CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the deaths of TC & SN
Hearing dates:	4 December 2019
Date of findings:	20 December 2019
Place of findings:	Coroner's Court of New South Wales at Lidcombe
Findings of:	Magistrate Derek Lee, Deputy State Coroner
Catchwords:	CORONIAL LAW – homicide, intentionally self-inflicted death
File number:	2015/27703, 2015/277034
Representation:	Ms S Harding, Coronial Advocate Assisting the Coroner
Findings:	TC died on 21 September 2015 at Campsie NSW 2194. The cause of TC's death was hanging. TC died as a result of actions taken by her with the intention to end her own life. SN died on 21 September 2015 at Campsie NSW 2194. The cause of SN's death was hanging. SN died as a result of actions taken by her mother, TC. The manner of death is therefore homicide.
Non-publication orders:	Pursuant to section 75(2) of the *Coroners Act 2009* publication of any matter (including the publication of any photograph or other pictorial representation) which identifies any of the following persons is prohibited: 1. TC 2. SN 3. QN 4. TTC 5. THC 6. TDN

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1. Introduction

1.1 On 21 September 2015 a young mother, TC, and her 17 month old daughter, SN, died in extraordinarily tragic circumstances. SN was born with a number of significant and complex medical conditions. SN's life-limiting conditions required extensive care and support, and placed considerable physical, mental, and emotional strain on her parents, especially her mother. Despite the enormous love that she had for her daughter, TC made the heart-rending decision on 21 September 2015 to prematurely end both her, and SN's, life.

2. Why was an inquest held?

2.1 Under the *Coroners Act 2009* (**the Act**) a Coroner has the responsibility to investigate all reportable deaths. This investigation is conducted primarily so that a Coroner can answer questions that they are required to answer pursuant to the Act, namely: the identity of the person who died, when and where they died, and what was the cause and the manner of that person's death. All reportable deaths must be reported to a Coroner or to a police officer.

2.2 Section 27(1)(a) of the Act provides that an inquest must be held if it appears to a coroner that a person has died, or might have died, as a result of homicide. In case the case of TC and SN, the evidence gathered during the police investigation that took place following 21 September 2015 established that SN died as a result of homicide. This made the holding of an inquest mandatory.

2.3 In this context it should be recognised at the outset that the operation of the Act, and the coronial process in general, represents an intrusion by the State into what is usually one of the most traumatic events in the lives of family members who have lost a loved one. At such times, it is reasonably expected that families will want to grieve and attempt to cope with their enormous loss in private. That grieving and loss does not diminish significantly over time. Therefore, it should be acknowledged that the coronial process and an inquest by their very nature unfortunately compels a family to re-live distressing memories several years after the trauma experienced as a result of a death, and to do so in a public forum.

2.4 Inquests have a forward-thinking, preventative focus. At the end of many inquests Coroners often exercise a power, provided for by section 82 of the Act, to make recommendations. These recommendations are made, usually, to government and non-government organisations, in order to seek to address systemic issues that are highlighted and examined during the course of an inquest. Recommendations in relation to any matter connected with a person's death may be made if a Coroner considers them to be necessary or desirable.

3. Family history

3.1 QN moved from Vietnam to Australia in 2007, leaving behind his ex-wife and daughter. Sometime in 2012 QN met TC through a work colleague. They formed a relationship soon afterwards. In 2013 TC became pregnant with her first child.

3.2 SN was born on 15 April 2014. Shortly after her birth SN was diagnosed with bilateral micropthalmia resulting in blindness in both eyes. She was also diagnosed with adrenal insufficiency, hypotonia

(poor muscle tone) and motor developmental delay. These significant life-limiting conditions meant that SN had difficulties with mobility and feeding.

3.3 The day after SN's birth hospital staff administered a postnatal depression scale to TC. This indicated a very low level of emotional distress and no suicidal ideation or thoughts of self-harm.

3.4 Due to SN's significant health conditions she required regular appointments with medical specialists and allied health professionals (including a paediatrician, endocrinologist, ophthalmologist, physiotherapist and occupational therapist) following her discharge. SN's high and complex care needs placed significant emotional strain on both TC and QN, and their relationship. As both parents were not working due to SN's high care needs, they also experienced considerable financial stress. Family members observed that TC suffered significant weight loss and was often emotional and sad, frequently isolating herself from family support. It was also observed that QN's alcohol consumption increased.

4. Provision of support services

4.1 On 28 April 2014 a nurse from Bankstown Community Health Centre conducted a visit to the family home in Campsie and administered another postnatal depression scale. TC returned a score indicating a high level of emotional distress and probable depression, requiring further assessment. Following the home visit a further assessment was performed to determine the family's level of vulnerability and support needs. It was determined that the family required early intervention, together with ongoing and active follow-up, due to vulnerabilities associated with SN's conditions and TC's moderate anxiety and depression.

4.2 Following a referral from her GP TC attended eight sessions with a psychologist between July 2014 and October 2014 for cognitive behavioural therapy and treatment of symptoms consistent with postnatal depression.

4.3 On 23 November 2014 QN returned home after work and found TC intoxicated and in a bedroom with SN, with her hands around SN's neck. Emergency services were contacted and TC was subsequently taken by ambulance to Canterbury Hospital Emergency Department. A mental health assessment was subsequently performed in which TC disclosed that she had been depressed for the last three to four months due to SN's health conditions. Further, TC reported that about one month earlier she had experienced homicidal thoughts in relation to SN, and suicidal thoughts in relation to herself.

4.4 TC was subsequently admitted as an involuntary patient. Hospital staff made arrangements for an after-hours social worker to see QN and SN, and also made a Risk of Significant Harm (**ROSH**) report to the Child Protection Helpline. TC was subsequently transported to a mental health inpatient admission office at Concord Hospital for further psychiatric assessment. This assessment concluded that TC did not present as clinically depressed, suicidal or homicidal, and that the risk of suicide was low with no foreseeable risk of harm to others. On this basis TC was discharged home on 24 November 2014 for follow up the next day by the local Community Mental Health Service (**CMHS**).

4.5 The ROSH resulted in a referral to the Lakemba Community Services Centre (**CSC**). A CSC caseworker subsequently spoke to QN and staff at Concord Hospital. Further, Canterbury CMHS subsequently contacted TC by phone and arranged for a Clinical Nurse Specialist and Registered Nurse to later

conduct a home visit. The assessment identified that the immediate risk of suicide and homicide was low due to the presence and support of extended family members. However the assessment also identified that longer-term risks were moderate to high. Follow-up action in the form of ongoing mental health treatment, support from Canterbury CMHS, and linking the family to other supports was initiated.

4.6 During a further home visit on 26 November 2014, a psychiatrist diagnosed TC with major depressive disorder and recommended that she commence taking antidepressant medication, although TC was resistant to this. Referrals to other support services were also made.

4.7 During December 2014 further home visits were conducted by social workers from Canterbury CMHS and a child and family health nurse from Canterbury Early Childhood Centre (**ECC**). During these visits TC reported continued depressed mood, constant exhaustion and ruminations of guilt and anger. However she denied any suicidal ideation, and continued to refuse antidepressant medication. On 22 December 2014 Lakemba CSC made a referral to Barnardos Family Referral Service (**Barnardos**), and subsequently closed the case the following day.

4.8 Home visits conducted by Canterbury CMHS and ECC, and Barnardos continued in January 2015. On 9 January 2015 QN indicated that he sought in-home child care support for SN as he planned to return to work. Barnardos subsequently made a referral to the Sydney Day Nursery (**SDN**) Brighter Futures program which was accepted on 12 January 2015.

4.9 On 18 January 2015 caseworkers from SDN visited the family to conduct a safety assessment. The assessment determined that SN was safe as no dangers were identified that required immediate intervention. However it was noted that TC's overwhelming sense of guilt remained an ongoing issue and that the vulnerabilities that triggered her thoughts of infanticide could re-occur if she did not appropriately engage with therapeutic support.

4.10 Further home visits by a treating psychiatrist, mental health social worker, and a child and family health nurse took place in January and February 2015. On 26 February 2015 TC and SN attended an appointment at Tresillian, Sydney In-Home Care Service. A psychosocial risk assessment was conducted with TC's responses indicating thoughts of self-harm. She was subsequently seen by a psychologist who documented a management plan which involved psychiatric assessment. On 27 February 2015 TC underwent two separate mental health assessments. They identified chronic thoughts of suicide but no acute suicidal risk, and encouraged continued treatment recommendations from the Canterbury CMHS.

4.11 In March 2015 further home visits were conducted by a mental health social worker and a child and family health nurse. During a visit on 20 March 2015 the treating psychiatrist and mental health social worker noted that whilst TC had ceased taking antidepressant medication, she denied current suicidal ideation and appeared to have experienced an improvement in mood compared to previously. On 23 March 2015 the SDN caseworker submitted an application to Sydney In-Home Care Service. The referral was subsequently accepted on 12 April 2015.

4.12 On 14 April 2015 the child and family health nurse conducted a home visit. It was observed that TC and SN appeared much happier. The following day Sydney In-Home Care Service started working with the family to provide eight hours of in-home childcare each weekday over a 13 week period. On

21 April 2015, a week after in-home childcare started, TC reported an improvement in her mood and motivation, feeling less stress, and that SN's general health and sleep had improved. TC also denied any recent suicidal or homicidal thoughts and felt that re-commencement of antidepressant medication was unnecessary. On 23 April 2015 the SDN caseworker completed a risk assessment. It was noted that SN remained at risk if TC's mental health deteriorated due to stress or inappropriately managed feelings of guilt.

4.13 Further contact by the SDN caseworker and mental health social worker took place in May 2015. During a home visit on 7 May 2015 TC and QN told the SDN caseworker that they had decided to separate on a trial basis. A referral was made to Relationships Australia for counselling and they were advised to speak to their GP. At TC's request, the in-home care service was reduced from five days to three days per week to allow her more time to visit friends.

4.14 During a further home visit on 26 May 2015 TC advised the SDN caseworker that she wanted to withdraw from the in-home care service. TC said that she felt able to manage SN's care independently, and that her (TC's) mother had arrived from Vietnam for a six-month stay to help with SN's care. TC and QN also told the caseworker that they did not need a referral for counselling or relationship therapy.

4.15 On 11 June 2015 TC reported that she was coping much better with her relationship difficulties and did not feel that antidepressant medication was necessary. Subsequently on 5 July 2015 TC advised the SDN caseworker that she had separated from QN and moved with SN and her mother from Campsie to her sister's house in Hurstville. On 28 July 2015 TC reported that she was coping much better, particularly since her mother's arrival. She also reported that her relationship problems remained but denied any crisis. On 30 July 2015 the SDN caseworker had a meeting with her team leader in which consideration was given to closing the case as it was identified that risks had reduced and the family were no longer living in an area covered by SDN.

4.16 On 13 August 2015 TC reported to the child and family health nurse that SN had made good progress with solid foods and was gaining weight. The nurse noted that TC was living mostly out of the area and that her mother and sister provided a very supportive environment. This was TC's last contact with the Canterbury ECC.

4.17 On 18 August 2015 the mental health social worker spoke to TC who reported that she felt she no longer needed follow-up from the Canterbury CMHS and that she would contact her GP for assistance as needed. TC also indicated that she planned to travel to Vietnam with her mother and SN in October to seek traditional treatment for SN. The social worker assessed that there was nil current risk or concern and documented a plan to discharge TC from the service. This was TC's last contact with Canterbury CMHS.

5. What happened on 18 September 2015?

5.1 On 18 September 2015 TC called the SDN caseworker to ask if she would accompany her to an appointment at the Department of Housing on 21 September 2015. The SDN caseworker noticed that TC sounded upset over the phone and asked if she could see her. TC agreed and a home visit was conducted.

5.2 During the visit TC told the SDN caseworker that she had found text messages on QN's mobile phone suggesting that he was thinking about reconciling with his ex-wife who was still in Vietnam. A file note of the visit revealed that TC spoke about her conflicting emotions towards QN and mentioned that she wanted to hurt him back for how he had hurt her. The file note also records that TC mentioned she had written notes for her mother and sister, and thought of killing herself and SN because she felt that this may hurt QN, but she would not go through with it. It appears that TC wrote these notes and had suicidal thoughts about a week earlier. In a subsequent statement the SDN caseworker said that TC was "*calm throughout the visit*" and that their "*time together was normal*".[1] The SDN caseworker said that she did not get any impression during the visit that TC was any more emotionally vulnerable from any other time that she had dealt with her. At the end of the visit TC indicated that she was feeling better, reminded the SDN caseworker of the plan to meet in three days' time for the Department of Housing appointment, and told the SDN caseworker that she was considering going to Vietnam with her mother in November 2015.

5.3 The SDN caseworker later returned to her office and called the mental health social worker seeking some follow-up information. The mental health social worker advised that she had seen TC about a month earlier, at which time she had been doing fine, and had moved to stay with her sister and mother in Hurstville. On this basis TC had been discharged from the Canterbury CMHS (although the discharge summary had not been finalised as at 18 September 2015). The mental health social worker also advised that as TC was living in the St George area any further concerns should be directed to the St George CMHS. The mental health social worker also provided contact details for a Vietnamese speaking psychologist, and advised that TC should see her GP to obtain a referral to the psychologist.

5.4 There is a difference in the accounts regarding the home visit by the SDN caseworker on 18 September 2015. According to the SDN caseworker she told the mental health social worker about her conversation with TC, and that TC had mentioned her thoughts of killing herself and SN. However the mental health social worker said that she was not told this, and that indeed she was not told at all that the SDN caseworker had spoken to TC that day.

5.5 Notwithstanding the above, the SDN caseworker later called TC to advise that she seek a GP referral to see a Vietnamese speaking psychologist. TC indicated that she would think about it as she did not feel that she needed to see a psychologist at that time.

5.6 It is not possible to resolve the factual inconsistency between the accounts of the SDN caseworker and the mental health social worker. What the evidence establishes however is that SDN policies and procedures which existed at the time required the SDN caseworker to make a ROSH report in relation to TC's disclosure on 18 September 2015, and to escalate the matter to her immediate team leader. However this did not occur as the SDN caseworker perceived that such action was not required. It appears that this perception was based on her assessment of the otherwise positive impression given by TC on 18 September 2015, and unawareness that TC had disengaged from Canterbury CMHS and ECC in August 2015. Issues associated with information sharing and inter-agency collaboration are discussed further below.

[1] Exhibit 1, Volume 1, Tab 37 at [50].

6. The critical events of 21 September 2015

6.1 On 21 September 2015 TC saw her sister and mother in the morning. She told her mother that SN had an appointment at the hospital. Sometime between about 9:00am and 10:00am TC called QN told him that she wanted to go out, and asked him to return home (meaning the previous family home in Campsie). QN said that he was too far away and asked her to wait until the afternoon, noting that TC did not say where she wanted to go.

6.2 At about 11:00am TC and SN arrived for a routine hearing assessment at the audiology department at the Children's Hospital at Westmead. The appointment was unremarkable and concluded in about 30 minutes. This is the last time that TC and SN were seen alive.

6.3 At about 12:20pm on Monday, 21 September 2015 TC called the SDN caseworker. TC said that SN's appointment at the hospital had finished, and asked if it was possible to meet earlier in relation to the Department of Housing appointment. The SDN caseworker asked if the arranged meeting time of 2:00pm could be kept and TC agreed. According to the SDN caseworker TC "*sounded fine over the phone and there was nothing unusual or concerning*".[2]

6.4 At about 1:25pm TC called QN's sister and told her that she had asked QN to come home, but that he had declined. TC asked QN's sister to call him and convince him to do so. QN's sister agreed and later called her brother. However he told her that he was busy and asked her to go in his place.

6.5 QN's sister initially went to TC's sister's house in Hurstville and found that TC was not there. TC's mother told her to instead check QN's house in Campsie. When she arrived QN's sister found the front door unlocked. She entered and found TC and SN suspended from an electrical cord which had been placed around their necks and attached to a ceiling fan. TC and SN showed no signs of life.

6.6 Emergency services were called and paramedics arrived on the scene a short time later. TC and SN were brought down to the ground and resuscitation commenced immediately. SN and TC were subsequently taken to St George Hospital as resuscitation attempts continued. These attempts were ultimately unsuccessful and TC and SN were subsequently both pronounced deceased.

7. What was the cause and manner of TC's and SN's deaths?

7.1 TC and SN were both later taken to the Department of Forensic Medicine at Glebe. On 23 September 2015 Dr Jennifer Pokorny, forensic pathologist, performed post-mortem examinations. Dr Pokorny subsequently prepared autopsy reports in which she expressed the opinion that the cause of death for both TC and SN was hanging.

7.2 During the subsequent police investigation TC's mobile phone was examined. It contained a number of photos and videos which clearly demonstrated happy moments with SN and TC's love for her. However, the examination also revealed that video is taken from 15 September 2016 onwards were of a more sombre nature. In particular, the examination identified six video recordings made at about 1:30pm on 21 September 2015. The videos contained farewell messages from TC to SN, QN, and TC's mother as well as expressions of suicidal intent by TC. One video captures the last moments

[2] Exhibit 1, Volume 1, Tab 37 at [55].

of SN's and TC's lives and clearly depicts preparatory steps taken by TC to cause her own, as well as SN's, death.

7.3 Two handwritten notes were also found in TC's handbag, with one addressed to TC's mother. Both notes contained expressions of suicidal intent. Finally, a note was located in TC's car. It contained instructions regarding the disbursement of TC's finances.

7.4 Having regard to the videos located on TC's mobile phone, the notes written by her, and the history described above following SN's birth it is clear that TC died as a result of actions taken by her with the intention to end her life. It is equally clear, having regard to the same evidence, that SN died as a result of actions taken by her mother. Therefore, SN died as a result of homicide.

8. Investigation following the deaths

8.1 The NSW Ombudsman subsequently conducted an investigation into the conduct of the Department of Family and Community Services (**FACS**, as it then was), Sydney Local Health District (**SLHD**), and SDN. As part of the investigation the following issues were identified:[3]

(a) Following the initial ROSH, Lakemba CSC did not seek further information about TC's mental health from any source other than Concord Hospital. This prevented a more thorough exploration of the issues raised in the ROSH report. Information obtained by this process could have been shared with other agencies and used to plan for SN's safety.

(b) There was a missed opportunity to hold an interagency case discussion at an early stage to talk about the risks to TC and SN, and the supports and proposed intervention available for them.

(c) It would have been more appropriate for the CSC to have initially referred SN and TC to SDN rather than Barnardos.

(d) Internal reviews conducted by SLHD in relation to the support provided by Canterbury CMHS and ECC found that relevant staff undertook adequate assessments and responded appropriately to the clinical presentation of TC and SN. However, the reviews also found that risks to SN were not always considered holistically, that some staff responded to TC's emotional distress by making new referrals rather than reviewing the effectiveness of existing therapeutic strategies, and that there was inadequate communication and case planning within and between services.

(e) Canterbury CMHS did not develop an overarching care plan that specifically addressed SN's needs, and there was not an adequate focus on assessing and monitoring the child protection risks in SN's case.

(f) From November 2014 to August 2015 there was no allocated case manager with overall responsibility across the SLHD services, there was infrequent and inadequate communication between the services and with external agencies, and there was no evidence of collaborative case planning within SLHD services, or between SLHD and external agencies.

[3] Exhibit 1, Volume 2, Tab 14.

(g) Inadequate discharge planning resulted in a missed opportunity for Canterbury CMHS to consider whether continued support and transfer to a community health provider in TC's new area was needed, and what information should be provided to other agencies to inform the ongoing work with TC and SN.

(h) Significant changes in family circumstances should have prompted a holistic assessment by SDN of the potential risks to SN, informed by information from other services.

(i) There was the absence of a case plan developed by SDN which could have been used to actively monitor the appropriateness of interventions and the outcomes of casework strategies for the family.

(j) A decision was made to transfer the family out of the Brighter Futures program in July 2015, despite there being little substantive change in the risks facing SN since the time of initial referral.

(k) TC's disclosure on 18 September 2015 did not result in the making of a ROSH report, escalation to the SDN caseworker's manager, or consultation with the Mandatory Reporter Guide.

8.2 The NSW Ombudsman subsequently issued a provisional statement of findings and recommendations in June 2016. In response, Family and Community Services, SDN, SLHD and the NSW Ministry of Health all responded by indicating that the provisional statement identified a number of issues which needed to be addressed, and that the provisional recommendations were supported.

8.3 In its final investigation report of October 2016, the NSW Ombudsman made a number of final recommendations. Relevantly it was recommended that FACS, SLHD and SDN "*should meet to consider the practice issues and lessons to be learned from [the case involving TC and SN], particularly those relating to interagency practice. The proposed discussion should consider, but not be limited to, issues including:*

(a) the identification, monitoring of, and response to, child protection risks – particularly in the context of service provision that is focused on resolving parental vulnerabilities;

(b) inter-agency communication and coordination of service delivery to families with complex needs in the context of individual services being engaged to target discrete aspects of the family's function; and

(c) how the principle of shared responsibility should have applied in practical terms in [the case involving TC and SN] given the multi-agency involvement and high level of service intervention and activity…".[4]

8.4 As part of the coronial investigation, responses were sought from FACS, SDN and SLHD in relation to the issues identified above. The response provided by FACS established the following:

[4] Exhibit 1, Volume 2, Tab 14.

(a) Since 2015 FACS has developed various initiatives aimed at improving the ability of the department and the non-government sector to identify and respond to child protection risks. These initiatives include the launch of the NSW Practice Framework, rollout of Group Supervision state-wide, a review of the Brighter Futures Program, and a proposal to establish a Child Protection Academy to provide more cooperative training to caseworkers. The following is noted:

(i) The NSW Practice Framework provides an integrated reconceptualisation of the approach, values, standards, tools and rules that currently guided the NSW statutory child protection system.

(ii) The Brighter Futures Program is undergoing two separate trials to improve the service model and achieve better outcomes, including the SafeCare Trial (a highly structured, empirically supported parenting program that addresses parental behaviours) and the Voices and Choices Trial (a new model of support for vulnerable families which is tailored to a family's individual circumstances to address traumatic experiences and build self-regulation capabilities).

(b) Publication of a new casework practice advice which provides practical guidance to assist and encourages caseworkers to work collaboratively with families to ensure they are engaged in planning, to establish relationships with interagency partners, to share information and learn from interagency partners, and to meet regularly with families and interagency partners to review progress, and talk about changes and concerns.

(c) Changes have been made at Lakemba CSC to improve practice and strengthen relationships with non-government organisation and interagency partners, including weekly contact with such service partners to discuss referrals to the services and receive feedback on referrals.

8.5 The response by SDN established the following:

(a) In January 2016 SDN distributed a revised child protection procedure which ensured that the emphasis on child safety was as clear as possible, highlighting how the immediacy of any risk of harm needs to be ascertained, and ensuring that all roles and responsibilities throughout the organisation are correctly referenced.

(b) A review and updating of existing child protection training for staff has been conducted to ensure that additional guidance is provided on how to balance objectivity against building rapport and partnerships with parents when assessing risk to children.

(c) Improvements in staff recruitment, induction and training have been made to ensure that staff are adequately equipped to respond to risk of harm to children, case management and child protection issues.

(d) Supervision training for Brighter Futures Managers and Team Leaders has been strengthened.

(e) Electronic case management systems have been updated to flag gaps in record-keeping and missed supervision sessions, including implementing an alert for overdue key tasks which will be escalated to the reporting manager.

(f) There has been collaboration with other agencies to discuss the issue of shared responsibility and information exchange, whilst reinforcing with staff the importance of coordinating decision-making in service delivery where children may be at risk of harm.

8.6 The response provided by SLHD established the following:

(a) Development of a Mental Health Shared Care Program, being implemented across the SLHD, which provides for more routine and standardised information sharing, and identifies agreed roles and responsibilities of the GP and the mental health clinician.

(b) Development of a more comprehensive training and support project for community mental health clinicians to increase their confidence in identifying, assessing and responding to the needs of children; to improve the standardisation of documentation of assessment, referral and planning; and to encourage improve engagement with external agencies, including by increased use of teleconferencing. In this regard teleconferencing facilities for CMHS staff has been provided to establish case conferences a short notice with service partners so as to avoid potential delay in multi-agency coordination.

(c) Enhancement of the perinatal model of care for SLHD mental health services to clearly identify families where provision of specialist perinatal input would enable a more holistic assessment and reduction of risk. This has included employment of a consultant psychiatrist and to clinical nurse consultant positions to provide a postnatal outreach to clients.

8.7 Having regard to the appropriate remedial action taken by FACS, SDN and SLHD in response to the issues identified in the NSW Ombudsman and coronial investigation, it is unnecessary to make any further recommendations.

9. Acknowledgments

9.1 Before turning to the findings that I am required to make, I would like to acknowledge, and express my gratitude to Sasha Harding, Coronial Advocate, for her considerable assistance during both the preparation for inquest, and during the inquest itself.

9.2 I also thank and commend Detective Senior Constable Joseph Sara for conducting a thorough investigation and for compiling a comprehensive initial brief of evidence.

9.3 I thank both of them for the sensitivity and empathy that they have shown in this particularly tragic matter.

10. Findings pursuant to section 81 of the *Coroners Act 2009*

10.1 The findings I make under section 81(1) of the Act in relation to TC are:

Identity
The person who died was TC.

Date of death
TC died on 21 September 2015.

Place of death
TC died at Campsie NSW 2194.

Cause of death
The cause of TC's death was hanging.

Manner of death
TC died as a result of actions taken by her with the intention to end her own life.

10.2 The findings I make under section 81(1) of the Act in relation to SN are:

Identity
The person who died was SN.

Date of death
SN died on 21 September 2015.

Place of death
SN died at Campsie NSW 2194.

Cause of death
The cause of SN's death was hanging.

Manner of death
SN died as a result of actions taken by her mother, TC. The manner of death is therefore homicide.

11. Epilogue

11.1 Even in the last moments of SN's life, and despite the tragic circumstances surrounding these moments, TC's enormous love for SN is plainly evident. In such circumstances perhaps some measure of solace can be taken from the fact that TC and SN were together in their last moments.

11.2 On behalf of the Coroner's Court of NSW, I offer my deepest heartfelt sympathies and most respectful condolences to the family of TC and SN for their devastating and heartbreaking loss.

11.3 I close this inquest.

Magistrate Derek Lee
Deputy State Coroner
20 December 2019
Coroner's Court of NSW