairis, Exhibit 1, Tab 12, p.268 at [18].
[80] TN 18/12/23, p.78:39-50.
[81] DSC Bisa and SC Barton submissions 15/03/24.

further step and contact the afterhours DCSSDS hotline for advice, especially when problems emerged at the nominated accommodation.

100. The decision to allow RB to enter someone else's house and to leave the family alone at those premises was flawed. There was a need to engage with child protection workers to assist.

101. The evidence also discloses a clear need for increased emergency supported accommodation.

Issue 4: What other involvement did Queensland and/or New South Wales Police have with Baby Q parents in the period September – November 2018 and did this involvement prompt reports to relevant child welfare authorities?

QLD Police Service

102. RB came to the attention of the QPS for homelessness, intoxication and/or aggression on a least five occasions between September and November 2018 (namely on 5 and 6 September, 7 and 27 October and 16 November 2018).

103. The full history of these interactions can be seen in the chronology attached to these reasons and will not be repeated here, but two examples are noted. On 5 September 2018, Bradley Fitzsimmons, a council worker, located JM and the children living in a tent in the sand dunes. Mr Fitzsimmons told JM that they were unable to camp in the sand dunes and provided information for support services for homeless people. It was apparently agreed that she would leave the beach by Friday (7 September 2018).

104. JM then spoke with RB who approached Mr Fitzsimmons, threw a VB bottle and other items at him while verbally abusing him. RB next armed himself with a stick and chased Mr Fitzsimmons who activated his body worn camera and locked himself in his car. Mr Fitzsimmons called the police whilst RB JM and the children walked away.[82]

105. QPS were initially unable to locate the family, but they were later able to identify RB and issue him with a Notice to Appear.[83] Neither Mr Fitzsimmons

[82] Lovell, Exhibit 1, Tab 6A, p.127-128.
[83] Lovell, Exhibit 1, Tab 6, p.71 at [53], 149-150.

(who was not a mandatory reporter) nor QPS made a report to DCSSDS. In my view this was a missed opportunity to provide information to DCSSDS.

106. On 27 October 2018, QPS responded to a report regarding RB being present with other homeless people (including JM and the children) and yelling and swearing at people. RB was chased across the border into NSW and ultimately informed QPS that he was homeless and living in parks with his partner and two young children. There does not appear to be a corresponding DCSSDS Report.[84]

107. In his evidence, A/Detective Superintendent Clarke acknowledged that child harm reports ought to have been made on these occasions and he stated that he expected this would occur now having regard to increased police training and understanding about the need to record and identify cumulative harm to children.

108. I note that QPS does not concede that all interactions between the family and QPS in the period September – November 2018 should properly have resulted in a QPS child harm report. I accept that some of the contact between the family and the QPS involved less serious incidents which may not, by themselves, have been likely to prompt an officer to make a report of child harm. The difficulty is when seen together and with the benefit of hindsight they create a picture of ongoing and escalating risk that was not available to any other agency.

109. I accept counsels assisting's submission that there is sufficient evidence on the two occasions described above to make a finding that QPS missed opportunities to notify DCSSDS of the family being homeless and that the young children were exposed to aggressive, intimidating and intoxicated behaviour from RB

NSW Police Force

110. RB and/or the family came to the attention of the NSWPF on eight occasions between early October 2018 and Baby Q death. Again, the full detail of each interaction will not be summarised here. I note the following examples.

[84] Lovell, Exhibit 1, Tab 6, p.77-78 at [66], 147.

111. On 3 October 2018 NSWPF were called to bushland near the Tweed River to respond to a male pitching a tent. The male, now known to be RB had a sleeping child with him. Upon being approached by police, RB became extremely agitated, began to aggressively grind his teeth and yelled "This is my land". Officers made observations of the children (they had fresh nappies and no nappy rash) and then left the area. The officers called for backup as a result of his behaviour, but no corresponding report was made to DCJ.[85]

112. On 11 October 2018, made a report about the family to the Tweed Heads Police Station and to the DCJ Child Protection Helpline.[86] Mr was passing on concerns raised by that a family was regularly attending and trashing the parenting room and using the sinks to wash the children's clothes.[87]

113. On 2 November 2018, NSWPF attended a park in Tweed Heads in response to a report regarding a family with a toddler and a baby living out of a black van.[88] Upon speaking with JM officers noted that the children 'appear to be well fed, appeared clean and not showing any signs of not being looked after by their parents'.[89] They enquired with JM about sourcing accommodation and she replied that RB does not like handouts from the government. NSWPF created a report identifying that the family did not have housing but that 'the children's physical and emotional state appears both children appear fine…'.[90] This report was processed at the Police Child Wellbeing Unit [PCWU] and entered into Child Story by Assessment Officer Church on 6 November 2018.[91]

114. I accept counsels assisting's submission that the evidence demonstrates that some important information was provided by NSWPF to DCJ during this period. However, there were also incidences which could be considered to be missed

[85] Osborne, Exhibit 1, Tab 38, p.942-943.
[86] Exhibit 1, Tab 87, p.1634-1635; DCJ documents, Exhibit 4, p.7.
[87] Exhibit 1, Tab 88, p.1639-1640.
[88] TN 19/12/23, p.81:11
[89] Jennings, Exhibit 1, Tab 33A, p.929-930.
[90] Jennings, Exhibit 1, Tab 33A, p.931.
[91] Dixon, Exhibit 1, Tab 41, p.954 at [11].

opportunities where the circumstances in which the children were living could have prompted consideration of further contact by DCJ.

115. For example, no child at risk report was made by the NSWPF following the interaction with the family on 3 October 2018. The NSWPF submit that this decision should be viewed in context, as RB did not display any signs of aggression to JM or the children, and the officers did not observe any signs that the children were being neglected. The NSWPF further submit that it is unsurprising that no report was made to DCSSDS, particularly given this was the first interaction between NSWPF officers and the family.[92]

116. The evidence reflects the fact that while both NSWPF and QPS provided some information to the relevant child protection agencies, there were also missed opportunities to provide information which could have alerted the relevant child protection agencies to the fact that there were homeless children who may be in need of support.

117. Unfortunately, with homelessness can come the risk that children are not seen by mandatory reporters such as doctors, teachers, social workers and childcare workers. If a family is also transient and socially isolated the risks are increased. It is telling that records indicate that on a number of occasions it was strangers or members of the public who contacted police to voice their concerns. In my view, it takes very significant concern to trigger a notification of this sort. While police are not expected to be child protection experts, when they receive this kind of information or come across families with young children who appear to be homeless but antagonistic to the idea of support, that information must be passed on to the experts so that it can be properly reviewed. As counsels assisting submits, evidence of neglect might only emerge incrementally and unless there is a full picture, there can be no effective assessment of risk.

118. Information sharing of all sorts was an important theme running through this inquest. In recommendations I address the need for child protection agencies to have as much information as possible to ground their assessment and decision making processes.

[92] NSWPF submissions 15/03/24.

Issue 5: What new information did the Queensland DCSSDS and/or the New South Wales DCJ learn about Baby Q and her family circumstances in the period September – November 2018

DCSSDS

119. At about 8:30pm (AEDT) on 28 August 2018, QPS were called to the apartment on Old Burleigh Road after neighbours contacted them regarding an ongoing problem with RB being intoxicated and abusing neighbours while making a large amount of noise. RB was found a short time later at the beach lying in shallow water and was arrested on an outstanding warrant.[93]

120. Police spoke to JM and observed the children, who appeared well. According to QPS records, JM said that RB was intoxicated and had a right to be. She said he had been drinking, returned home and began yelling and banging on doors.

121. QPS made a notification of suspected harm to a child which said "concerns for their mental health are present. They were not upset in an environment where neighbours could hear the noise from the other end of the unit complex."[94]

122. This notification was reviewed by the Gold Coast District Suspected Child Abuse and Neglect ('SCAN') Team representative which led to a notification on 30 August 2018 to the South East Regional Intake Service of DCSSDS.[95]

123. The subsequent Child Concern Report record that resulted from this assessment incorporated extracts from earlier reports in sections called "Most Recent Child Protection History"[96] and "Prior child protection history."[97] "Prior child protection history" noted "Both parents were identified to have mental health issues"[98] and "two 24 hour notifications recorded within 12 months of each other; both relating to the families lack of stable accommodation and living

[93] Lovell, Exhibit 1, Tab 6, p.82 at [73].
[94] Lovell, Exhibit 1, Tab 6, p.82 at [73].
[95] QCS documents, Exhibit 5, p.184.
[96] QCS documents, Exhibit 5, p.186.
[97] QCS documents, Exhibit 5, p.186.
[98] QCS documents, Exhibit 5, p.186.

in care; and worries about the father's alcohol abuse issues."[99] When considering the next steps, DCSSDS took into account various factors, including but not limited to, that there was "no information provided to indicate that the children were upset by their exposure or that they were harmed as a direct result of their exposure".[100]

124. I accept counsels assisting's submission that DCSSDS's assessment was inadequate and that it failed to adequately analyse the information provided and available at that point. This was appropriately recognised in the Queensland Child Death Review Panel's Panel 75 report, which stated, "There was no understanding that there were very concerning patterns of parental behaviour including incidents of domestic and family violence and parental mental health issues that contributed to frequent periods of homelessness and ongoing risk of emotional harm and neglect for the children"[101] There was a lack of recognition of the effect of RB alcohol use and inadequate analysis of what was actually behind the family's homelessness.

125. The analysis of the children's reaction to RB aggression was particularly problematic. Dr O'Neill observed ongoing exposure to trauma and violence may desensitise children and that "quietness" in these circumstances can be indicative of a need for increased curiosity. It was a point also noted in the Panel 75 Report.[102]

126. In any event, Ms Ryan conceded that the DCSSDS response to the report of 28 August 2018 was inadequate. She conceded more work should have been done at this point.[103] I accept her view.

127. The job of a caseworker is difficult and it may be that DCSSDS workers would benefit by having access to specialised psychologists in circumstances such as have been described. It is an issue to which I will return.

[99] QCS documents, Exhibit 5, p.187.
[100] QCS documents, Exhibit 5, p.130-131.
[101] Panel 75 Report, Exhibit 1, Tab 44, p.1010.
[102] Panel 75 Report, Exhibit 1, Tab 44, p.1016.
[103] TN 20/12/23, p 20-23:34-44.

DCJ

128. DCJ's involvement with the family occurred at a later stage and was limited to three Child Protection Helpline notifications, only one of which was screened as meeting the threshold of risk of significant harm and one home visit.

129. As outlined at paragraph [112], on 11 October 2018 at 8:19pm, [redacted] made a report to the DCJ Child Protection Helpline, stating that a young mother and two children were living in a park behind the mall and "trashing" the parenting room.[104] He said he had called local Police to ask them to do a welfare check on the family.

130. The Helpline SR Pilot caseworker contacted the Tweed Heads Police, who confirmed that an officer had visited the park earlier that evening but was unable to locate the family. The Helpline notification also indicated that the children had been wearing wet clothing for three days and the Helpline Caseworker requested a welfare check. The Helpline Caseworker contacted Tweed Heads police three times that night regarding the outcome of the welfare check.

131. The DCJ Helpline After Hours Team screened the report as 'Unknown family' at Risk of Significant Harm and referred it to Tweed Heads CSC recommending a less than 24-hour response.[105]

132. On 12 October 2018, a DCJ Caseworker, Tweed Heads CSC allocated the report for further information gathering. However no further work was undertaken in response apparently due to a lack of available resources at the CSC on Friday, 12 October 2018 and Monday, 15 October 2018.[106]

133. I accept that this was a busy period for the Tweed Heads CSC team and specifically for the DCJ Caseworker.[107] I have considerable sympathy for workers placed in this position, but the evidence clearly indicates a systemic staffing issue existed at that time if a matter such as this could not be dealt with in a timely matter.

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[104] [redacted] Exhibit 1, Tab 87, p.1634-1635; DCJ documents, Exhibit 4, p.7-8.
[105] The DCJ Caseworker, Exhibit 1, Tab 55, p.1213-1214; DCJ ICDR, Exhibit 1, Tab 53, p.1183.
[106] The DCJ Caseworker, Exhibit 1, Tab 55, p.1214 at [14]-[15].
[107] The DCJ Caseworker, Exhibit 1, Tab 55, p.1214 at [14-15]

134. On 16 October 2018 a support worker from non-government organisation, [redacted] contacted Tweed Heads CSC and spoke directly to the DCJ Caseworker referred to above. The support worker raised concerns about a young mother and her two children who were "sleeping rough" in circumstances where the mother had been overheard to say they were "escaping domestic violence" in Queensland. The [redacted] worker expressed concern that the mother was mistrusting of services, possibly trying to avoid child protection, and had temporary accommodation which would expire the next day. The DCJ Caseworker asked the worker to place a mandatory report, which she did the next day.[108]

135. This prompted the DCJ Caseworker to think back to the unnamed family the subject of a report from the previous week. She asked for a request to be made to the Interstate Liaison Team to seek information from DCSSDS about the possibility of prior involvement with the family.[109] The resulting information was received from DCSSDS on 17 October 2018[110], *after* the initial visit between DCJ and JM had already occurred.

136. At approximately 3:00pm on 16 October 2018, the DCJ Caseworker and her colleague (another DCJ Caseworker) arrived at the Motel where JM and the children were staying, as funded by Link2Home, for the purpose of conducting a Safety Assessment during a "home visit".

137. Case notes indicate that LB and Baby Q were observed to be settled, clean, dressed for the weather and that they appeared comfortable with JM who was attentive to them during the visit. JM provided a background of her relationship with RB and the family's involvement with DCSSDS. She said that she did not have any mental health issues and there was no violence between her and RB but that they were "on a break". She said that she and the children would be travelling to Geelong, Victoria once she received her Centrelink payment (the next day) where she intended to stay with her family until she "got back on her feet". She said RB would likely stay in Tweed Heads or return to Queensland. JM described the previous incident in

[108] The DCJ Caseworker, Exhibit 1, Tab 55, p.1214-1215 at [16].
[109] The DCJ Caseworker, Exhibit 1, Tab 55, p.1215 at [19], p.1266.
[110] The DCJ Caseworker, Exhibit 1, Tab 55, p.1218-1219 at [35].

Tweed Heads with RB as "someone pissed him off and he smashed something at Broadbeach". JM told caseworkers she had lost her wallet and did not have keycard, pension card or a charger for her phone.[111]

138. There is no doubt that JM was frequently able to present well to those in authority. Interestingly, the QPS officers who observed her from a distance interacting with RB on the evening of 17 November 2018 may have obtained a clearer view of her real mental state.

139. Before leaving Murwillumbah to return to Tweed Heads, the caseworkers telephoned their manager to talk about their conversation with JM and their observations of the children. The caseworkers advised the manager that there were no immediate safety concerns or dangers identified during the safety assessment and the children were safe in the mother's care.[112]

140. Shortly after the caseworkers left the Motel (possibly only an hour later), Police were called to evict JM and RB from the Motel for "rowdy behaviour".[113] There was no reference to children being present when Police attended. DCJ did not become aware of this development until 18 October 2018[114] and the DCJ Caseworker (being the main caseworker assigned to the family at the time, and first referred to at paragraph 132 above) herself asserts that she did not learn of the eviction until sometime on 19 October 2018, *after* completing her Safety Assessment.[115]

141. On 17 October 2018, the DCJ Caseworker tried to speak with JM but there was no answer, so she left a message.[116]

142. As noted above, information from DCSSDS was received by DCJ on 17 October 2018. This included information about previous episodes of homelessness, the fact that RB was a "heavy drinker and had schizophrenia" and Police records indicating that each parent was known for mental health issues. It also referred to JM having previously been subject of an

[111] The DCJ Caseworker, Exhibit 1, Tab 55, pp.1216-1217, 1279-1281.
[112] The DCJ Caseworker, Exhibit 1, Tab 55, pp.1216-1217, 1279-1281.
[113] DCJ ICDR, Exhibit 1, Tab 53, p.1192-1193.
[114] DCJ ICDR, Exhibit 1, Tab 53, p.1192-1193; The DCJ Caseworker, Exhibit 1, Tab 55, p.1216.
[115] TN 18/12/23, p.56:24-28.
[116] The DCJ Caseworker, Exhibit 1, Tab 55, p.1218 at [33].

emergency mental health assessment in 2016 when she stopped taking her medication, and details of QPS being called out to the home in August 2018.[117]

143. The DCJ Helpline assessment was completed as part of the Helpline and Northern NSW District Streamlined Response Pilot. The Helpline Caseworker made further inquiries by speaking to the worker at OTCP, the Tweed Valley Motel and Murwillumbah Police (leading to details of the Police attendance at the Motel).

144. The report was ultimately screened as 'Non-Risk of Significant Harm' and referred to Tweed Heads CSC on 18 October 2018.[118]

145. Meanwhile on 18 October 2018 the DCJ Caseworker had made a further attempt to speak to JM without success.[119]

146. On 19 October 2018 the DCJ Caseworker completed the Safety Assessment Decision Report based upon what was known as a result of the interview with JM on 16 October 2018 and incorporating reference to some of the information she had obtained after the interview. The DCJ Caseworker determined that the children were 'safe'.[120]

147. The DCJ Caseworker and the Tweed Heads CSC had no further contact with the family after the interview on 16 October 2018. The DCJ Caseworker proceeded to conduct a Risk Assessment.

148. This Risk Assessment took into account further information obtained by DCJ beyond the information received from JM in the interview conducted on 16 October 2018.

149. On 31 October 2018 the DCJ Caseworker assessed the children as being at high risk of neglect and moderate risk of abuse.[121]

150. On 8 November 2018 DCJ sent a notification to the Victorian child protection authority providing the address JM had given as her parents' home. The

[117] The DCJ Caseworker, Exhibit 1, Tab 55, p.1218.
[118] DCJ documents, Exhibit 4, p. 99.
[119] The DCJ Caseworker, Exhibit 1, Tab 55, p.1219 at [36].
[120] The DCJ Caseworker, Exhibit 1, Tab 55F, p.1219 at [37]; p.1291-1294.
[121] The DCJ Caseworker, Exhibit 1, Tab 55G, p.1300.

matter was then closed by Tweed Heads CSC as there had been no contact with the family since 16 October 2018.[122]

151. I am critical of the decision to close the file at this point. There was clear evidence that the family were transient and insufficient attempts to find them were undertaken at this point. As the Internal Child Death Review Report noted there were opportunities for caseworkers to have engaged the local service system to keep an eye out for the family, when JM could not be reached. There is no evidence that these kinds of strategies were attempted.

152. The Victorian child protection authority ultimately closed the case on the basis that neither LB nor Baby Q were living in Victoria. DCJ only became aware of this plan in Victoria on or around 17 November 2018.[123]

DCJ's Safety Assessment and Risk Assessment

153. It appears that during her interview with DCJ on 16 October 2018, JM avoided important issues. For example, she said:

a) She did not have any mental health issues[124];

b) Alcohol or substance abuse was not an issue for the family[125]; and

c) She had the capacity to maintain stable housing in the medium to long-term[126].

154. Much of what is now known about the family history was not known to the DCJ Caseworker at the time of her interview. Even accepting this, the Internal Child Death Review Report, the evidence of Simone Czech, Deputy Secretary, and the evidence of the DCJ Caseworker herself confirms that there were a number of things that should have prompted further discussion with JM at the time.

155. In particular, the Internal Child Death Review Report identified that:

[122] Czech, Exhibit 1, Tab 56, p.1325-1326.
[123] The DCJ Caseworker, Exhibit 1, Tab 55E, p.1270.
[124] The DCJ Caseworker, Exhibit 1, Tab 55, p.1221 at [48].
[125] The DCJ Caseworker, Exhibit 1, Tab 55, p.1221.
[126] The DCJ Caseworker, Exhibit 1, Tab 55, p.1221.

> The context of the family's circumstances at the time needed caseworkers to think beyond that day in the motel. After experiencing weeks of homelessness, JM Baby Q and LB were living in temporary motel accommodation that expired the next morning. More attention should have been given to what JM plans were when the temporary accommodation ended.
>
> …
>
> There were a number of opportunities for the caseworkers to have been more inquisitive about the information JM provided, and to have explored more deeply her family's experience and how this influenced the children's safety and wellbeing for example…very early in the meeting JM said that RB was not violent toward her and she explained RB absence by telling caseworkers she and he were 'on a break'. Regrettably there was no further exploration with JM about why the break was necessary, whether it was permanent or temporary…Towards the end of the meeting JM said RB would 'be back later' to help her with things. This information should have prompted further exploration with JM about what this meant; was RB staying with them at the motel or elsewhere? If he was staying at the motel, it may have provided an opportunity to include him as part of the safety assessment.[127]

156. I accept the opinions expressed in that report and agree that further curiosity was called for at this time.

157. By the time the Safety Assessment Decision Report was completed on 19 October 2018, the DCJ Caseworker had additional information from DCSSDS and the Helpline which provided further detail around the risk of domestic or family violence. However, even this did not prompt the type of curiosity which was called for.

158. The Safety Assessment document (which was later incorporated into the Safety Assessment Decision Report) relevantly stated:

[127] DCJ ICDR, Exhibit 1, Tab 53, p.1188-1189.

D9 Domestic/family violence between adults in the household exists and poses an imminent danger of serious physical and/or psychological/emotional harm to the child/young person/unborn child upon birth. Answer: No

Narrative: This danger is not identified at this time. This was considered at the time of assessment as it was noted in Housing NSW system (Link 2 Home) that JM stated she was escaping DV from father of the children but did not provide further information. [redacted] to CW [the DCJ Caseworker] on 16/10/18 that JM also reported to [redacted] but again provided no further information. JM denied any violence in the relationship between her and RB She stated they are currently on a break and she is going to move back to Geelong, Victoria and he is going to stay in Tweed Heads or return to North QLD where he is from. RB was not at [sic] present at the hotel…[128]

159. The DCJ Caseworker apparently understood that her Safety Assessment needed to be limited to the information she had available at the time of the interview at the Motel (although her Safety Assessment Decision Report included reference to information later provided by DCSSDS).[129]

160. Additionally, the DCJ Caseworker could not recall later having any specific conversation with her Manager regarding the information provided by DCSSDS.[130]

161. The evidence of Ms Czech was important in understanding the options open to the DCJ Caseworker once she received the information from DCSSDS and other information *after* the Motel visit. This information included the following:

a) That the family had left stable accommodation on multiple occasions;
b) That the family had been homeless intermittently for the last 12 months;
c) That RB had a history of schizophrenia and substance abuse;
d) That two investigations in QLD by DCSSDS had occurred but neither were substantiated because the parents were willing to engage in external services;

[128] The DCJ Caseworker, Exhibit 1, Tab 55F, p.1289 and 1294.
[129] TN 18/12/23, p.48: 4-6; p.50:20-50; p.54:7-30.
[130] TN 18/12/23, p.52: 7-24.

e) That RB had another child who was subject to long term guardianship order;
f) That RB had been the subject of an involuntary treatment order but it was not currently known if he was being treated;
g) That RB had a criminal history and a history of being reluctant to engage with services; and that JM mental health was also of concern given (so it was said) a diagnosis of schizophrenia or a delusional disorder and that she had been subject to an EEA.[131]

162. As Ms Czech observed:

> On 19 October 2018 the caseworker completed her written safety assessment which reflected the observations and findings made at the home visit on 16 October 2018. The information about the family which was provided to DCJ after that visit was not considered in any depth. In my view there was an opportunity for DCJ to review the children's safety in light of the further information received. With the benefit of hindsight, the further information ought to have led DCJ to review the children's safety and to consider whether further enquiries needed to be made about the family.[132]

163. The fact that new information did not trigger a review or re-assessment was an issue which caused me considerable concern and is one that counsels assisting considered in draft recommendations. Ms Czech provided a further statement after giving evidence in December 2023 which touched on this and other issues. In this statement of 13 February 2024 Ms Czech confirmed that current policy makes clear that if further information becomes available, the caseworker should prepare a 'review Safety Assessment'. It is an issue to which I will return.

Information received by DCJ after the Safety Assessment Decision Report was completed

164. DCJ received further information relevant to the whereabouts of the children after the DCJ Caseworker completed her Safety Assessment Decision Report

[131] DCJ documents, Exhibit 4, p.69-75.
[132] Czech, Exhibit 1, Tab 56, p.1325 at [55].

on 19 October 2018. This information was not received by the DCJ Caseworker or Tweed Heads CSC.

165. On 1 November 2018 Senior Constable Chayne Foster of NSWPF pulled over a black van being driven by RB with JM and the children unrestrained in the back.[133] Concerned about what he saw SC Foster made a report which was verified by his supervisor and referred to DCJ on 5 November 2018.

166. The e-Report raised concerns for Neglect – physical shelter/environment. The narrative included:

> Father is alcohol dependent. Children located in back of van on a bed. Not in a seat and not secured by a seatbelt. The father has extensive history with Police in both NSW and QLD where alcohol is a major factor to him coming under notice…The child was dirty in appearance and clothes dishevelled. Child is living with father and mother in a van where there is no apparent sufficient food or shelter. Not covered with appropriate clothing.[134]

167. The e-Report was initially overlooked at the Helpline and therefore not actioned. It was not then noticed until 17 November 2018, the day Baby Q died.[135]

168. This oversight was attributed to a backlog of 1560 contact records being processed through the Helpline's e-Reporting portal.[136] This indicates a significant resourcing problem which directly impacted on the safety of children.

169. The e-Report was belatedly referred to the Helpline Streamline Response Pilot Program for Northern NSW where it was first screened as Risk of Significant Harm but later rescreened as non-ROSH after further inquiries were made.[137]

170. In the events that transpired the decision to rescreen the e-Report as non-ROSH did not actually affect the outcome for Baby Q because of the delay in screening the e-Report in the first place.

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[133] Foster, Exhibit 1, Tab 30E, p.913-916.
[134] Foster, Exhibit 1, Tab 30E, p.915.
[135] DCJ ICDR, Exhibit 1, Tab 53, p.1198.
[136] Czech, Exhibit 1, Tab 56, p.1326 at [61].
[137] Czech, Exhibit 1, Tab 56, p.1326-1327.

171. The reasons behind the decision to rescreen the e-Report as non-ROSH though, again highlight the difficulty involved in getting child protection caseworkers to recognise an accumulation of factors pointing to risk of neglect.

172. As summarised in the Internal Child Death Review Report:

> The decision to close this report at the Helpline was worrying because it did not adequately consider all of the information available to the SR Pilot team. While the SR Pilot team spoken to for this review said they considered all the information available to them before deciding to close the report at the Helpline, it remains unclear why the findings of the safety assessment (dated 16 October 2018) were preferenced (to support the decision to close the matter) over more recent and relevant information…that suggested the children were unsafe and at high risk (in their parents care).

173. Ms Czech has since told the Court that today, all reports made to the Helpline, whether screened as meeting ROSH or non-ROSH, are available on the subject person's ChildStory timeline.[138] Presumably a Caseworker working with the family would have cause to look at the Child Story timeline from time to time and notice any new reports, even if screened as non-ROSH.

Information otherwise entered into ChildStory after the Safety Assessment Decision Report was completed

174. On 2 November 2018 two NSWPF Officers met the family after being called to attend a park in Tweed Heads. This is outlined above at [113].

175. On 6 November 2018 Police then created a Community Service e-Report which was triaged by the Police Child Welfare Unit ('PCWU'). The PCWU ascertained that Tweed Heads CSC were, in the words of Police, case managing the family.[139]

176. The PCWU Assessing Officer entered a "Short Description" into ChildStory that read "Passer-by has reported concerns Baby Q (9 months) and LB (1) were unsupervised and family living in a van. Police attended where family advised

[138] Czech, Exhibit 13, p.8 at [28].
[139] Dixon, Exhibit 11, p.5 at [21].

repairs being done on van and they will soon be moving off to Victoria. Open with Tweed Heads CSC.[140]

177. Unfortunately, Tweed Heads CSC were not alerted to look for the "Short Description" that had been entered into ChildStory and thus missed knowing this further piece of information.

178. The 2013 Child Wellbeing Unit Operating Guidelines are annexed to Exhibit 13. Section 4.6 provided:

> In instances where there already is an open case plan for the family held by Community Services, the MRG should still be used to assist the CWO to determine if the concerns meet the threshold for suspected ROSH. If the concerns do not meet the threshold, then the CSC…should be contacted and advised of the concerns. It is best practice to encourage mandatory reports to have an open dialogue with the CSC…about the case.[141]

179. As at November 2018, there was no system in place at NSWPF to give effect to this part of the CWU Operation Guidelines.

180. In 2018, in order for a DCJ user to view the Short Description in ChildStory, they would need to view Baby Q profile, scroll down and select the Engagements tab and then select the CWU tab to view a list of CWU engagements. The Short Description field would then be visible.[142] However, it is clear that DCJ caseworkers would need to be advised about the need to search in the Engagements tab, otherwise given the workload of caseworkers, the record is essentially lost in the system.

181. It is an issue highlighted by counsels assisting and one to which I will return.

182. There is little doubt that both DCSSDS and DCJ received relevant information about the family during the period from the end of August up until November 2018. Unfortunately it was not given sufficient weight to trigger consideration of a statutory response.

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[140] Dixon, Exhibit 11, p.5 at [22].
[141] Czech, Exhibit 13, p.75.
[142] Czech, Exhibit 13, p. 6 at [20].

183. DCSSDS received new information at the end of August 2018. This new information was not adequately assessed against the family's known history and DCSSDS failed to place sufficient weight on the potential impact of parental mental health on the lives of the children. This was a missed opportunity.

184. While the family were new to DCJ, it is clear that its response was flawed in a number of significant respects. It is difficult to assess what role a lack of resources played, but there was a failure to properly engage with the information provided and a premature decision to close the file.

Issue 6: Was information about Baby Q and any risks posed by her family adequately shared across state boundaries and between Police and child welfare authorities? Did state boundaries impact upon the response to Baby Q and her family?

185. I accept counsels assisting's submission that the most significant systemic failings occurred *within* state boundaries, for example:

a) Occasions when QPS (for example, on 5 September 2018 and 27 October 2018308) could have made a report to DCSSDS but did not.

b) A failure by DCSSDS to critically analyse information suggesting that the family's homelessness was a result of multiple complex factors which combined to put the children at risk of neglect and abuse.[143]

c) A failure by DCJ to conduct a review safety assessment once aware of additional information from DCSSDS and NSWPF after the interview with JM on 16 October 2018 was completed.

d) A failure by DCJ to do further case work once they were unable to contact JM on 18 October 2018, instead assuming JM had left for Victoria.

e) A failure by NSWPF, when making an entry into ChildStory on 6 November 2018 referring to the children being unsupervised and family living in a van[144] to bring this to the attention of Tweed Heads CSC. Had the CSC

[143] See for example the assessment from June 2018 within QCS documents, Exhibit 5, p.159.
[144] Dixon, Exhibit 11, p.5 at [22].

been made aware of this information this should have alerted the CSC to the fact the family remained in the local area.

f) A 12 day delay in the DCJ Helpline processing the e-Report from NSWPF received on 5 November 2018. This was the report arising from the family being pulled over with the children unrestrained in the black van. As referred to earlier, this report was not actioned by the Helpline until 17 November 2018 and was ultimately closed at the Helpline. If the information had been conveyed to Tweed Heads CSC on or around 5 November 2018 it likewise should have alerted the CSC to the fact the family remained in the local area

g) The report of suspected harm created by QPS on 17 November 2018 required the sign off of a Detective Sergeant and therefore the earliest it could have been provided to DCSSDS was sometime after 9am on 19 November 2018, after Baby Q death.

186. In terms of delay in information sharing when it occurred across state borders, the evidence shows that when DCJ made an appropriate and early request for information from DCSSDS on 16 October 2018, that information was provided the next day. I accept that there was no delay by staff in either department. Nevertheless, receipt of that information from DCSSDS *prior to* the home visit might have prompted a different response from DCJ, including consideration of whether a safety plan was appropriate while the risk assessment proceeded.[145]

187. I note that NSWPF submit that the evidence supports a conclusion that information about Baby Q and her family was appropriately shared between NSWPF and QPS.[146] I accept that submission.

188. It is clear that no single agency had all the important information about Baby Q and her family as it was spread across different agencies and was sometime buried among records held.

189. As I have stated, I accept counsels assisting's submission that the most significant missed opportunities were internal and were not caused by the need to access interstate information. Nevertheless there appear to be opportunities

[145] As suggested in the DCJ ICDR, Exhibit 1, Tab 53, p.1188.
[146] NSWPF submissions 15/03/24, p. 7.

to expedite information sharing across borders and it is a matter to which I will return.

Summary of changes since Baby Q death

190. In the time since Baby Q death significant changes to child protection and police practice and procedures have taken place. I will refer only to the most significant changes of immediate relevance to these proceedings.

QPS

191. The Court had the benefit of evidence from Denzil Clark, A/Detective Chief Superintendent of Crime within the Crime and Intelligence Command of QPS, outlining reviews by the Independent Commission of Inquiry into Queensland Police Service response to domestic and family violence and the Women's Safety and Justice Taskforce.

192. A/Detective Chief Superintendent Clark referred to a cultural change in how police respond to occurrences regarding vulnerable people (including children) and family violence. This includes a greater focus on upon trauma informed and cumulative harm responses and shifting away from a "siloed" approach towards a broader "victim centric" response. He stated that police are now trained to not just think about what "is in front of them". For example, when police attend to execute a drug search warrant, they are taught to also be observant for any domestic violence and/or child harm concerns. To facilitate this QPS now has additional training in domestic and family violence (a further five day course in addition to the two day training currently required).[147] I have no doubt the work done by the Independent Commission of Inquiry into Queensland Police Service response to domestic and family violence and the Women's Safety and Justice Taskforce is driving change in QPS, nevertheless it will be a long process and will require significant cultural change over many years.

193. The court was informed that in January 2020, QPS introduced the Self-Service of Document Retrieval ('SSoDR'), a State-wide information portal. The portal can provide Queensland criminal history and domestic and family violence information from QPS records and Information Management Exchange

[147] TN 19/12/23, p.21:34-42.

(QPRIME) to approved DCSSDS staff. This preliminary information can better inform follow up via s. 159 requests for further information. SSoDR will be superseded by Unify, DCSSDS's replacement client management system, which is expected to be implemented by mid-2024.[148] This appears to be a significant information systems improvement and one that I will return to.

194. The court was also informed about the National Criminal Intelligence System ('NCIS'), which is the national information exchange between law enforcement agencies, although not all states and territories are involved. According to A/Detective Chief Superintendent Clark, from mid-2023, QPRIME data was made available on NCIS (as well as CoPS information), and QPS officers can now log in and see occurrences from CoPS in NSW, Western Australia and Victoria.[149] This is a positive step for law enforcement across state borders. The usefulness of ready access by child protection workers to certain police data across state borders is an issue to which I will return.

195. There was also evidence that local arrangements are now made for providing NSWPF in the Tweed-Byron Police District with access to daily meetings held by QPS. This kind of local information sharing is to be commended.

NSWPF

196. Evidence from NSWPF regarding changes to the approach to understanding and responding to neglect came via statements from Chief Inspector Mark Dixon of the Child Wellbeing Unit, PoliceLink Command and Detective Inspector Brendon Cullen. Detective A/Inspector Gary Sheehan also provided a statement and gave evidence before me.

197. The court was informed that an initiative is being developed within the Tweed Byron Police District in recognition of the amount of homelessness seen in the area, which involves a multi-agency approach between NSWPF, local councils, DCJ, the Ministry of Health and various non-government organisations. Detective A/Inspector Sheehan told the court that over the last 18 months, these groups have been trying to come up with a pilot project regarding an appropriate

[148] TN 19/12/23, p.40:23-35.
[149] TN 19/12/23, p. 69:30-35.

approach when Police come across homeless people in the area. He said the focus is less on "policing" and more on assisting these individuals in whatever way is deemed necessary.[150] This initiative is commendable and should receive significant support.

198. The court was informed that fortnightly domestic violence safety action meetings are now held in every Police district comprised of Police, DCJ Housing, DCJ Children, Corrective Services, Education, Health and other non-government organisations. The concept is to discuss domestic violence matters (including where children are involved) that have occurred the previous fortnight at a roundtable, and every agency has an opportunity to inform each other of what they know, and try to come up with solutions.[151] This appears to be another appropriate partial strategy to ensure better information sharing between local agencies.

199. In relation to communication between the Police Well-being Unit and DCJ, the court was informed that consideration was been given to a "work around" for the problem of entries being made into ChildStory by an assessment officer at the Police Well-being Unit without a relevant CSC being alerted. Now, the assessment officer is required, under the Standard Operating Procedures, to send an email to relevant DCJ officers summarising or attaching the relevant information so that DCJ is aware of the entry in the CWU tab within ChildStory.[152]

200. Ms Czech also confirmed that currently, a ChildStory user who has access to a family's ChildStory record no longer needs to scroll down the screen in order to review the Engagements tab. However, the Short Description is still not available on the ChildStory timeline, and is only available by taking the steps referred to above, by accessing the CWU tab.[153] It is an issue to which I will return.

[150] TN 20/12/23, p.63:21-34.
[151] TN 19/12/23, p.78:45-50.
[152] TN 20/12/23, p.63:21-34.
[153] Czech, Exhibit 13, p.6 at [27].

DCSSDS

201. In respect of DCSSDS, the court had the benefit of the Queensland Child Death Case Review Panels, Panel 75 report, a statement from Chief Practitioner Dr Meegan Crawford, and written and oral evidence from Ms Tracey Ryan, Regional Executive Director for the South East Region of DCSSDS. Changes at DCSSDS include the following.

202. The court was informed that currently SSoDR (managed by QPS) exists and Unify will be implemented by mid-2024. Ms Ryan described the expectation that Unify will be more "person-profile centred. So it brings all of the information around the profile of the child – the young person, and organised information in a much… better way… so SSoDR will be captured through that system."[154] Unify will capture Police information as well as information from non-government services, such as if a referral has been accepted or declined.[155] This upcoming change to information systems sounds promising.

203. The court was informed that there have been changes within the Child Safety Practice Manual following a review of the Structured Decision Making tools and the introduction of new practice guides. The new guides aim to encourage greater analysis from caseworkers when assessing harm by moving away from the repetitive use of 'tick a box' assessment tools and by placing greater emphasis on caseworkers exercising their own professional judgment. As Ms Ryan told the court, this is particularly relevant to how caseworkers assess cumulative harm when there are multiple notifications.[156]

204. Although not a new initiative, Ms Ryan also referred to the emphasis now given through the Safe and Together initiative upon "a stronger focus on holding perpetrators of domestic and family violence to account, including perpetrator mapping tool and what coercive control may look like".[157] This is particularly relevant to the history given about this family of RB engaging minimally in

[154] TN 20/12/23, p. 36:5-11.
[155] Crawford, Exhibit 1, Tab 45, p.1049 at [45].
[156] TN 20/12/23, p.30:1-20.
[157] TN 20/12/23, p.32.

interviews, while the responsibility of keeping the children safe was left to JM

DCJ

205. For DCJ, the court had the benefit of the Internal Child Death Review and the evidence of Ms Simone Czech, Deputy Secretary, Child Protection and Permanency, District Youth Justice Services, DCJ. Ms Czech's statement referred to a number of initiatives. I do not intend to repeat the detail of her statement, but note the following matters.

206. The court was informed that the Child and Family Secretaries ('CAFS') group is developing a national electronic platform, Connect for Safety, to permit child protection workers to see if a child or family is "known" to child protection authorities in other states and territories.[158] The platform does not provide all the information that the other authority holds, but quickly alerts caseworkers to the existence of a child protection history interstate. This can prompt a more targeted requests for information through interstate liaison teams[159], and teams can refer to urgency to expedite a response if necessary.[160]

207. A leadership program now exists for casework managers to improve their practice leadership, in recognition of their role in supervising caseworkers. This includes improving "their capability in understanding work that's on hand, what might be overdue, putting some systems in place to make sure that records… are completed in a timely manner, so that they're available for people to review and consider as part of the decision-making.[161] It should be remembered that the DCJ Caseworker gave evidence that she could not recall speaking to her manager after she received the Queensland information.[162] In contrast it was Ms Czech's evidence that for Baby Q and her family, once further information came in after the safety assessment, there "must have been" a further assessment review performed involving the manager casework. [163] Any

[158] Czech, Tab 56, Exhibit 1, p.1330 at [82].
[159] TN 20/12/23, p.73:1-4.
[160] TN 20/12/23, p.74:40-41.
[161] TN 20/12/23, p.74:40-41.
[162] TN 18/12/23, p.52:24.
[163] TN 20/12/23, p.45:10-23.

initiatives that strengthen practice leadership and supervision of caseworkers is an important reform.

208. The court was informed that improvements have occurred within ChildStory including the timeline feature where a PDF document will be displayed showing every record that exists in relation to the child in chronological order.[164] Any improvement which assists a caseworker to see the complete picture of contact with a child or family is important, particularly where neglect may be an issue.

209. The court was informed that greater use of missing persons reports from DCJ to NSWPF has been instituted.[165] In circumstances where a family disappear or seem to "fall off the radar", this development may be useful.

210. The court was informed that a 'Neglect Practice Kit' will be released in July 2024.[166] This will be a significant resource that can be accessed by all DCJ caseworkers to assist them in identifying the signs and understanding the impact of neglect, including with respect to cumulative harm. In my view this is an important development and one that is likely to have a positive impact.

211. I accept that DCJ have made some significant changes.

The need for recommendations

212. Section 82 of the *Coroner Act* 2009 (NSW) confers on a coroner the power to make recommendations that he or she may consider necessary or desirable in relation to any matter connected with the death with which the inquest is concerned. It is essential that a coroner keep in mind the limited nature of the evidence that is presented and focusses on the specific lessons that may be learnt from the circumstances of each death.

213. I acknowledge that my task in considering recommendations is reduced given the changes already made. Nevertheless, at the conclusion of proceedings, counsels assisting put forward a number of draft recommendations for consideration. I will deal with each in turn.

[164] TN 20/12/23, p.42:41-46.
[165] TN 20/12/23, p.48:1-17.
[166] Czech, Exhibit [13], p.11 at [36].

To QLD Director-General, Department of Child Safety, Seniors and Disability Services

In situations where DCSSDS refer a family to a family well-being service in the course of an Investigation and Assessment, consideration be given to requiring the family well-being service (however described) to inform DCSSDS if the family disengages prematurely from the service and the reason for the disengagement.

214. The recommendation arose from evidence that JM disengaged from the non-government service Kalwun almost immediately, while at the same time that relationship was relied upon as a protective factor by DCSSDS.

215. In written submissions DCSSDS drew a distinction between procedures where a referral had been made by them and when a family may have some voluntary contact with a non-government service that had not commenced by way of formal referral from DCSSDS.

216. DCSSDS informed the court that current policy already provides that when a family does not engage with a support service *after DCSSDS referral* or where a family cannot be located the service provider is required to advise the referrer, typically the Child Safety Officer who made the referral. However, DCSSDS conceded that agencies may not always be complying with the requirement and I understand DCSSDS are open to giving the issue further consideration. I intend to make the recommendation as drafted.

That consideration be given to improving access for DCSSDS caseworkers to expert psychological opinion to help them assess risk to children, when working with a family with complex mental health needs.

217. During the evidence, an issue arose in relation to the availability of expert psychologists to caseworkers in DCSSDS. Dr Alison O'Neil was informed in court by Counsel for DCSDDS that there is a "significant shortage" of psychologists in Queensland generally, and it is even more difficult to find psychologists with child protection experience and qualifications. She was informed that this was the case whether the psychologist was employed

internally or externally to DCSSDS. Dr O'Neill accepted that it would be "difficult but not impossible" to find psychologists to fit that role.[167]

218. In response to that evidence counsels assisting suggested a recommendation aimed at providing caseworkers with more support. I note that, subject to "implementation practicalities", it was not opposed by DCSSDS.

219. I intend to make the recommendation as drafted.

To the NSW Secretary, Department of Communities and Justice, and the Commissioner of the NSW Police Force

That consideration be given to amending ChildStory so that if an Assessment Officer in a Child Wellbeing Unit makes an entry under the CWU tab for a family where there is an open file at a CSC, the CSC is automatically alerted to the entry having been made (for example, recording contact with the family and concerns assessed as non-ROSH).

220. The recommendation arose out of evidence that an important entry made by the CWU was not seen by the relevant CSC. The issue was accepted by the parties and the court was informed that there is now a method which should alert CSC staff to a relevant CWU entry.

221. The court was informed that the current "work around" is that the NSWPF, through an assessment officer will cause an email to be sent to the relevant CSC where there is an open case.[168] This email is not generated automatically but requires an assessment officer to take that step.

222. The draft recommendation suggested that consideration be given to a systems amendment that would mean an *automatic notification* is generated. Counsels assisting emphasise that the utility of an automatic notification is not undermined by the fact that there is a current work around, where the work around is

[167] TN 21/12/23, pp.27:43-50; 28:1-17.
[168] NSW Police Submissions at [23]-[24].

dependent upon the assessment officer taking the additional step of emailing the relevant CSC and is not infallible.

223. NSWPF support the recommendation indicating that it would ensure that CSC caseworkers would have greater visibility and that it would increase the likelihood that this information would be accessed by caseworkers in a timely fashion.[169]

224. DCJ opposed the recommendation, setting out several reasons including that the recommendation including that it,

a) Is unnecessary,[170]
b) Would still require a request under Chapter 16A of *the Children and Young Persons (Care and Protection) Act* 1998;[171]
c) May have significant resourcing consequences;[172]
d) Raises questions as to who should receive, and the mechanism for the provision of, such an alert;[173]
e) May result in less direct communication, via the Helpline between CWU and DCJ, and, paradoxically, may also result in DCJ being inundated with too much information.[174]

225. I have considered the matter carefully and in my view it is appropriate to give further consideration to an automatic notification. Email or other contact can still be made, but the best way to make sure the notification is made is to have it automatically generated as the information is entered. I intend to make the recommendation as drafted.

[169] NSW Police Submissions at [26].
[170] DCJ Submissions at [75(a)-(c)].
[171] DCJ Submissions at [80].
[172] DCJ Submissions at [81].
[173] DCJ Submissions at [82].
[174] DCJ Submissions at [84] and [85].

That consideration be given to trialling an information sharing portal that gives DCJ direct access to limited but relevant information on CoPS (such as criminal history and domestic and family violence information) to better inform an assessment of risk and the preparation of Part 16A requests. The Queensland Self Service of Document Retrieval and Unify initiatives provide a useful precedent.

226. Throughout the inquest, a consistent theme emerged recognising that timely information sharing is an important aspect of child protection work which should be prioritised and supported. The speed with which information is shared can be crucial in working with families at risk. As has been noted above, the court heard some evidence about the way information is shared between QPS and DCSSDS using the Queensland Self Service of Document Retrieval and Unify initiatives.

227. Counsels assisting put forward a draft recommendation that consideration be given to trialling an information sharing portal that gives DCJ direct access to limited but relevant information on the NSW Police system CoPS (such as criminal history and domestic and family violence information) to better inform an assessment of risk and the preparation of Part 16A requests, using the Queensland systems as a useful precedent.

228. DCJ did not oppose the recommendation, but noted that it is primarily a matter for NSWPF, who have ownership of the information held on CoPS. DCJ also noted that the recommendation could have significant resourcing implications for both agencies.

229. Counsel for the NSWPF Commissioner indicated in principle support for the recommendation.

230. Having taken all the information into account I intend to make the recommendation as drafted. It appears appropriate that the recommendation goes to both NSWPF and DCJ for discussion.

To the Commissioner of the QLD Police Service, and the Commissioner of the NSW Police Force

That a proposal be taken by QPS and NSWPF to the Australian Criminal Intelligence Commission, which oversees the National Criminal Intelligence System to trial an information sharing portal that would permit state and territory child protection authorities to have direct access to limited but relevant information on NCIS (such as criminal history and domestic and family violence information) to better inform an assessment of risk and the preparation of further lawful requests for information under state or territory law.

231. Counsels assisting explored the idea that it would benefit state and territory child protection authorities to have direct access to relevant information on NCIS (such as criminal history and domestic and family violence information) to better inform their assessment of risk and the preparation of further lawful requests for information under state or territory law.

232. The recommendation was not opposed by the QPS in principle. However, in noting it is directed towards the respective Commissioners of QPS and NSWPF, QPS suggested that the recommendation should properly be directed to the Australian Criminal Intelligence Commission (ACIC). It appears that the Acting Commissioner of QPS would accept "taking the proposal" to the NCIS, however noted that it would be a matter for ACIC to decide upon, given that body is responsible for priorities and expenditures of NCIS.

233. I note the Commissioner of NSWPF indicated support for the recommendation.

234. I intend to make the recommendation and have it directed to the respective Commissioners of QPS and NSWPF. However, noting QPS' submission, I have included specific reference to the proposal being taken to the ACIC.

To the NSW Secretary, Department of Communities and Justice

That DCJ Caseworker training and policy documents explicitly address the need to conduct a further safety assessment, if relevant additional information is received after an initial safety assessment has been completed prior to concluding a Risk Assessment.

235. Since the inquest was held, DCJ have served further evidence, comprising of a number of policy and training manuals[175] regarding review Safety Assessments that are provided to caseworkers. This material clearly outlines when a review Safety Assessment is required.

236. For example, the process of Safety Assessment is described as part of the Structured Decision Making Safety, Risk and Risk Reassessment Manual. That Manual describes the difference between three types of safety assessments: initial, review or closing. A review is described as follows:

> **Review**: Any Safety Assessment that is completed because conditions changed while a case is open and the case will remain open.[176]

237. Further, the Assessment Basics course is a mandatory course for all casework staff, which has online e-learn components and in-person workshops. The online component includes Part 3: Safety Assessment, which explains the three types of assessments:

> **Review Safety Assessment**: completed when there is a change in circumstance or change in information known about the family and there is no ROSH report.[177]

238. Given this evidence, DCJ did not support the recommendation on the basis that it was unnecessary, as there "is already adequate training and policy regarding review safety assessments" (DCJ also provided other training and policy material not summarised above).

[175] NSW DCJ bundle of policies and training materials re review safety assessments, Exhibit 15.
[176] NSW DCJ bundle of policies and training materials re review safety assessments, Exhibit 15.
[177] NSW DCJ bundle of policies and training materials re review safety assessments, Exhibit 15.

239. I accept counsel for DCJ's submissions on this issue and do not intend to make the recommendation.

Findings

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

Identity

241. The person who died was Baby Q

Date of death

242. She died on 17 November 2018

Place of death

243. She died at Tweed Heads, NSW

Cause of death

244. The cause of her death is unascertained

Manner of death

245. Baby Q was a child known to some degree by child protection authorities in three states. Baby Q and her family were also known to Police in Queensland and NSW, and her mother and father were known to mental health services in various states. She was killed by her father who was suffering severe psychosis.

Recommendations pursuant to section 82 of the Coroners Act 2009

246. For the reasons stated above I make the following recommendations.

To QLD Director-General, Department of Child Safety, Seniors and Disability Services

Recommendation 1: In situations where DCSSDS refer a family to a family well-being service in the course of an Investigation and Assessment, consideration be given to requiring the family well-being service (however described) to inform DCSSDS if the family disengages prematurely from the service and the reason for the disengagement.

Recommendation 2: That consideration be given to improving access for DCSSDS caseworkers to expert psychological opinion to help them assess risk to children, when working with a family with complex mental health needs.

To the NSW Secretary, Department of Communities and Justice, and the Commissioner of the NSW Police Force

Recommendation 3: That consideration be given to amending ChildStory so that if an Assessment Officer in a Child Wellbeing Unit makes an entry under the CWU tab for a family where there is an open file at a CSC, the CSC is automatically alerted to the entry having been made (for example, recording contact with the family and concerns assessed as non-ROSH).

Recommendation 4: That consideration be given to trialling an information sharing portal that gives DCJ direct access to limited but relevant information on CoPS (such as criminal history Fand domestic and family violence information) to better inform an assessment of risk and the preparation of Part 16A requests. The Queensland Self Service of Document Retrieval and Unify initiatives provide a useful precedent.

To the Commissioner of the QLD Police Service, and the Commissioner of the NSW Police Force

Recommendation 5: That a proposal be taken by QPS and NSWPF to the Australian Criminal Intelligence Commission, which oversees the National Criminal Intelligence System to trial an information sharing portal that would permit state and territory child protection authorities to have direct access to limited but relevant information on NCIS (such as criminal history and domestic and family violence information) to better inform an assessment of risk and the preparation of further lawful requests for information under state or territory law.

Conclusion

247. I offer my sincere thanks to counsels assisting Donna Ward SC and Martha Barnett SC, and their instructing solicitors Alexander Jobe and Elizabeth May for their very great assistance in this matter.

248. Both Lizzie Jarrett and Nicolle Lowe, Aboriginal Coronial Information and Support Program workers offered support and information to members of Baby Q family. I thank them also.

249. I further thank Detective Sergeant Daniel Lovell of the Homicide Squad and all other officers involved for their diligent and thorough work in this traumatic matter.

250. Finally, I offer my sincere condolences to Baby Q family. Baby Q was a beautiful child whose life was cut short. It is out of respect for her life that these proceedings were conducted. It is clear that members of the community who reported her circumstances to police and who offered her family material support could see she needed help. How she fell through the cracks is a matter of considerable concern to me. I note the cooperative manner in which the involved parties approached these proceedings and accept that they were open to looking for and understanding the missed opportunities to provide Baby Qwith the help she needed.

251. I close this inquest.

Magistrate Harriet Grahame

NSW State Coroner
State Coroners Court
18 April 2024

MFI "A"

Inquest into the death of Baby Q

Chronology of Key Events prepared by Counsel Assisting

Deputy State Coroner Grahame

- Glossary of terms included behind chronology
- Queensland child protection authority referred to as Queensland Child Safety ("QCS") within chronology
- Time markings refer to NSW time
- Where relevant, references to the source documents are followed by references to where Dr O'Neill refers to the incident within her report (Exhibit 1, Tab 115)

Number	Date/Time (NSW)	Event	Reference (at p. # of BOE)
1.	2 August 1971	Baby Q father RB born in Mackay, QLD. He is a Torres Strait Islander man. He was raised in Western Australia and Queensland. He is the father of four children; the youngest being Baby Q	Tab 8 – *R v RB* at p. 223, [9].
2.	5 November 1995	Baby Q mother JM born in Victoria. She was raised in Victoria by her parents, and She has one younger sibling.	Tab 105 – Statement of at p. 1742, [4].
3.	1996/1997	RB first child, Baby Q half-brother, born. The mother of RB son moved to Sydney with his son when his son was still young.	Tab 21b – ERISP transcript at p. 378. Tab 107 – Statement of at p. 1787, [26], [33].
4.	July 2000	RB first admitted to a psychiatric facility (age 29) and diagnosed with alcohol induced psychotic disorder. He presented with auditory hallucinations	Tab 8 – *R v RB* at pp. 231-232, [72]-[73].

Number	Date/Time (NSW)	Event	Reference (at p. # of BOE)
		and reported suicidal thoughts and homicidal thoughts directed to family members.	Tab 115 – Report of Alison O'Neill at p. 1881.
5.	2000-2013	RB is admitted on at least 35 occasions to psychiatric facilities for psychotic episodes. He is also subject to numerous Involuntary Treatment Orders. "*Throughout these years recurring among the delusions reportedly suffered by* RB *were hallucinations of being commanded to kill people and to kill a baby, delusions concerning black magic, spirits, and elders and, curiously, the singer Britney Spears*."	Tab 8 – *R v RB* at pp. 231-232, [72]. Tab 115 – Report of Alison O'Neill at p. 1881.
6.	9 February 2009	RB first daughter (second child), Baby Q half-sister, born. She later became subject to a Long-Term Guardianship Order managed by Mackay CSC.	Tab 48f – Assessment Outcome Report at p. 1101. Tab 43 – QCS Systems and Practice Review Report at p. 992.
7.	2014/2015	When JM was 18 or 19 years old, her parents noticed a rapid deterioration in her mental health. JM would cry because she felt God was going to punish her. During this time she was extremely religious and was of the opinion that she was the mother Mary and she was going to give birth to baby Jesus. Her parents organised for JM to talk to a priest from the local church to explain the true meaning of certain bible passages but JM ended up walking out. According to her father, she appeared to be talking down to people and felt that others were beneath her because of this 'mission' she had to fulfill.	Tab 105 – Statement of [redacted] at pp. 1743, 1745, [16], [29]. Tab 105A – Statement of [redacted] at pp. 1755-1756. Tab 106 – Statement of [redacted] at p. 1758.

Number	Date/Time (NSW)	Event	Reference (at p. # of BOE)
		JM later went missing from family home, was located by police and began preaching religion to them. She was admitted to various hospital, psychiatric and out-patient facilities following these events.	
8.	February 2015	JM first prescribed anti-psychotic medication (Aripiprazole) under the PBS.	Tab 110 – PBS Patient Summary at p. 1821.
9.	Early February 2016	JM moved from Victoria to the Gold Coast and allegedly commenced a double degree in Human Services and Criminology at Griffith University. She commenced working in a café.	Tab 102 – Statement of JM at p. 1709, [9].
10.	March 2016	JM and RB first met at Surfers Paradise beach. RB was homeless at the time. Within about two weeks, an intimate relationship developed. JM abandoned her studies and job and travelled to Mackay with RB	Tab 102 – Statement of JM at p. 1709, [10]. Tab 115 – Report of Alison O'Neill at p. 1882.
11.	10 April 2016	JM parents reported her missing to the QPS and her father travelled to the Gold Coast to search for her. (JM father) reports that he received concerning texts that she was on a Christian mission and that she was hanging around with a homeless man named "RB" QPS conducted inquiries and told by Vic Mental Health that JM has not been formally diagnosed with any mental health issues but had previously suffered from psychotic episodes and was prescribed anti-psychotic medication.	Tab 105 – Statement of at p. 1746, [33]. Tab 6 – Statement of Daniel Lovell at p. 162. Tab 115 – Report of Alison O'Neill at p. 1883.
12.	May 2016	JM re-established contact with her parents and travelled to Geelong, Victoria to visit them. Shortly afterwards JM was admitted on an involuntary basis to the acute psychiatric unit at Geelong Hospital (10/05/16-27/05/16). JM then	Tab 106 – Statement of at pp. 1759, [15], 1780.

Number	Date/Time (NSW)	Event	Reference (at p. # of BOE)
		became a voluntary patient on a sub-acute facility, namely Barwon Health's Prevention and Recovery Centre (PARC). Treated for mood disturbance (manic episode) and psychotic symptoms "*most likely as part of Bipolar Affective Disorder type 1*". Differential diagnosis includes delusional disorder. Longitudinal assessment needed to confirm diagnosis.	Tab 115 – Report of Alison O'Neill at p. 1883.
13.		JM found out she was pregnant with her first child while at Barwon. [redacted] believes JM tried to get pregnant so that the child would be born on Christmas Day.	Tab 102 – Statement of JM at p. 1710, [15]-[16]. Tab 106 – Statement of [redacted] at p. 1758.
14.	August 2016 (approx.)	JM was discharged from Barwon to a community based mental health treatment service at Belmont. After about a month she commenced living with RB in a house in South Geelong, Victoria.	Tab 102 – Statement of JM at p. 1710, [17].
15.	20 September 2016	RB depot medication had previously been managed via a clinic in Mackay. RB first appointment with Dr David Russell (GP) at Wathaurong Health Services, Victoria. History unclear and Dr Russell calls Mackay for details of paliperidone, script later issued and is filled.	Tab 109B – Records from Wathaurong Health Service p. 1808-46.
16.	21 September 2016	RB, along with JM, attended upon Dr Russell for depot injection (paliperidone). Dr Russell records "*long standing history of paranoid schizophrenia… Did previously have issues with violent behaviour when unwell. Ongoing voices who he talks to, but considers these to be good spirits who will encourage him to go on walks or talk to them but do not cause him harm. No paranoia or intention to harm self or others. Used to drink to excess*	Tab 109B – Records from Wathaurong Health Service p. 1808-47.

Number	Date/Time (NSW)	Event	Reference (at p. # of BOE)
		but cut back since meeting JM *in March. Unable to book in a further appointment as he does not know when he will be back from QLD*."	
17.	1 November 2016	RB attends upon Dr Russell for depot injection. Did not have his last depot as planned – never attended in Mackay.	Tab 109B – Records from Wathaurong Health Service p. 1808-48.
18.	11 November 2016	RB in Mackay for a court matter. JM whereabouts are unknown. RB receives a mental state examination by Case Manager (Social Worker) in Mackay. Does not seem to be a planned appointment or examination: '*RB came into Community Mental Health "to say hello to his CM*"".. RB indicates that Geelong is his new home. Recorded that RB understands that his mental health has been well controlled on depot injections. Case Manager discusses plan to discharge him from ITO with psychiatrist. Nothing to suggest RB is assessed by a psychiatrist prior to decision to discharge. RB Involuntary Treatment Order was revoked under the *Mental Health Act 2000* (QLD). "*RB is showing insight into his illness and is committing to remain compliant with medication*"…"*RB partner is a protective factor for* RB*. He states* JM *cooks for me and she's into health and fitness and now I'm eating vegetables, she drives me to depot appointments and reminds me of when I'm close to being due and she is making me go to the dentist to get me teeth fixed.*'" Leads to discharge summary dated 14 November 2016: "*RB has limited IQ and has residual symptoms (auditory hallucinations) despite olanzapine treatment. The voices do not generally bother him and he considers them special ("a gift"). It is documented when* RB *becomes unwell he presents with auditory and visual hallucinations, commanding him to kill people…in the past, repeated Authorities to Return's have been necessary to ensure* RB	Tab 109C – Records from Mackay re involuntary treatment order pp. 1808-70-73.

Number	Date/Time (NSW)	Event	Reference (at p. # of BOE)
		receives his depot medication and attends psychiatrist reviews. On occasions when RB *has been sighted in the community whilst overdue for depot injections he has presented agitated and confused therefore staff have been cautious when approaching* RB *whilst overdue without police assistance*."	
19.	30 November 2016	RB attends upon Dr Russell for depot injection back in Victoria. Last depot injection evident from GP records from Wathaurong Health Service. Medicare records do not record any later depot prescriptions/attendances for depot injection.	Tab 109B – Records from Wathaurong Health Service p. 1808-49. Tab 109 – RB Medicare records at p. 1805.
20.	27 December 2016	LB born in University Hospital, Geelong. RB was not present at the hospital at the time of the birth but (JM mother) was present.	Tab 106 – Statement of at p. 1759, [18]. Tab 115 – Report of Alison O'Neill at p. 1883.
21.	11 January 2017	Per GP records from Wathaurong Health Service "*noted that* RB *has not shown up for his depot for 6 weeks. Called on the 2 numbers supplied. Neither number went through. Baby due about this time. Will add to reminder list*." No further records available and therefore no information to suggest any further contact with RB	Tab 109B – Records from Wathaurong Health Service p. 1808-49.
22.	Mid 2017 (approx.)	On one account from JM, the family travelled from South Geelong, Victoria to Mackay, QLD. During this time, they were living out of their car.	Tab 102 – Statement of JM at p. 1711, [22].

Number	Date/Time (NSW)	Event	Reference (at p. # of BOE)
23.		JM found out she was pregnant with Baby Q. RB "*did not welcome the news of* JM *pregnancy and told her that the unborn child was a 'bad spirit'. He was intent on the* JM *having an abortion, but she refused*."	Tab 8 – *R v RB* at p. 224, [15].
24.	October 2017	According to JM, family arrived in Mackay, QLD and she and LB lived with the father's sister-in-law, , for a few weeks. RB regularly stayed elsewhere.	Tab 102 – Statement of JM at p. 1712, [25].
25.	27 October 2017	JM attends Dr Norris (GP) in Brisbane.	Tab 110 – Medicare records JM at p. 1818.
26.	1 November 2017	Family self-referred to Kalwun Child, Youth and Family Services (**Kalwun**) regarding family's homelessness.	Tab 69 – Kalwun Corporation Family Wellbeing Files at p. 1415. Tab 115 – Report of Alison O'Neill at p. 1886.
27.	3 November 2017	Notification made to QCS by providing information that JM was seven months pregnant and had a 10-month-old son, and among other concerns: the family were living out of a car after relocating from Victoria, the mother left Victoria due to fighting with her parents, the mother and son looked extremely unclean and had not bathed for days, the son had insect bites, scratches and scabbing on his body, the father had schizophrenia and was a "*heavy drinker*", and there were concerns for unborn baby as mother looked physically unwell.	 Tab 43 – QCS Systems and Practice Review Report at pp. 972-973. Tab 115 – Report of Alison O'Neill at p. 1886.

Number	Date/Time (NSW)	Event	Reference (at p. # of BOE)
28.	6 November 2017	Additional Notified Concerns report received from a second Professional Notifier (not [redacted]). Reports, amongst other things, JM [redacted] did not have any available funds, crisis accommodation secured for 1 night initially, mother recontacted the agency on 3 November and was provided 4 additional night's accommodation, mother checked out of accommodation next day despite having further 3 night's accommodation, mother did not attend scheduled appointment and was not returning calls.	Tab 43 – QCS Systems and Practice Review Report at pp. 972-973
29.	9 November 2017	[redacted] attempted to convince JM [redacted] to stay in pre-arranged accommodation but she refused.	[redacted] Tab 6 – Statement of Daniel Lovell at p. 177.
30.	7 November 2017 – 23 November 2017	Investigation and Assessment conducted by QCS. JM [redacted] was interviewed on 7 November 2017 and a Safety Assessment was completed the same day with an 'outcome of safe'. RB [redacted] was interviewed at the Aboriginal and Torres Strait Islander Family Wellbeing Service on 8 November 2017. Said that he has not taken medication for one year. Said did not have a problem with alcohol. Said he was on a suspended sentence (charges not disclosed). On 17 November 2017 JM [redacted] advised QCS that the family was living with RB [redacted] cousin (in Mackay) and would be applying for public housing. On 20 November 2017 Housing officers advised that JM [redacted] had attended to update her housing referral and to be linked with community supports. No concerns were raised. Placed family on priority list for housing.	Exhibit 5 – QLD DCSSDS bundle re reports and assessments at pp. 70-76. Tab 43 – QCS Systems and Practice Review Report at pp. 973-974. Tab 115 – Report of Alison O'Neill at pp. 1887-1888.

Number	Date/Time (NSW)	Event	Reference (at p. # of BOE)
		Assessment and Outcome approved on 22 November 2017 with an outcome of: "*Unsubstantiated in relation to* LB *and unborn Baby. Aboriginal and Torres Strait Islander Family Support Service transferred the case to a relevant service in City2*." (Girudala Indigenous Family Wellbeing Program)	
31.	Mid November 2017	Family living in Slade Point/Mackay with RB family members – 1 Finch Street, Slade Point and 4 Sandpiper Court, Slade Point.	Tab 108 - Statement of [redacted] at p. 1796, [12]-[15]. Tab 102 – Statement of JM [redacted] at p. 1712, [25]. Tab 6 – Statement of Daniel Lovell at p. 177.
32.	Late 2017/early 2018	The family rented and moved into a house in Slade Point, Mackay, QLD (1 Rosella Street, Slade Point).	Tab 102 – Statement of JM [redacted] at p. 1712, [26]. Tab 105 – Statement of [redacted] at p. 1749, [52].
33.	27 January 2018	JM [redacted] issued with an infringement notice in Mackay for driving with an infant greater than 6 months but less than 4 years old unrestrained.	Tab 6b – Statement of Daniel Lovell, chronology of QPS holdings at p. 162.
34.	2 February 2018	Baby Q [redacted] born at Mackay Base Hospital, QLD.	Tab 102 – Statement of JM [redacted] at p. 1712, [27].

Number	Date/Time (NSW)	Event	Reference (at p. # of BOE)
			Tab 115 – Report of Alison O'Neill at p. 1890.
35.	17 April 2018	Baby Q seen by Dr Murshed Khan in Slade Point, Mackay. According to Medicare records, this was the only time Baby Q was seen by a doctor who billed Medicare.	Tab 114 – QB Medicare records at p. 1876.
36.	26 April 2018	QPS receive report of a man unconscious on the side of the road. Police attend and locate RB walking on roadway. Initially arrested for being drunk in public place but Police discontinue arrest and release him into partner's JM) care at 1 Rosella St, Slade Pt.	Tab 6b – Statement of Daniel Lovell, chronology of QPS holdings at pp. 162, 171.
37.	April 2018 (approx..)	According to JM the family moved to Surfers Paradise and rented an apartment. JM parents paid half of the rent.	Tab 102 – Statement of JM at p. 1713, [31].
38.	2 May 2018	Police occurrence in Mackay. RB appeared intoxicated, was incoherent and yelling at himself. Police located two knives in a bag concealed in the waistband of his pants.	Tab 6b – Statement of Daniel Lovell, chronology of QPS holdings at pp. 162, 170.
39.	3 May 2018	RB is arrested for being intoxicated in a public place, in Surfers Paradise.	Tab 6b – Statement of Daniel Lovell, chronology of QPS holdings at p. 161.

Number	Date/Time (NSW)	Event	Reference (at p. # of BOE)
40.	4 May 2018	QPS detained RB at Broadbeach, QLD after locating him acting aggressively, threatening self-harm and eating dirt and twigs. RB was heavily intoxicated, and he was taken to Robina Hospital for an emergency assessment. "*Initial report from the informant stated that a child had been hurt. Police TUW informant who stated that she had not seen any harm to child but was concerned with the behaviour of the POI around the child. Police TUW with the mother of the child who arrived back after police initially attended. She stated that the POI was the father of the child and she was seeking emergency housing in the coming days through Robina. Nil signs of harm to child. Child happily playing*."	Tab 6b – Statement of Daniel Lovell, chronology of QPS holdings at p. 169. Tab 6 – Statement of Daniel Lovell at p. 104 [133]. Tab 115 – Report of Alison O'Neill at pp. 1891-1892.
41.		Details re informant to police being concerned with RB behaviour around a child not passed onto Hospital. Robina Hospital Mental Health Services General Assessment of RB • Brought to ED after being picked up by Police in an intoxicated state. Reported acting bizarrely, aggressive to police and eating dirt, suicidal ideation. No insight into his mental health. • On assessment seemed somewhat guarded, but now he is sober he denies any suicidal ideation and is reporting no psychotic symptoms. Unable to obtain any collateral information from his partner or sister, so assessment limited by this. • Historical diagnosis of schizophrenia managed under ITO with paliperidone however on assessment no evidence of psychotic symptoms on review. • Discussed with Dr Krishnaiah, consultant psychiatrist on call. Discussed no current evidence of thought disorder or psychotic symptoms. Risk appears to be approaching baseline now no longer intoxicated. • Plan:	Tab 109A – Robina Hospital records at pp. 1808-11,1808-12, 1808-29, 1808-39, 1808-43. Tab 115 – Report of Alison O'Neill at p. 1892.

Number	Date/Time (NSW)	Event	Reference (at p. # of BOE)
		1. Revoke recommendation – no evidence of an illness that would enable us to keep him under the mental health act. 2. Give contact details to RB for ACT and offer appointment with community ACT. D/W clinician on overnight will hand over to morning team to contact RB partner. Informed that there are 3 numbers to try. 3. ACT to contact family in the morning for collateral and information on mental state and offer support if required. 4. Referral to HHOT [Homeless Health Outreach Team] for ongoing contact. • Diagnosis: Acute alcohol intoxication, no evidence of psychotic symptoms on horizontal assessment. • "*Reports has 2 children but no contact with them [redacted] CIMHA reports more children but limited or no contact with them.*"	
42.	5 May 2018	RB again detained by QPS at Broadbeach, QLD for being highly intoxicated. Transported to Southport watch house to "*sober up*". JM and children were "*transported to Miami One where she stated she was staying with a friend. Children were happy, had milk and nappies and seemed in good health.*"	Tab 6(b) – Statement of Daniel Lovell, chronology of QPS holdings at pp. 161, 168. Tab 115 – Report of Alison O'Neill at p. 1893.
		Nurse, Kristi Gardner, from Robina Acute Care Team, tries to call JM and RB on numbers provided to ED. Leaves messages for a return call. No evidence to suggest calls ever returned.	Tab 109A – Records from Robina Hospital (extracts) p. 1808-14.
43.	7 May 2018	Alison Stinton from Robina Acute Care Team calls HHOT re RB, and HHOT indicates that he is well known to them. Letter is also sent to Aboriginal & Islander Community Health, MacKay.	Tab 109A – Records from Robina Hospital (extracts) pp. 1808-1-1808-17.

Number	Date/Time (NSW)	Event	Reference (at p. # of BOE)
44.	10 May 2018	RB arrested for public nuisance and possession of weapons in Surfers Paradise. He is found with a credit card knife inside a small pouch inside his pocket.	Tab 6b – Statement of Daniel Lovell, chronology of QPS holdings at pp. 161, 167-168.
45.	11 May 2018	After charge: public nuisance, RB referred for assessment by a Court Liaison Clinician. RB offered an assessment for mental health needs however declined to participate and no indication of need to conduct on an involuntary basis.	Tab 109A – Records from Robina Hospital (extracts) p. 1808-22.
46.	14 May 2018	RB failed to appear in Mackay to have his identifying particulars taken for resist arrest, incite, hinder, obstruct police.	Tab 6b – Statement of Daniel Lovell, chronology of QPS holdings at p. 161, 166.
47.	27 May 2018	The QPS located RB Baby Q and LB "*sleeping rough*" in a park at Surfers Paradise. The children were noted to be "*clean, appeared well fed and the father had supplies of nappies and milk formula for the infants*." The QPS holdings note that the RB had a history of mental illness and extensive criminal history. Officers attempted to locate accommodation for RB and the children on the Gold Coast but were unsuccessful. A 'Child Harm Referral Report' was created and disseminated to the Gold Coast Suspected Child Abuse and Neglect (SCAN) Team for review. The SCAN Team is a QPS initiative, and its purpose is to "*enable a coordinated, multi-agency response to children where statutory intervention is required to assess and meet their protection needs*."	Tab 6b – Statement of Daniel Lovell, chronology of QPS holdings at pp. 164-166. Tab 115 – Report of Alison O'Neill at p. 1893. Tab 29a – QPS Operational and Procedures Manual as at July 2023 at p. 751.
48.		Notification made to QCS (by QPS) that children sleeping in a park and both parents having historical mental health issues.	Tab 6b – Statement of Daniel Lovell, chronology of QPS holdings at pp. 164-166.

Number	Date/Time (NSW)	Event	Reference (at p. # of BOE)
		Details include "Police information system records outline issues of both the mother and father having mental health issues and the father's public intoxication. The mother is listed in 2016 as requiring an EEA for mental health assessment of her paranoid schizophrenia whereby she was of the belief at that time she was about to give birth to the child of Christ (subject child LB). QPS notes outline the mother "went off her medication" at this time. JM was contacted by Joseph Leadbetter, Child Safety Officer at QCS. Mr Leadbetter secured and funded accommodation for the family for two nights at a motel. Interviews and assessments followed. Following a Safety Assessment (children assessed as safe) an "Assessment and Outcome" on 7 June 2018 recorded the matter as "unsubstantiated" as "*there is no information that either* LB *or* Baby Q *has suffered significant harm… RB consumes alcohol outside the home…* JM *is a parent who is willing and able to meet the above identified needs of her children.*" Further details of assessment process referred to below.	Exhibit 5 – QLD DCSSDS bundle re reports and assessments at p. 82. Tab 43 – QCS Systems and Practice Review Report at p. 975. Tab 46 – Statement of Joseph Leadbetter at p. 1060, [8]-[10]. Tab 48f – Statement of Elissa Brewer, Assessment Outcome Report at p. 1103. Tab 115 – Report of Alison O'Neill at pp. 1893-1895.
49.	28 May 2018	QCS Investigation & Assessment commenced, tasked to Greta Weertman, Child Safety Officer. Both children sighted at a motel where the family were staying. Children appeared clean and appropriately dressed. No concerns were noted about the children's presentation or interactions with JM JM said they had found it difficult to secure accommodation. Staff observed JM with a blood shot eye and bruising which she said she sustained playing football. JM denied RB was violent towards her. RB sister, , was present as a support person during the interview and QCS notes state that said, "*you're scared of him (referring to* RB	Tab 48 – Statement of Elissa Brewer pp. 1067-1068, [8a]-[8c]. Exhibit 5 – QLD DCSSDS bundle re reports and assessments at p. 145.

Number	Date/Time (NSW)	Event	Reference (at p. # of BOE)
		to which JM *replied '*RB *the head of the family, I can't stand over him*"".	Tab 43 – QCS Systems and Practice Review Report at p. 976. Tab 115 – Report of Alison O'Neill at p. 1896.
50.	29 May 2018	QCS received further information regarding the family from the QPS referred to in the QPS holdings reference QI1800966268. Includes reference to RB extensive criminal history with specific details of relevant matters from 2011-2018 and an offer to provide full history on request. Child Safety Officers Crystal Sandford and Madeline Kelly again visited JM, LB and Baby Q at a motel. RB not present. JM agreed to work with Aboriginal and Torres Strait Islander Family Wellbeing Service and said had accommodation in motel for two nights. JM observed to have bruising around her eye. Safety Assessment completed by Greta Weertman. She recorded outcome of 'safe.' Rationale: The notified concerns suggested that the following harm indicators may be present: harm indicator 4 (Parent contributes to hazardous living conditions that pose an immediate threat to the health or safety of child) due to concerns that the family were homeless and living in a situation that was hazardous to the children and did not align with their needs. However after interviewing JM and sighting LB and Baby Q it was assessed that he was not at immediate risk of suffering harm as: A. JM has sourced a 3 month lease and is currently supporting her family in motel accommodation until she can access that; B. JM has reengaged with Kalwun FSS who are supporting her in working with housing to get bond loan;	Tab 6b – Statement of Daniel Lovell, chronology of QPS holdings at p. 163. Tab 48 – Statement of Elissa Brewer pp. 1068-1069, [10a]-[10e], 1076. Tab 43 – QCS Systems and Practice Review Report at p. 976. Tab 115 – Report of Allison O'Neill pp. 1896-1897.

Number	Date/Time (NSW)	Event	Reference (at p. # of BOE)
		C. JM has engaged readily with the department and kept services updated about her and the children's whereabouts; D. LB and Baby Q were sighted to be clean, happy and appeared generally well cared for. As such a safety decision for the household of SAFE has been determined.	
51.	30 May 2018	Ms Weertman received information via a s.159 request from Child Protection Advisor and Paediatrician at Gold Coast University Hospital, children not known to the Gold Coast Health Service, mother had a documented mental health admission on February 2015 with delusional disorder, self-ceased medication on October 2015, was listed as a missing person in Victoria, documentation that JM had left her accommodation and job to live with 40 year old RB or "God" and she was planning to have "God's baby. Her parents reported concerns about JM having religious delusions. Father had significant contact with health services across QLD, history of schizophrenia and alcohol dependence.	Tab 48 – Statement of Elissa Brewer p.1070, [14] and "EB4" p. 1088
52.	31 May 2018	JM advised Ms Weertman that the family was approved for a bond loan and would be moving into a unit the next day.	Tab 43 – QCS Systems and Practice Review Report at p. 977. Tab 48 – Statement of Elissa Brewer p. 1070, [15]. Tab 115 – Report of Alison O'Neill at p. 1900.

Number	Date/Time (NSW)	Event	Reference (at p. # of BOE)
53.	4 June 2018	Ms Weertman and Child Safety Support Officer Kristy Wright conducted an unannounced home visit at the apartment where the family was residing. RB was not home. Staff said they would need to speak to him, but JM said it was preferable for this to be done over the phone. JM advised that her parents were helping with the rent and would be visiting in a few weeks.	Tab 48 – Statement of Elissa Brewer p. 1070, [16]. Tab 43 – QCS Systems and Practice Review Report at p. 977. Tab 115 – Report of Alison O'Neill at p. 1900.
54.	5 June 2018	RB advised Ms Weertman via telephone call that the family had somewhere to stay. He did not wish to speak any further to Departmental officers. Passed phone to JM . Ms Weertman offered support for RB alcohol use. JM stated she did not believe RB would engage, and that he did not drink at home. She advised that the family had engaged well with the Aboriginal and Torres Strait Islander Family Wellbeing Service .	Tab 48 – Statement of Elissa Brewer p. 1070, [17]. Tab 43 – QCS Systems and Practice Review Report at p. 977. Tab 115 – Report of Alison O'Neill at p. 1901.
55.	7 June 2018	Kalwun *"had discussions with* JM *regarding referral to DV and supports put into place around* RB *not taking his medication for schizophrenia*."	Tab 69 – Kalwun Corporation Family and Wellbeing Program Files at p. 1552.
56.	5 June 2018-7 June 2018	The Assessment was completed on 5 June 2018. It was then approved on 7 June 2018. Assessment and Outcome: "*Unsubstantiated, Child Not in Need of Protection*". The final risk level of moderate was determined. The form was approved by Elissa Brewer.	Tab 48 – Statement of Elissa Brewer at p. 1071, [18]. Tab 43 – QCS Systems and Practice Review Report at p. 977.

Number	Date/Time (NSW)	Event	Reference (at p. # of BOE)
			Tab 115 – Report of Alison O'Neill at pp. 1902-1903.
57.	12 June 2018	Tanya Blackhall, Intake Gold Coast Officer, Kalwun, indicates that Kalwun does not think that the children are at unacceptable risk due to the protective nature of the mother, and agrees with the outcome of the investigation and assessment of QCS.	Tab 68 - Kalwun Corporation Recognised Entity Program Files pp. 1438-1439.
58.	15 June 2018	Contact between Kalwun and JM at Cascade Gardens. Kalwun raised concerns regarding domestic violence, RB mental health and alcohol use. JM stated: • There was no domestic violence in their relationship. • RB was "*going through a bad stage*" regarding his mental health due to being homeless and "*the situation*" but is "*much better now and doesn't need any supports*.". • RB was not drinking at that time but was before due to stresses around being homeless. JM declined any support, and stated she had to support her (presumedly a reference to RB sister), and RB who is temporarily staying with them. She said her landlord told her yesterday that she would extend their lease after the three months. JM agreed to her family's case being closed, and said she would contact them if she needed any further support. Kalwun records: "*This is not a mandatory service and once a family say they want to close we have to respect their decision*". Kalwun closed the case on 19 June 2018.	Tab 69 – Kalwun Corporation Family Wellbeing Program Files at pp. 1552-1553. Tab 115 – Report of Alison O'Neill at p. 1906.
59.	16 July 2018	RB appears agitated during a street check with QPS. He calms down and goes with his sister	Tab 6b – Statement of Daniel Lovell, chronology of QPS holdings at p. 157.

Number	Date/Time (NSW)	Event	Reference (at p. # of BOE)
60.	August 2018	JM parents visited the family at their apartment in Surfers Paradise. They noticed a cigarette burn in the centre of JM forehead, which she said she had done herself. RB appeared to be heavily intoxicated but was friendly and not aggressive.	Tab 105 – Statement of [redacted] at pp. 1751-1752, [66] and [72]. Tab 115 – Report of Alison O'Neill at p. 1906.
61.	1 August 2018	RB is found to be intoxicated in a public place by the QPS.	Tab 6b – Statement of Daniel Lovell, chronology of QPS holdings at p. 157.
62.	4 August 2018	RB is found to be intoxicated in a public place and begging at 12:37pm, he is placed under arrest.	Tab 6b – Statement of Daniel Lovell , chronology of QPS holdings at p. 156.
63.	28 August 2018	The QPS called to a disturbance at the family's address, Police met by a number of other neighbours at front gate, RB and partner had taken two children to beach. When Police arrived at the beach RB became aggressive before running away into the darkness. Another Police crew located him short time later laying in shallow water. Arrested on warrant. JM told police RB was intoxicated and had a right to be. …RB had been out drinking, returning home, began yelling and banging doors…Neighbours have called police with concerns for welfare of the children and their own families. Neighbours say this is an ongoing matter where RB will become intoxicated and abuse neighbours while making a large amount of noise….children appeared well although concerns for their mental health are present. They were not upset in an environment where neighbours could hear the noise from the other end of the unit complex.	Tab 6a – Statement of Daniel Lovell, chronology of QPS holdings, at p. 129. Tab 115 – Report of Alison O'Neill at p. 1907.

Number	Date/Time (NSW)	Event	Reference (at p. # of BOE)
64.	30 August 2018	'Child Concern Report' made to QCS by the QPS in respect of events on 28 August 2018. There were: "*Serious concerns for the welfare of the children due to father's erratic behaviour whilst under the influence of alcohol… The mother appears to have no concerns for her partner's behaviour in front of the children*." The report was reviewed by QCS, and recorded as a CCR. The CCR noted the following as matters QCS were 'worried' about: • "*exposed to their father's alcohol use, which resulted in erratic and abusive behaviours*"; • "*father ran from police and when located was verbally aggressive towards them*"; • "*children seemed un-phased by their father's actions and seemed to be used to the incidences*"; and • "*two 24hr notifications recorded within 12 months of each other; both relating to the families lack of stable accommodation and living in cars; and worries about the father's alcohol abuse issues*". When considering the next steps, QCS took into account: • "*no information provided to indicate that the children were upset by their exposure or that they were harmed as a direct result of their exposure*"; • "*no information provided to indicate that* JM *was under the influence, or was not a parent able to take primary care of the children when* RB *drank*"; • "*family have maintained stable housing since the closure of the IA, and there have been no concerns reported of a similar nature since the IA, indicating an escalation of parental behaviour*".	Tab 6a – Statement of Daniel Lovell, chronology of QPS holdings, at pp. 130-131. Exhibit 5 – QLD DCSSDS bundle re reports and assessments at p. 187. Tab 115 – Report of Alison O'Neill at pp. 1908-1910.
65.	August 2018 (more likely September on the information available to the Court)	Throughout August 2018 (more likely September on the information available to the Court) [redacted] in Tweed Heads, reported seeing a mother and her two children regularly attending the parenting room located within the shopping centre. [redacted] reported that the family were '*dirty*' and '*smelt bad*' and occasionally saw the	Tab 88 – Statement of [redacted] at p. 1638-1640.

Number	Date/Time (NSW)	Event	Reference (at p. # of BOE)
		father with them. She stated that the mother would lay blankets on the floor for the children to sleep on and used the sink to wash the children's clothes. On 11 October 2018, [redacted] reported the situation to [redacted] who notified the NSWPF (Tweed Heads Police Station) and 'DOCS' (Family and Community Services) about the family.	Tab 87 – Statement of [redacted] at p. 1634, [4]. Tab 6 – Statement of Daniel Lovell at p. 71 [51]. Tab 115 – Report of Alison O'Neill at pp. 1906- 1907.
66.	Early September 2018	JM [redacted] called her mother and told her not to worry about paying the rent on the Broadbeach unit as they had left unit. She did not tell [redacted] where she was going. The family started living rough on the streets between Northern NSW and South Eastern Qld.	Tab 106 – Statement of [redacted] at p. 1760, [24]. Tab 102 – Statement of JM [redacted] at p. 1713, [35]. Tab 115 – Report of Alison O'Neill at pp. 1910-1911.
67.	5 September 2018	Bradley Fitzsimmons, an employee of the City of Gold Coast Council responded to reports of people illegally camping in the sand dunes at Pratten Park, Broadbeach. Fitzsimmons located JM [redacted] and the children living in a tent in the sand dunes. Fitzsimmons advised JM [redacted] that it was against council regulations for them to camp there and provided her information for homeless support services. Shortly after RB [redacted] confronted Fitzsimmons verbally abusing him, throwing a VB bottle at him, and arming himself with a stick.	Tab 30 – Statement of Senior Constable Chayne Foster at p. 882. Tab 6 – Statement of Daniel Lovell at pp. 71 [53], 149.

Number	Date/Time (NSW)	Event	Reference (at p. # of BOE)
		The Police were contacted but were initially unable to locate RB JM or the children. Police were later able to link this matter to RB and issue him with a Notice to Appear. No report made to QCS.	Tab 115 – Report of Alison O'Neill at p. 1911. Transcript for 19 December 2023 at p. 33:31-35.
68.	6 September 2018	The QPS detained RB at Broadbeach as a result of him being '*severely affected by intoxicating substances'* and '*barely able to speak'*. At the time, RB was armed with a '*large metal bar'* which he had concealed under his jacket.	Tab 29a – QPrime history contained within Report of Suspected Harm, QPS Report No: QP1802145443 at p. 882. Tab 6 – Statement of Daniel Lovell at p. 74 [55]. Tab 115 – Report of Alison O'Neill at p. 1912.
69.	7 September 2018	A QCS Case Worker emailed Kalwun with updated referral information for [redacted] Family raising "*additional worries*" for the family and asked Kalwun to consider the information as a referral update for their work with the family. Information included reference to RB older child subject to long term guardianship order, reported information from Police attendance on 30/08/18 (which in turn incorporated most recent child protection history).	Tab 69 – Kalwun Family Wellbeing Program Files at p. 1526. Tab 6 – Statement of Daniel Lovell at p. 195.

Number	Date/Time (NSW)	Event	Reference (at p. # of BOE)
			Tab 115 – Report of Alison O'Neill at p. 1912.
70.	18 September 2018	Kalwun unable to contact or locate family for referral intake as they were homeless at the time.	Tab 69 – Kalwun Corporation Family Wellbeing Program Files at p. 1454. Tab 6 – Statement of Daniel Lovell at p. 179. Tab 115 – Report of Alison O'Neill at p. 1912.
71.	September/ October 2018	During this period, a witness by the name of Maxine Johnson, who resided in the vicinity of Bay Street, Tweed Heads, reported seeing JM RB and the children in the vicinity of her home on approximately 6 occasions. On one occasion Johnson described RB as carrying the children in a '*rough manner*'.	Tab 96 – Statement of Maxine Johnson at pp. 1678-1680. Tab 6 – Statement of Daniel Lovell at p. 75 [58]. Tab 115 – Alison O'Neill at pp. 1912-1913.
72.	October 2018	The family access Fred's Place in Tweed Heads several times for basic services.	Tab 65a – Statement of Alysia Hopkins, case notes at p. 1409. Tab 6 – Statement of Daniel Lovell at p. 107, [147].

Number	Date/Time (NSW)	Event	Reference (at p. # of BOE)
			Tab 115 – Report of Alison O'Neill at p. 1917.
73.	3 October 2018	Constable Danielle Osborne and Senior Constable Cogin (NSWPF) were called to bushland near the Tweed River to respond to a male pitching a tent with a sleeping child, and the male reportedly looking around and acting suspicious. The officers observed the family living in a tent, with fishing rods and chairs set up. RB became agitated when officers questioned what they were doing in the area, grinding his teeth and yelling '*THIS IS MY LAND'*. The officers requested back-up due to the father's agitation, and Senior Constable Andrew Greenup and Senior Constable Barry Carr subsequently attended. The mother was changing Baby Q nappy and the officers noted she did not have nappy rash and there were fresh nappies for her. The officers left the area and returned to other duties.	Tab 38 – Statement of Danielle Osborne at pp. 942-943. Tab 115 – Report of Alison O'Neill at pp. 1913-1914.
74.	6 October 2018	JM called her mother and asked her to immediately book flights to Victoria for her, LB and Baby Q. Tickets were booked for that evening however JM, LB and Baby Q never arrived.	Tab 106 – Statement of [redacted] at p. 1760, [26]. Tab 115 – Report of Alison O'Neill at p. 1915.
75.	7 October 2018	Ms Prouten, a member of the public, calls '000' after observing a male hit bins and tables with a stick with aggression, stating that the baby and toddler were clothed only in nappies and the mother appeared to be under his control. Street check for a disturbance by QPS at 6:52pm with RB and JM both named. No details on LB or Baby Q	Tab 80 – Statement of Jazmin Prouten at pp. 1610-1611, [5]-[8]. Tab 6b – Statement of Daniel Lovell, chronology of QPS holdings at p. 148.

Number	Date/Time (NSW)	Event	Reference (at p. # of BOE)
76.	11 October 2018	Notification to DCJ Child Protection Helpline: at 7:19pm [redacted] made a report to the Helpline, stating he had received an email stating a young mother and two children were living in a park behind the mall and '*trashing'* the parenting room. He said that he had called local police to ask them to do a welfare check on the family. The Helpline SR Pilot caseworker contacted the Tweed Heads Police. At 9:26pm, police confirmed that an officer had visited the park earlier that evening but was unable to locate the family. The Helpline notification also indicated that the children had been wearing wet clothing for three days, the reporter requested a welfare check. The Helpline Caseworker contacted Tweed Heads police three times that night regarding the outcome of the welfare check. The DCJ Helpline After Hours Team screened the information about '*Unknown Unknown* family' as Risk of Significant Harm, and referred it to Tweed Heads CSC recommending a less than 24-hour response.	Tab 88 – Statement of [redacted] at p. 1638-1640. Tab 87 – Statement of [redacted] pp. 1634-1635. Tab 55 – Statement of [redacted] at p. 1213 [9]- [10]. Tab 53 – Internal Death Review at pp. 1182-1183. Tab 115 – Report of Alison O'Neill at pp. 1915-1916.
77.	12 October 2018	Caseworker, [redacted] Tweed Heads CSC allocated the report for further information gathering, however no further work was undertaken in response due to the absence of identifying information about the family, as well as limited resources at the CSC on Friday 12 October 2018 and Monday 15 October 2018. The CSC allocated one ROSH report for a face to face (safety) assessment on 12 October, and four ROSH reports for face to face (safety) assessments on 15 October.	Tab 55 – Statement of [redacted] at p. 1214, [14]. Tab 53 – Internal Death Review at p. 1183-1184. Tab 115 – Report of Alison O'Neill at p. 1917.
78.	15 October 2018	[redacted] a support worker from [redacted] (now known as [redacted] a community-based organization, observed on her lunch break a young woman and an Indigenous man sitting in	Tab 62, Statement of [redacted] at pp. 1372-1375.

Number	Date/Time (NSW)	Event	Reference (at p. # of BOE)
		a set of fire stairs near the entrance of Tweed Mall. The location was known to be frequented by homeless people. She also observed a toddler boy with the couple, sitting in the child section of a front of the trolley. When she arrived back at the office, she observed the same lady and toddler out the front of the office. She also observed a baby lying in the trolley. [redacted] introduced herself as working at [redacted] and asked if the lady needed any help. The lady said that she had just fled QLD from a DV situation, she didn't want to talk about it or be supported for it as the Police were involved. She said she needed accommodation. She stated her name was JM [redacted] invited JM [redacted] inside and assisted her in contacting *Link2Home*. JM [redacted] subsequently obtained two nights' accommodation at the Tweed River Motel at Murwillumbah. [redacted] also provided JM [redacted] with formula, nappies, food items and some bottles, and offered assistance travelling to Murwillumbah, which was declined. JM [redacted] and the children left. [redacted] asked her colleague, [redacted] to submit a report to DCJ.	
79.	16 October 2018	In the morning, [redacted] contacted Tweed Heads CSC and spoke to [redacted] to discuss her worries for JM [redacted] LB and Baby Q According to [redacted] recollection, [redacted] told [redacted] she could see there were numerous reports regarding an unknown lady with two dark children living in a trolley under a tarp in the park close to the Boat Harbour area, Tweed Heads. [redacted] asked the condition of the children, whether JM [redacted] identified as having drug and alcohol issues, and about their general well being. [redacted] told her that the three presented happy, well bonded, and that she could not detect any drug and alcohol or mental health issues. [redacted] asked [redacted] to place a mandatory report. [redacted] recalled the report about the unknown family received five days earlier.	Tab 63 – Statement of [redacted] at pp. 1379-1380. Tab 55 – Statement of [redacted] at p. 1214, [16]-[21] Tab 53 – Internal Death Review at p. 1184. Tab 115 – Report of Alison O'Neill at p. 1920.

Number	Date/Time (NSW)	Event	Reference (at p. # of BOE)
		[redacted] spoke with a colleague from NSW Housing co-located within Tweed Heads CSC re temporary accommodation offered to family and also completed a Pre-Assessment Consultation with A/Manager Casework.	
80.		**At 2:19pm (AEDT)**, [redacted] requested that an email be sent to DCJ's Interstate Liaison Team to request advice from QCS about whether they had any prior involvement with the family.	Tab 55 – Statement of [redacted] at p. 1214, [19]. Tab 115 – Report of Alison O'Neill at p. 1920.
81.		**At approximately 3:00pm (AEDT)**, [redacted] and colleague [redacted] arrived at the motel in Murwillumbah where JM [redacted] LB and Baby Q were staying for the purpose of conducting a Safety Assessment. A Safety Assessment helps practitioners determine the immediate safety needs of the child and if they may safely remain in the home, with or without a safety plan in place. LB and Baby Q were observed to be settled, clean, dressed for the weather and appeared comfortable with JM [redacted] who was attentive to them during the visit. JM [redacted] provided a background of her relationship with RB [redacted] and the families' involvement with QCS. She said that she did not have any mental health issues and there was no violence between her and RB [redacted], but that they were "*on a break*". She said that she and the children would be travelling to Geelong, Victoria once she received her Centrelink payment (the next day) where she intended to stay with her family until she "*got back on her feet*". She said RB [redacted] would likely stay in Tweed Heads or return to Queensland. JM [redacted] described previous incident in Tweed Heads with father as "*someone pissed him off and he smashed something at Broadbeach*".	Tab 55 – Statement of [redacted] at pp. 1216-1217, [22]-[28], 1279-1281. Tab 56 – Statement of Simone Czech at p. 1322, [42]. Tab 53 – Internal Death Review at pp. 1185-1187. Tab 115 – Report of Alison O'Neill at p. 1921.

Number	Date/Time (NSW)	Event	Reference (at p. # of BOE)
		JM told caseworkers she doesn't have keycard, lost wallet, no pension card and no charger for phone. Caseworkers offered to return to Murwillumbah the following day and transport JM and children to Tweed Heads where she could organise her flights to Victoria (offer was declined by JM). JM provided her mobile number to caseworkers and agreed for them to call her the next day to see if she needed additional accommodation or other support. Before leaving Murwillumbah to return to Tweed Heads, the caseworkers telephoned their manager to talk about their conversation with JM and observations of the children. The caseworkers advised the manager that there were no immediate safety concerns or dangers identified during the safety assessment and the children were safe in the mother's care.	
82.		Later in the day police dispatched to hotel and evicted 'a couple' for 'rowdy behaviour'. CAD record – inft "CAN HEAR MAL POSSIBLY ASS AF AA 2 CHILDREN CRYING WHILE ON CALL POI WAS SEEN OS UNIT - POI DESC ABORIGINAL APP 5FT10 SKINNY BLK HOODIE BLK LONG PANTS NIL MENTION OF WEAPONS AMBOS DECLINED POI MAY BE ICE AFFECTED". Narrative : *Police attended and spoke with all parties. The male and female were evicted from hotel for rowdy behaviour . There was no offence detected. The male appeared to be a bit simple and was clumsy in actions. The family was clam and spoke freely with police. She laughed when police asked if anything happened to her. She said she had nil fears and there was no argument. She was unhappy with being asked to leave and that was it. They were planning on going back to Victoria the following day and were making their way to Coolangatta for the night where their flight was departing from. Nil fears for anybody's safety. Nil offence. Nil argument. Nil DV.*	Tab 53 – Internal Death Review at pp. 1192-1193. Exhibit 9 – CAD record – Tweed River Hotel at p. 1.

Number	Date/Time (NSW)	Event	Reference (at p. # of BOE)
		No mention of children in CAD narrative.	
83.	17 October 2018	[redacted] from [redacted] made a formal notification to the DCJ Helpline regarding the family's homelessness. The DCJ Helpline initially screened the report made as '*Risk Of Significant Harm'* for '*Neglect: Inadequate Basic Care'* and recommended a response be provided in less than 10 days. Later reviewed by Helpline SR Pilot managers who requested caseworker obtain further details. The Helpline Caseworker tried to contact [redacted] from [redacted] at 5:05pm to obtain more information however was advised to call back tomorrow. Meanwhile, QCS provided information about its involvement with the family while they lived in Queensland. [redacted] attempted to contact JM [redacted] by phone however she did not answer the calls or respond to the voicemail message.	Tab 63 – Statement of [redacted] at p.1381, [29]. Exhibit 4 – NSW DCJ bundle re reports and assessments pp. 92-93. Tab 53 – Internal Death Review at pp. 1191-1193. Tab 55 – Statement of [redacted] at pp. 1218, [33]-[34]. Tab 115 – Report of Alison O'Neill at pp. 1923-1924.
84.	18 October 2018	Early afternoon, Helpline Caseworker contacted [redacted] and spoke to a support worker (not [redacted]) to ask for clarification on the report received. Helpline Caseworker then contacted the Tweed River Motel reception and spoke to a male at 4:25pm. Confirmed JM [redacted] was given 2 nights accommodation…arrived with "a man" who JM [redacted] said was "just dropping her off". However the man was still at the motel the next morning.	Tab 63 – Statement of [redacted] at p. 1381, [29]. Exhibit 4 – DCJ notifications and associated documents at pp. 92-93.

Number	Date/Time (NSW)	Event	Reference (at p. # of BOE)
		Receptionist said Police were contacted on Tuesday by another guest as the male caused a "*disturbance*". The receptionist would not provide details of the disturbance and advised the Helpline Caseworker to contact Police to obtain additional information. Helpline Caseworker contacted Murwillumbah Police at 5:23pm and was told about the occurrence as recorded in the CAD record at entry 81 above. The Helpline Caseworker consulted with her team manager and a decision was made to re-screen the report as non-ROSH. The report was then referred to Tweed Heads CSC at 7:33pm, recommending the CSC "*liaise with Victoria Child Protection because of concerns that* JM *may be avoiding child protection services by travelling between states.*" Meanwhile, [redacted] attempted to contact JM [redacted] by phone however she did not answer the calls or respond to the voicemail message.	Tab 53 – Internal Death Review at p. 1193. Tab 115 – Report of Alison O'Neill at p. 1925. Tab 55 – Statement of [redacted] at pp. 1219, [36].
85.	19 October 2018	Safety Assessment outcome: [redacted] completed a written safety assessment (SARA) in ChildStory. The document referred to QCS's previous involvement with the family and referred to "Dispatch records show 'Police attended and spoke with all parties but not noted DV", however these details not factored into the Safety Assessment. The safety assessment finding of '*safe*' remained unchanged from the original assessment that was completed on 16 October 2018.	Tab 53 – Internal Death Review at p. 1195. Tab 55 – Statement of [redacted] at pp. 1219, [38], 1289, 1292-1295. Tab 115 – Report of Alison O'Neill at p. 1925.
86.	20 October 2018	In Palm Beach Coolangatta, Ms Reid, a member of the public, gave JM [redacted] a double pram, items for the children, and money. She returns to where the van was the next day with more items for the family but the van was not there and she could not find it.	Tab 100 – Statement of Christine Reid pp. 1696-1700.

Number	Date/Time (NSW)	Event	Reference (at p. # of BOE)
		JM is not wearing any shoes but the children have clothes on top but only nappies as bottoms. Both JM and RB interact with Ms Reid appropriately.	Tab 100A – Statement of Christine Reid pp. 1701-1704.
87.	22 October - 26 October 2018	away from Tweed Heads CSC attending mandatory ChildStory training in Sydney.	Tab 55 – Statement of at p. 1220, [43]. Tab 53 – Internal Death Review at p. 1195. Tab 115 – Report of Alison O'Neill at p. 1925
88.	25 October 2018	Mr Neely, a member of the public describes seeing the family with a black van with the children in Bay Street Tweed Heads. When cared for by RB the children would be crying loudly and for extended periods. RB was constantly swearing and yelling profanities. On this date he saw RB brandishing a stick in a striking motion at JM who had the infant in her arms. She ran away from him leaving the toddler near the side door of the van. Mr Neely calls '000', and later sees a police car drive past but was not able to speak with police. On 29 October 2018 he takes a picture of the same van in case he needs it for the future.	Tab 90 – Statement of John Neely pp. 1645, 1647-1648.
89.	27 October 2018	The QPS respond to report in Coolangatta regarding RB They issued him with a notice for yelling and swearing at people. RB had an outstanding warrant for a failure to appear. He was chased by Police on foot over the border to NSW, and then they were unable to arrest him because he was in NSW. RB informed the police he was homeless and living in parks with his partner and two young children. There did not appear to be a corresponding report to Child Safety.	Tab 83 – Statement of Tina McCarthy at pp. 1619-1620, [15]-[19]. Tab 6 – Statement of Daniel Lovell at pp. 77-78, [66].

Number	Date/Time (NSW)	Event	Reference (at p. # of BOE)
		Tina McCarthy reports, on an unknown date, RB throwing a can of bourbon at her and that he hit her on the back of her legs with a bat. She records that the Coolangatta Police are called.	Tab 6b – Statement of Daniel Lovell, Chronology of QPS Holdings at p. 147. Tab 115 – Report of Alison O'Neill at p. 1926.
90.	31 October 2018	Risk Assessment completed by NSW DCJ: [redacted] scored the risk assessment as '*High (Neglect)*.' "…. *At the time of the assessment,* JM *stated to CW's that she planned to return to Victoria on 18/10/18 because she has family support there and will live with them while she gets back on her feet. CW* [redacted] *has not been able to reach* JM *since this time to confirm she and the children went to Victoria.* JM *did provided [sic] CW* [redacted] *a forwarding address and CW will send an Interstate Notification to Victoria and QLD.*"	Tab 55g – Statement of [redacted] Risk Assessment at pp. 1296-1308. Tab 115 – Report of Alison O'Neill at pp. 1926-1927.
91.	Late October 2018	Michael Ward, a member of the public sees a father in a rage, strike the mother in the head with an open hand whilst she is carrying the baby and then throw the older child into the van from about a metre away. The father then calmly drives away. This occurred in Bay Street Tweed Heads. Mr Ward understands that the police are called by staff at the Seascape Apartments.	Tab 94 – Statement of Michael Ward at pp. 1672-1673, [9]-[12].
92.	1 November 2018	Senior Constable Chayne Foster (NSWPF) issued RB and JM with Field Court Attendances Notices for driving a vehicle with the children unrestrained in the back. NSWPF also later (5 November) made a notification to DCJ reporting a Risk of Neglect. See further details below.	Tab 30 – Statement of Chayne Foster at pp. 888-900. Tab 115 – Report of Alison O'Neill at pp. 1927-1928.

Number	Date/Time (NSW)	Event	Reference (at p. # of BOE)
93.	Early November 2018 (probably 2 November 2018)	[redacted] calls both the Police and (she believes) FACS Tweed Heads (which was in fact Tweed Heads Family Centre) and describes concerns regarding a family in a van. She also calls NSW Police Headquarters because she felt frustrated at not being taken seriously, she is transferred back to Tweed Heads Police Duty Officer and is told that the police would get to it as soon as they could. Later she is called back by the Police who indicate that they have located the black van but could not see anyone with it and it is explained that the Police had done all they could. Call leads to Police Response at Number 95.	Tab 77 Statement of [redacted] at pp. 1599-1600, [28]-[33]. Transcript for 19 December 2023 at p. 81:11.
94.	2 November 2018	[redacted] receives an email from the Family Centre, where she is informed that FACS requires the names of people to make a Mandatory Report.	Tab 77 – Statement of [redacted] at p. 1602.
95.	2 November 2018	[redacted] and [redacted] attended a park in Tweed Heads after receiving a call from a member of the public about a family with a toddler and a baby living out of a black van for the past few days. The officers spoke to JM [redacted] and noted that "*both children appear to be well fed, appeared clean and not showing any signs of not being looked after by their parents*". The officers enquired if JM [redacted] had tried to source accommodation and she indicated that RB [redacted] "*did not like handouts or assistance from the government*".	Tab 32 – Statement of [redacted] at pp. 924-933. Tab 33 – Statement of [redacted] at pp. 934-935. Tab 115 – Report of Alison O'Neill at pp. 1928-1929.
96.	4 November 2018	Subsequent to the NSWPF interaction with the family on 1 November 2018, S/C Foster creates COPS Event E 72382853 incorporating a '*Child/Young Person at Risk'* Report noting that the children were at risk of significant harm due to '*Neglect – Physical Shelter/ Environment'* as they had been living out of their vehicle for a month.	Tab 30e – Statement of Chayne Foster, Event Ref No: E 72382853 at p. 915.

Number	Date/Time (NSW)	Event	Reference (at p. # of BOE)
		"*Father is alcohol dependent. Children located in back of van on a bed. Not in a seat and not secured by a seatbelt. The father has extensive history with Police in both NSW and QLD where alcohol is a major factor to him coming under notice….The child was dirty in appearance and clothes dishevelled. Child is living with father and mother in a van where there is no apparent sufficient food or shelter. Not covered with appropriate clothing.*" [redacted] verified by supervisor on 5 November 2018 and automatically referred to DCJ. Report appears to have remained in backlogged queue of 1560 outstanding contact records at the Child Protection Helpline, until it was referred to the Helpline's SR Pilot team on 17 November 2018.	Tab 53 – Internal Death Review at pp. 1197-1198. Tab 115- Report of Alison O'Neill at p. 1929. Transcript for 19 December 2023 at p. 62:3.
97.	6 November 2018	Subsequent to the NSWPF interaction with the family on 2 November 2018 (in a Tweed Heads park), S/C Jennings created a '*Community Service Report* and noted concerns for the family as "*not in current housing and living out of van with parents. Only issue and staying in Park during the day…the children's physical and emotional state appears both children appear find. Dressed and appeared well fed."* Assessment officer at Police Child Wellbeing Unit records entry in ChildStory with Short Description "*Passer-by has reported concerns* Baby Q *(9 months) and* LB *(1) were unsupervised and family living in a van. Police attended where family advised repairs being done on van and they will soon be moving off to Victoria. Open with Tweed Heads CSC*" Entry in ChildStory does not come to the attention of Tweed Heads CSC.	Tab 33A – Statement of Matthew Jennings, Event Ref No: E 70143374 at pp. 929-931. Tab 6 – Statement of Daniel Lovell at p. 80, [69]. Exhibit 11, Second Addendum statement of Mark Dixon at p. 5 [22] Tab 115 – Report of Alison O'Neill at p. 1929.

Number	Date/Time (NSW)	Event	Reference (at p. # of BOE)
98.	7 November 2018 (approx.).	Aboriginal Elder Dianne Jacob met with the family in Byron Bay. Ms Jacob said that prior to the family leaving Byron Bay, RB asked her to take both his children because he was an alcoholic and using marijuana.	Tab 73 – Statement of Dianne Jacob at p. 1575 [8]. Tab 6 – Statement of Daniel Lovell at pp. 80-81, [70]- [71]. Tab 115 – Report of Alison O'Neill at p. 1930.
		RB involved in a motor vehicle collision in Byron Bay. Senior Constable Rebecca Krilich and Senior Constable Cooke (NSWPF) attended. RB returned a positive reading for alcohol. He was unkempt looking, slurring his speech and his eyes were bloodshot and glazed. He was taken to Byron Bay Police Station and cautioned. JM and the children were present however it is unclear if they were in the car at the time of the collision.	Tab 39 – Statement of Rebecca Krilich at pp. 944-947. Tab 115 – Report of Alison O'Neill at p. 1930.
99.	8 November 2018	sent an interstate notification to Vic Human Services outlining concerns for LB and Baby Q identified in the risk assessment. The case was then closed on ChildStory with the reason '*Client relocated'* with the rationale '*At this time it is believed the family have relocated to Lara, Victoria. An Interstate Risk of Harm notification was sent to VIC DHS with forwarding address provided. Risk Assessment was High*.'	Tab 55h – Statement of Interstate Risk of Harm Notification at pp. 1309-1313. Tab 115 – Report of Alison O'Neill at p. 1930.
100.	10 November 2018	RB was stopped and searched by NSWPF in Casino NSW after police received information that he had been wielding a crowbar in a threatening manner. Police located bicycle handlebars in his possession which he claimed to have for protection. He was issued with a move-on direction and indicated he was catching a train out of Casino that night. No reference to JM or the children being with RB	Tab 6 – Statement of Daniel Lovell at p. 82, [73]. Tab 115 – Report of Alison O'Neill at p. 1931.

Number	Date/Time (NSW)	Event	Reference (at p. # of BOE)
101.	15 November 2018	The QPS arrested RB by virtue of a warrant in Brisbane, QLD. RB was transferred to the Brisbane City Watch House. JM was present at the time of his arrest. The records do not refer to the children.	Tab 6 – Statement of Daniel Lovell at pp. 82, [74]. Tab 6b – Chronology of QPS Holdings at p. 147. Tab 115 – Report of Alison O'Neill at p. 1931.
102.	16 November 2018	**At 11:48am and 7:45pm (AEDT),** the QPS had interactions with RB in relation to concerns for welfare and then later being with a group who were drunk/drinking in the park. The QPS holdings record: '*Street check. CAD event for welfare check. Nil issues. POIs [persons of interest] did not want to speak with police'*. The records do not refer to the children. At approximately 6:13pm, Police were called to a large group of intoxicated Indigenous males causing trouble. They failed to find a group causing trouble. At approximately 6:45pm they observed RB JM, LB and Baby Q from a distance. S/C Scott observed the children being pushed in a shopping trolley dressed only in nappies.	Tab 6 – Statement of Daniel Lovell at pp. 83, [78]. Tab 6a – Statement of Daniel Lovell, chronology of QPS Holdings at p. 146. Tab 37 – Statement of Tracy Scott at p. 941, [7]. 115 – Report of Alison O'Neill at p. 1932.
103.	17 November 2018	**At 12:45am (AEDT),** Senior Constable Michael Zairis and Constable Cassie Dorricott (QPS) located the family sleeping in a park at the intersection of Chelsea Avenue and Old Burleigh Road, Broadbeach. A complaint had been	Tab 12 – Statement of Michael Zairis at pp. 266-274.

Number	Date/Time (NSW)	Event	Reference (at p. # of BOE)
		received from a member of the public about the children sleeping outside dressed only in nappies. The officers found RB and JM sleeping on the ground with LB and Baby Q in between them. The children were only wearing disposable nappies and the family had limited food and water. RB was described as intoxicated and unwilling to discuss the families' situation. JM said they did not like living in a house because it was "*cramped*" and declined officers' offers of assistance. The officers formed the view that "*although the children appeared to be healthy and not malnourished from what we could see, we were concerned the parents were not able to care for the children given the very limited food and basic requirements they had in their possession*." Assistance was sought from Plain Clothes Senior Constable Adrian Bisa and Plain Clothes Senior Constable Chloe Barton Gold Coast District Child Protection & Investigation Unit.	Tabs 12(a), 15(a) – BWV (available upon request). Tab 15 – Statement of Cassandra Dorricott at pp. 317-321. Tab 115 – Report of Alison O'Neill at p. 1932.
104.		**At 1:27am (AEDT),** body worn camera footage depicts PC S/C Bisa and PC S/C Barton arriving at the scene. In response to RB and JM being informed that it was not acceptable to have a 9-month-old child living on the streets, JM suggested she might be able to arrange travel to Victoria to live with her parents, however RB objected to this and said it was none of their business. The officers determined that the best course of action was to take the family to a 'place of safety'. The officers assisted the family to travel to Paulette Butterworth's address in Kingscliff. PC S/C Bisa knocked on Ms Butterworth's door however did not receive a response. He then spoke to a neighbour and confirmed that the apartment was Ms Butterworth's address. After attempts to raise Ms Butterworth, RB entered the unit through an open bathroom window. RB located paperwork in the unit, which was addressed to Ms Butterworth, who was not home at the time. At approximately **4:00am (AEDT)** officers left the family at Ms Butterworth's residence.	Tab 10 – Statement of Adrian Bisa at pp. 237-261. Tab 11 – Statement of Chloe Barton at pp. 262-265. Tabs 10(b), 12(b)-(d), 15(b)(c) – BWV (available upon request). Tab 115 – Report of Alison O'Neill at pp. 1932-1934.

Number	Date/Time (NSW)	Event	Reference (at p. # of BOE)
		Upon returning to Burleigh Heads Police Station, PC S/C Bisa created a 'Report of Suspected Harm – 520 Report', noting that the children were sleeping in a park in Broadbeach with "*minimal possessions, minimal clothing, minimal food, no money or access to money until Wednesday the 21/11/2018*.' Report of Suspected Harm needed to be reviewed internally within the QPS before sent to QCS. Ultimately received by QCS after Baby Q had died.	
105.		**At 9:32am (AEDT),** CCTV footage records the family boarding a bus at Kingscliff bound for Tweed Heads. The family went into Tweed Heads Shopping Centre before boarding another bus outside the shopping centre at 10:42am.	Tab 6 – Statement of Daniel Lovell at p. 85, [84]. Tab 115 – Report of Alison O'Neill at p. 1937.
106.		**At 10:52am (AEDT),** CCTV footage records the family getting off a bus at Tweed Heads. The family then spent the remainder of the day in the vicinity of Chris Cunningham Park and Jack Evans Boat Harbour, located at the intersection of Wharf and Bay Streets, Tweed Heads.	Tab 6 – Statement of Daniel Lovell at p. 85, [85]. Tab 115 – Report of Alison O'Neill at p. 1937.
107.		**About 2:30pm (AEDT),** the family approached a homeless woman, Kirsty Davis, in Chris Cunningham Park, and had a discussion about giving Baby Q to Ms Davis. RB asked Ms Davis to take Baby Q permanently, and he persuaded the mother to hand her to her. Ms Davis followed the family and returned Baby Q to them and said that she could not look after the baby when she lived on the streets. About an hour later, the family saw the woman again, and again there was an attempt to give Baby Q to her, but she refused.	Tab 6 – Statement of Daniel Lovell at p. 85, [86]. Tab 115 – Report of Alison O'Neill at p. 1937.

Number	Date/Time (NSW)	Event	Reference (at p. # of BOE)
108.		During the late afternoon/early evening a large storm accompanied by heavy rain impacted the Tweed Heads area and the family took refuge under a multi-level car park located at the Tweed Mall adjacent to Chris Cunningham Park.	Tab 6 – Statement of Daniel Lovell at p. 86, [88].
109.		**Between 6:34pm and 6:37pm (AEDT)**, CCTV footage records the family at Tweed Mall. JM was carrying LB and Baby Q was in a shopping trolley. Around this time, a witness, Emily Gregory reported seeing the family in the car park near the Bay Street entrance. Ms Gregory observed RB holding Baby Q to his chest with a red and black blanket wrapped over her. She observed RB, who was still holding Baby Q walk away from JM and LB down a ramp leading to Bay Street. CCTV footage confirms that the JM and LB remained in the car park.	Tab 6 – Statement of Daniel Lovell at pp. 86-87, [89]-[90].
110.		**At 6:47 (AEDT)**, a witness, Paul Thompson, observed a male matching RB description walk along the Southern footpath of Bay Street. The male had a blanket wrapped around his body. The male walked towards the river and climbed over the rocks (shoreline) moving close to the water. The male thew an "*object*" into the river. He moved back to the grass next to the river and fell onto his knees before lying flat on his stomach. He moved his hands to the side of his head. The male laid in this position for at least 10 minutes. At least three other witnesses who reside near the Tweed River observed a male lying on his stomach next to the riverbank in the pouring rain for a period of time. Further witnesses, Joanne Newman and John Waterhouse reported seeing a male lying on the ground next to the river, and item(s) floating in the river. Ms Newman described seeing two separate items, "*One was white and one was black. The white item looked like a t-shirt or a small towel, it was floating just under the surface.. about the same size as a tea towel or nappy… The black item was rounded on top and seemed to float on top of the later, it was buoyant…".* Mr Waterson described the object as a "*black coloured reasonable sized squarish object in the river. It was a shape more than a blob. I watched*	Tab 6 – Statement of Daniel Lovell at pp. 88, [92]. Tab 115 – Report of Alison O'Neill at p. 1937-1938.

Number	Date/Time (NSW)	Event	Reference (at p. # of BOE)
		the item for about 30 seconds as it bobbed up and down through the rough waters of the river towards the sea on the outgoing tide."	
111.		**At 7:01pm (AEDT)**, CCTV footage records that RB returned to the car park at Tweed Mall and met with JM and LB. RB returned without Baby Q	Tab 6 – Statement of Daniel Lovell at p. 91, [97].
112.		**Unspecified time on 17 November 2018**: an intake officer at the DCJ Helpline noticed the police e-report made on 5 November 2018 had not been processed and referred to the Helpline SR Pilot team for assessment. The reported concerns, which were that LB and Baby Q had been living out of a van for a month, were initially screened as meeting the ROSH threshold. Further information obtained from VIC Human Services and Tweed Police. After reviewing the previous safety assessments by Tweed Heads CSC, the report was re-characterised as non-ROSH and the report was closed at the Helpline.	Tab 53 – Internal Death Review at pp. 1197-1198.
113.	18 November 2018	**At 4:54am (AEDT**), RB JM and LB boarded a bus at Griffith Street, Coolangatta, bound for Broadbeach. They subsequently made their way to Surfers Paradise over the course of several hours.	Tab 6 – Statement of Daniel Lovell at p. 92, [99].
114.		**At 12:50pm (AEDT),** Police officers patrolling Surfers Paradise were alerted to an Indigenous male yelling and screaming in the streets and conducting himself in an aggressive manner. The Police attended and observed RB acting irrationally. He referred to his daughter being "*with the elders*". RB was arrested for public nuisance and conveyed to Southport Watch House, where he was released shortly after 5:00pm that afternoon.	Tab 115 – Report of Alison O'Neill at p. 1938.
115.	19 November 2018	**At about 1:25am (AEDT),** a witness, Alexander Owen, was walking along the beach at Surfers Paradise and discovered Baby Q body approximately three to four metres above the waterline. Mr Owen contacted emergency services	Tab 6 – Statement of Daniel Lovell at p. 94, [102].

Number	Date/Time (NSW)	Event	Reference (at p. # of BOE)
		who attended and attempted to resuscitate Baby Q At 1:51am (AEDT), QLD Ambulance service pronounced Baby Q life extinct.	Tab 115 – Report of Alison O'Neill at pp. 1938-1939.
116.		**Shortly after 1:36am (AEDT),** Senior Constable Taulapueoko Sipu and Constable Corey Lawrence responded to reports of a domestic violence incident between RB and JM at Broadbeach, QLD. A member of the public had witnessed RB punch JM in the head. The officers located RB JM and LB sleeping on the ground. They noted that RB was uncooperative, and JM was withdrawn and had bruising to her left eye. JM denied any domestic violence however said that they were upset because someone close to them had passed away. Cst Lawrence recognised RB and JM, and after establishing that there was only one child with them and being aware that a deceased child had been located on the beach at Surfers Paradise, he called his Shift Supervisor and informed her of his suspicions about the identity of the deceased child. RB was detained and taken to Broadbeach Police Station, before being transported to Southport Watch House and arriving **at about 2:45am (AEDT).** JM and LB were also taken to the police station.	Tab 28 – Statement of Taulapueoko Sipu at pp. 704-708. Tabs 28(a)-(b) – BWV (available upon request). Tab 25 – Statement of Corey Lawrence at pp. 649-652. Tab 115 – Report of Alison O'Neill at p. 1939-1940.
117.		**At about 5:16am (AEDT),** Senior Constable Ramsey placed RB under arrest for the '*unlawful killing*' of Baby Q at the request of the QPS Criminal Investigation Branch.	Tab 28 – Statement of Taulapueoko Sipu at p. 707, [36].
118.		**Between 3:48am-4:40am (AEDT),** JM participated in an electronically recorded interview with Detective Sergeant Troy Quinn at Broadbeach Police Station.	Tab 26 – Statement of Troy Quinn at pp. 653-658. Tab 26(a) – ERISP (available upon request).

Number	Date/Time (NSW)	Event	Reference (at p. # of BOE)
			Tab 26(b) – ERISP Transcript at pp. 660-681.
119.		**Between 2:07pm-3:02pm (AEDT),** RB was recorded in his cell confessing to killing Baby Q by throwing her in the Tweed River because she was evil and he wanted to rid the world of her.	Tab 6 – Statement of Daniel Lovell at p. 97, [110]. Tabs 20(a)-(f), Transcripts at pp. 340-434.
120.		**Between 4:03pm and 4:34pm (AEDT),** RB participated in an electronically recorded interview with Detective Senior Constable Renee O'Dell at Southport Watch House in which he made admissions to killing Baby Q	Tab 6 – Statement of Daniel Lovell at p. 97, [111]. Tab 21(a) – ERISP (available upon request). Tab 21(b) – Transcript at pp. 440-464.
121.	20 November 2018	Dr Andrzej Kedziora, Forensic Pathologist, Queensland Forensic and Scientific Services, conducted a post-mortem examination of Baby Q The cause of death is listed as undetermined.	Tab 2 – Autopsy report at pp. 2-20.
122.	21 August 2019	JM appeared before Magistrate Dunlevy at Tweed Heads Local Court charged with failure of a person with parental responsibility to care for a child (cause danger or death). She was discharged under s 32(3)(a) of the *Mental Health (Forensic Provisions) Act 1990* (NSW) and was ordered to comply with all directions and conditions imposed under her Victorian Community Treatment order, and released into the care of her father.	Tab 9 – Investigator's Note at p. 236.

Number	Date/Time (NSW)	Event	Reference (at p. # of BOE)
123.	4 November 2020	RB appeared before Justice Wilson in the Supreme Court of NSW and found 'not guilty by reason of mental illness of Baby Q murder and ordered that he be detained under s. 38 of the *Mental Health (Forensic Provisions) Act 1990* (NSW).	Tab 8 – *R v RB* at p. 22, [7]. Tab 115 – Report of Alison O'Neill at p. 1943, [12].

Glossary of terms

Acronym	Meaning
ACT	Acute Care Team
ANC	Additional Notified Concern
ATSI	Aboriginal and Torres Strait Islander
CAD	Computer Aided Dispatch
CCR	Child Concern Report
CIMHA	Consumer Integrated Mental Health and Addiction
COPS	Computerised Operational Policing System
CSC	Community Services Centre
CST	Constable
DCJ	Department of Communities and Justice (NSW)

	(at times also referred to as Department of Community Services (DOCS), or Family and Community Services (FACS))
DHS (VIC)	Department of Human Services, Victoria
D/S	Detective Sergeant
D/W	Discussed With
HHOT	Homeless Health Outreach Team
I & A	Investigation and Assessment
ITO	Involuntary Treatment Order
NSWPF	NSW Police Force
[redacted]	[redacted]
PARC	Prevention and Recovery Centre
PC S/C	Plain Clothes Senior Constable
POI	Person of Interest
QCS	Department of Children, Youth Justice, and Multicultural Affairs (at times also referred to as Queensland Child Safety)
QPS	Queensland Police Service
ROSH	Risk of Serious Harm
SARA	Safety and Risk Assessment
SCAN	Suspected Child Abuse and Neglect (Team)
TUW	Take up with