CORONERS COURT OF NEW SOUTH WALES

Inquest:	Inquest into the death of DB
Hearing dates:	16,17,19 October 2023 24 July 2024 16 October 2024
Date of findings:	1 May 2025
Place of findings:	NSW Coroners Court Lidcombe NSW
Findings of:	Magistrate Harriet Grahame, Deputy State Coroner
Catchwords:	CORONIAL LAW – Infant death – homicide – non-accidental injuries – FACS – Family and Community Services – DCJ – Department of Communities and Justice – risk of serious harm reports – The Benevolent Society – “malicious” reports – recording of Helpline calls
File Number:	2016/00382784

Representation:	Counsel assisting the inquest: R McMahon of Counsel i/b NSW Crown Solicitor Department of Communities and Justice: Ben Fogarty of Counsel i/b DCJ Legal AM: Matthew Minucci of Counsel i/b Kingston Reid SH: Patrick Rooney of Counsel i/b Clayton Utz The Benevolent Society: Trent Glover SC, i/b Pinsent Masons
Non publication orders:	Non publication orders made on 1 May 2025 A copy of the orders can be obtained on application to the Coroners Court registry.
Findings	**Identity** The person who died was DB. **Date of death** DB died on 20 December 2016 at approximately 9.12pm. **Place of death** DB died at Westmead Children's Hospital, Westmead NSW. **Cause of death** DB died as a direct result of sequalae of blunt force head and spinal cord injuries. **Manner of death** DB's death was the result of the fatal injuries resulting from deliberate assaults inflicted upon DB on 18 and 19 December 2016.

Recommendations	**The Department of Communities and Justice** DCJ consider developing guidance for child protection workers which: a. informs caseworkers and their managers of the availability of the audio Helpline reports; and b. provides managers with assistance to make decisions about when it may be appropriate for audio Helpline reports to be made available to support decision making.

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Introduction

1. This inquest concerns the death of DB.

2. DB was only two years and nine months old at the time of her death. She was the daughter of AS and AF. DB had an older brother, TW who was four years of age when DB died. TW had a different father to DB.

3. DB's brother, TW was assisted by a support worker[1] to provide the Court with a moving family statement. He remembered his sister with great affection.

   [DB] and I were inseparable. She would follow me everywhere, she was like my shadow. She looked up to me and we loved each other very much. We would run through the hallway and meet in the middle to hug each other and laugh. …. [DB] was also very connected with my Aunty and Uncle. She loved them, and they loved her, very much. She was very affectionate and would only eat dinner if she was holding my Aunty's hand. She was also very playful with my Uncle …… my Uncle describes [DB] as an absolute angel. He says that she was very clever and advanced for her age, always talking and chatting with me. We all miss her very much.

4. One day TW will be old enough, if he so chooses, to read these findings. For this reason I offer him my sincere personal condolences and acknowledge his strength. I am sorry we were unable to keep him and his sister safe.

5. I am aware of the traumatic nature of these proceedings and acknowledge that a number of witnesses were deeply impacted by these devastating events and by their investigation. I hope they understand the need for a public examination of what occurred.

The role of the coroner and the scope of the inquest

6. The role of the coroner is to make findings as to the identity of the nominated person and in relation to the place and date of their death. The coroner is also to address issues concerning the manner and cause of the person's death.[2] 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.[3]

7. The inquest was conducted pursuant to section 21 and 24 (1) (b) and (c) of the *Coroners Act 2009* (NSW).

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[1] The Court thanks TW's caseworker for her assistance.
[2] Section 81 *Coroners Act 2009* (NSW).
[3] Section 82 *Coroners Act 2009* (NSW).

8. There should be no dispute between the parties as to the cause and manner of DB's death. Taking into account the evidence before me, including material from the relevant criminal proceedings, it is established that DB died as a result of sequalae of blunt force head and spinal cord injuries. DB's fatal injuries were the result of deliberate assaults inflicted upon her on 18 and 19 December 2016 by Mohammed Khazma, who was convicted by a jury of the murder of DB. AS pleaded guilty to the manslaughter of DB. The Court had available sentencing remarks (*R* v *AS* [2018] NSWSC 930, *R* v *Khazma* [2019] NSWSC 416) which set out the circumstances of DB's death.

9. While it is extraordinarily painful to record, the nature and severity of DB's injuries cannot be glossed over or forgotten. The violence and cruelty inflicted upon DB was extreme. The post mortem examination took place over two days, so great were the number of injuries which needed to be recorded. DB had been struck, burnt and bitten. DB had injuries to her peri-anal region and her anal canal in keeping with blunt force penetrative injury to the anus and significant internal injuries, indicative of traumatic abuse. Examination of her brain and spinal cord showed areas of extensive haemorrhage. The nature of the bruising made it clear that she had been assaulted repeatedly over days. The pain she had suffered must have been unbearable.

10. Given the available evidence from the trial, this inquest focussed on the *circumstances* surrounding DB's death. In particular whether agencies involved could have done more to prevent the circumstances in which her death was able to occur. The Court needed to grapple with understanding whether enough had been done to support DB and her brother before these terrible assaults took place. The Court was keen to understand why she was not visible to people who could have assisted her.

11. Counsel for AM cautioned the Court against a finding that there was a direct causal nexus between the specific actions or omissions of individuals at the Department of Communities and Justice (DCJ) and the "ultimate outcome", which was described as DB's death. AM's submission stated that counsel assisting had not established "any comparative risk profile as between the circumstances of DB at the time she left the care of the Bankstown Community Service Centre (CSC) and the time that she encountered the criminal who ultimately murdered her". Further it was suggested that any such risk could not have been known by people working at Bankstown CSC at the relevant time.

12. The submission indicates a misunderstanding of these proceedings. It is perfectly clear that DB's death was a homicide, which occurred at a time when she had no contact with DCJ. Examination of the circumstances surrounding this homicide does not, as was suggested, call for a finding that DCJ (or the relevant CSC or any specific individual) "caused DB's death." There is no suggestion that the very specific risk that DB would

be very seriously injured or killed after AS commenced living with Mr Khazma could have been identified at the time her case was closed at Bankstown CSC. Nevertheless, in my view it can be established that DB's situation at the time of case closure involved potential danger which had been inadequately assessed and acted upon. DB was left unsupported.

13. DB's family had been involved with the Department of Family and Community Services (now DCJ[4]) for approximately three months in 2015. In short, there were seven Risk of Significant Harm (ROSH) reports made to the DCJ Helpline between 11 May 2015 and 5 August 2015 relating to DB and her brother. During this period DB's family was referred by DCJ to the Brighter Futures Program which was run by The Benevolent Society. DCJ's final contact with the family was on 7 August 2015. From 8 August 2015 to 19 December 2016 there is no record of any contact between DCJ and the family and no record of any further Helpline call or report. On 13 August 2015 the family was assessed as no longer eligible for the Brighter Futures Program and this was communicated to DCJ the same day. On 19 August 2015 DCJ closed DB's family's case. One year and four months later, she was dead.

14. The adequacy of DCJ's contact with the family was quite properly a focus of the inquest.

The evidence

15. The Court took evidence over five hearing days. The Court also received extensive documentary material in seven volumes and numerous exhibits. This material included witness statements, medical records, photographs, policies and procedures.

16. While I am unable to refer specifically to all the available material in detail in my reasons, it has been comprehensively reviewed and assessed.

17. The Court also had the benefit of expert evidence. Kate Alexander, Senior Practitioner of the Office of the Senior Practitioner, DCJ, and an independent child protection expert, Emeritus Professor Judith Irwin, gave evidence in conclave about the child protection issues arising in the investigation.

18. A list of issues was prepared before the proceedings commenced.[5] These issues guided the investigation, but an inquest tends to further crystalize the critical issues and

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[4] The Department of Family and Community Services/Department of Communities and Justice will be referred to in these findings as DCJ.

[5] List of issues: 1. The Cause and manner of DB's death; 2. The adequacy of Family and Community Services (FACS) and DCJ response to Helpline reports between 11 May 2015 and 5 August 2015; 3. Whether FACS' ending its involvement with AS and her children on 7 August 2015 was an appropriate decision in the circumstances; 4. Whether FACS policy and guidelines provided adequate guidelines to staff the purpose of supporting AS and her children; 5. The extent to which FACS/DCJ have assessed and implemented recommendations identified in the Serious Case Review dated July 2017; and 6. Whether any recommendations are necessary of desirable.

I note that parties addressed specific matters beyond the identified issues as they arose.

19. It is important to note the delay involved in these coronial proceedings. Firstly the investigation was properly suspended pursuant to section 78 of the *Coroners Act 2009* (NSW) until the conclusion of the criminal proceedings and all appeal periods were spent. The matter was further delayed by the ongoing resourcing issues at this Court. I acknowledge that delay has the capacity to complicate the grief process for everyone with an interest in proceedings and to weaken the death prevention function of this Court. It is regrettable.

Background

20. Prior to the commencement of proceedings, those assisting me drafted a chronological summary of the key events from the available documentary evidence, with input from the interested parties. The parties agreed that this document,[6] which was tendered, contained an accurate summary of the relevant events. I attach a copy of that document as an annexure to these reasons and do not intend to repeat all the material contained in it. I adopt its content and will not repeat each detail here.

21. Counsel assisting also produced comprehensive closing submissions summarising much of the oral evidence. Given the parties explicitly acknowledged the accuracy of her outline, I have also relied heavily upon her document in recording my written reasons, at times directly adopting her words. I have reviewed the evidence carefully where differences in fact or emphasis are noted by the parties and in all matters the conclusions are my own.

22. AS was 19 years of age when DB was born at Royal Prince Alfred Hospital, Camperdown NSW. DB was AS's second child.

23. AS had a significant history with DCJ herself. Her childhood had been disadvantaged and traumatic. Some of the details of her background are set out in the agreed facts.[7] AS had come to the attention of DCJ when she was nine years old.[8]

24. AS came to the attention of DCJ in February 2012 when she was 20 weeks pregnant with her first child, TW. At the time, AS was 17 years old, had been "kicked out of home" and was renting with a friend.

25. DB's father was AF. DCJ records reveal 28 reports relating to AF and his siblings being physically abused and neglected as children.

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[6] Ex1: Agreed Facts (also Annexure 1 to these findings).
[7] Ex 1: Agreed Facts at [8] (also Annexure 1 to these findings).
[8] Ex 1: Agreed Facts at [8] (also Annexure 1 to these findings).

26. At the time of DB's death AS and AF were separated. AS had a new boyfriend, Mr Khazma.

27. Mr Khazma and AS met on Facebook about two months before DB's death. It is reported that they were living together from about 28 November 2016.

28. It appears that Mr Khazma's violence against DB began very soon after he commenced living with AS. The very significant violence was systematic, unrelenting and frequent. I accept and adopt the findings of Fullerton J at [37] in this regard.

29. On 18 and 19 December 2016 Mr Khazma deliberately inflicted the injuries which were causative of DB's death. He did so with the intention of causing her grievous bodily harm. I adopt the findings of Fullerton J extracted in the agreed facts. [9]

DB's death in the context of DCJ's child protection responsibilities

30. DCJ is the NSW Government department with statutory responsibility for assessing whether or not a child or young person is in need of care and protection.[10] It is the minister's role to promote a partnership approach between government, non-government agencies, families, corporations, business agencies and the community in taking responsibility for dealing with children and young persons who are in need of care and protection under the *Children and Young Persons (Care and Protection) Act 1998* (the Act). While broad cooperation within the sector is called for, there are times when only a statutory response is appropriate and that lies exclusively with DCJ. Ultimate responsibility for child protection cannot be shifted by referral arrangements.

31. The work of DCJ has been examined in a number of recent inquests,[11] but perhaps more significantly it has also been the subject of extensive public reviews and evaluations, most recently the "NSW Auditor General report – Oversight of the Child Protection System" dated 6 June 2024 (Auditor General report)[12] and the NSW Ombudsman's "Protecting children at risk report" dated July 2024.[13]

32. I accept counsel assisting's submission that the findings of the Auditor General report are deeply concerning. The overall finding demonstrates a system in desperate need of significant and wide-ranging reform in order to meet its statutory responsibilities[14]:

> *The NSW child protection system is inefficient, ineffective, and unsustainable. Since 2018–2019 there have been increasing child protection reports, escalating out of*

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[9] Ex 1: Agreed Facts at [19] (also Annexure 1 to these findings).
[10] *Children and Young Persons (Care and Protection) Act 1998* (NSW).
[11] For example: Inquest into the death of ML (findings delivered 4 March 2025); Inquest into the death of MO (findings delivered 26 March 2024); Inquest into the death of AW (findings delivered 24 October 2023).
[12] Ex 6: NSW Auditor General report – Oversight of the Child Protection System dated 6 June 2024.
[13] Ex 10: NSW Ombudsman 'Protecting children at risk report' dated July 2024.
[14] Ex 6: NSW Auditor General report – Oversight of the Child Protection System dated 6 June 2024, p 2.

home care costs, insufficient placement options for children with complex needs, and limited services or support for children and families engaged in the child protection system. Despite numerous reviews into these issues, DCJ has failed to make the necessary changes to ensure its child protection service model meets the needs of children and families.

33. I accept this conclusion without reservation. The report went on to make 11 recommendations which DCJ has either accepted or accepted in principle.[15]

34. Mr Stuart Malcher, Executive Director, Child and Family Directorate, Systems Reform Division gave evidence before me. He stated that there were also four other key reviews[16] that were recently reported or which were yet to be reported at the time he gave evidence.[17]

35. Mr Malcher told the Court that DCJ has undertaken a thematic analysis of these reports and identified the following five themes that will assist and inform the broader system reform planning[18]:

    i. System settings, including strengthening prevention, early intervention and therapeutic supports.

    ii. Safeguarding Aboriginal children and families.

    iii. Service delivery and practice.

    iv. Quality assurance and monitoring.

    v. Accountability and governance.

36. Mr Malcher informed the Court that DCJ had commenced addressing some of the key findings and recommendations including Child Protection Assessment Policy Review; Prioritisation, Triage and Allocation Policy Review; Design and development of an outcomes framework and measurement for child protection and out-of-home care.[19] Mr Malcher stated that[20]:

    DCJ is simultaneously progressing a range or [sic] projects and initiatives to improve

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[15] See Annexure A to Third statement of Stuart Malcher of 9 October 2024, Ex 9: Tab 1.

[16] Auditor-General performance audit, Safeguarding the rights of Aboriginal children in the child protection system, 6 June 2024; NSW Children's Guardian, Strengthening the out-of-home care and broader system, 29 August 2024; Advocate for Children and Young People, Special inquiry into children and young people in Alternative Care Arrangements, 31 August 2024; NSW Ombudsman, Review of the DCJ complaint system in respect of its Aboriginal child protection functions, 6 November 2024 (pending at the time of Mr Malcher's evidence being given).

[17] Ex 9: Tab 1, Third statement of Stuart Malcher dated 9 October 2024 at [14]. Mr Malcher refers to other independent reviews and inquiries are expected to be finalised by mid-2025 at [17] of his statement.

[18] Ex 9: Tab 1, Statement of Stuart Malcher dated 9 October 2024 at [15].

[19] Ex 9: Tab 1,Statement of Stuart Malcher dated 9 October 2024 at [16].

[20] Ibid at [18].

system performance, financial sustainability and in response to key recommendations and themes of the completed reports while concurrently developing a broader strategy for reform of the statutory child protection and out-of-home care system.

37. The Court is heartened to think that broad reform is contemplated as it is perfectly clear that tinkering around the edges of some of these intractable problems has not worked. Nevertheless, the Court has no way of knowing whether the serious and long-term systemic issues associated with DCJ's child protection practice will be adequately addressed in the near future. Many of these issues are neither new or novel. Many of the issues have been identified by the Office of the Senior Practitioner during individual death reviews and during inquests over many years. What is required is a commitment for real change incorporating major increases to resourcing and significant attention to restructure at the highest level.

38. There is enormous public interest in reform of the child protection system in this state. The work needs to be done urgently.

39. In that context, I pause to say that while I am extremely critical of DCJ's work with DB and her family, I am not blind to the very difficult circumstances experienced by individual child protection caseworkers both within and without DCJ. I recognise many who work in child protection are skilled, caring and committed. Over the years dedicated caseworkers have appeared before me, trying to explain their attempts to do the right thing in a sometimes toxic or under-resourced environment. Major reform must occur to allow these workers a chance to adequately support children in need of care and protection to the best of their ability.

DCJ's involvement in DB's life

40. It is important to note at the outset that counsel for DCJ placed on the record that DCJ accepted that it missed numerous opportunities to protect DB and TW, that it did not use its people well and that it did not respond with appropriate urgency and skill to consistent information that DB and TW were in danger.[21] I accept that these were the findings of the Serious Case Review team's Internal Child Death Review Report (ICDR) in July 2017. Further, I accept that Kate Alexander, Senior Practitioner of the Office of the Senior Practitioner and Stuart Malcher, Executive Director, Child and Family Directorate, Systems Reform Division gave candid oral evidence and made fair and appropriate concessions about some DCJ practices, systems and procedures at the relevant time that could have been improved. I will deal with the specific improvements that have been made or are foreshadowed when considering the need for

[21] DCJ Closing submissions at [3].

recommendations.

41. Notwithstanding these general concessions it remains useful to publicly examine the critical decisions made. This was not a situation where there was a single poor decision. DCJ was involved with DB's family between 11 May 2015 (date of the first ROSH report) and 19 August 2015 (date of the file closure). During this period there were seven ROSH reports made to DCJ's Helpline. The ROSH reports raised serious concerns about AS's behaviour towards DB and TW including allegations of AS being physically and verbally abusive towards the children and neglecting them. Some of the reports recorded that the children were coming into contact with people who may be dangerous.

42. Counsel for DCJ noted that while DCJ's initial responses to the Helpline reports met the recommended response timeframes, the responses themselves were not adequate. Further it was conceded that important contextual information was not always included in the information passed on and this meant that critical information was not always provided to caseworkers at Bankstown CSC.

43. Counsel assisting submitted that there is ample evidence to find that DCJ's Bankstown CSC's response to the Helpline reports between May 2015 and August 2015 was inadequate. She took me to a series of decisions and actions, which she submitted, individually and collectively compromised the safety and wellbeing of DB and her brother. As will become obvious I accept that submission.

44. As I have stated, my attention was also drawn to AS's interactions with DCJ at an earlier time. SH, the DCJ caseworker initially tasked to meet the family, agreed that AS's care background and her own vulnerabilities were relevant to the support she needed. SH agreed that people with a background of trauma may also have difficulties with trusting others.[22] Counsel assisting submitted that insufficient attention was paid to AS's trauma background and insufficient time was allocated to discussing her background and identifying the necessary supports. I accept that submission. In my view AS's attitude to DCJ was not the subject of sufficient curiosity, nor was her trauma background sufficiently considered. This impacted the casework provided to the family from the start.

The ROSH reports and referral to Brighter Futures

45. There is a detailed summary of the ROSH reports, DCJ responses, interactions between staff members of the DCJ, The Benevolent Society and DB's family (and other relevant information arising from the brief) between 11 May 2015 and 13 August 2015 in the Agreed facts at [50]-[130]. I will now deal with some of the specific issues that

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[22] Transcript 16.10.23, p23.42.

arise.

The first ROSH report and initial DCJ home visit

46. The first ROSH report was made on 11 May 2015. Upon being rejected by the Joint Investigation Response Team (JIRT) (as it did not meet the JIRT criteria for neglect), the case was referred to Bankstown CSC.

47. On 12 May 2015, at 3:30pm BG (Manager Casework, Bankstown CSC) convened a Pre-Assessment Consultation meeting with SH and another DCJ caseworker. Later that day, SH and the other DCJ caseworker attended AS's home and conducted a home visit. At an assessment consultation meeting at 6:45pm on 12 May 2015, attended by SH, the other DCJ caseworker and BG, it was determined that a referral to the Brighter Futures program was appropriate.

48. SH was the DCJ caseworker who was assigned to work with DB's family. SH was an experienced caseworker. While she had also performed the more senior role of Manager Casework for eight years, at the time of being assigned responsibility for DB's family's case, she was employed in the position of caseworker. SH reported to BG (Manager Casework). BG reported to AM (Manager Client Services).

49. As set out in the Agreed Facts, on 25 May 2015, AS was referred to The Benevolent Society's 'Brighter Futures' program. CT was the caseworker (Child Family Practitioner) assigned to work with AS and her children, and KD, in the role of Team Leader, was her direct supervisor.

The referral to Brighter Futures was premature

50. Prior to the first home visit on 12 May 2015, there were a long list of issues identified by SH and BG in the pre-assessment consultation. SH noted that it would have been 'impossible' to address all of those issues given the duration of the home visit was only 1 hour and 15 minutes. Professor Irwin and Ms Alexander both indicated that it would have been necessary to go through *at least* those issues prior to a referral being made to Brighter Futures. Clearly this did not occur.

51. SH conceded that had she spent more time on these issues (including finding out more about AS's own mental health and vulnerabilities), she would have been in a better position to assess whether this case was too serious to refer to Brighter Futures at this time.

52. I accept that the referral was premature and that this had a devastating flow on effect. It meant that staff from Brighter Futures were placed in a difficult position from the start. In relation to their initial visit at AS's home on 1 June 2015, CT agreed she had only a limited understanding of the risks and dangers.

53. At the second visit on 17 June 2015, CT did not believe that a number of important issues were explored with AS. These included physical abuse towards TW, AS's mental health and AS's alleged drug use.

54. KD stated the Brighter Futures program worked well particularly when there was a robust assessment at the "*front end*" and a "*warm, joint visit with DCJ"* and where the family wanted to engage. However, in AS's case the referral was almost immediate and very limited information was passed on.

55. Ms Alexander was of the opinion that the referral to Brighter Futures was premature as it was based on a superficial assessment of the children's safety and risk and that a longer period of engagement with AS was needed in order to undertake a more holistic assessment.[23] Ms Alexander further stated that[24]:

> *It is likely that if this had occurred, the assessment would have highlighted that the children were unsafe, requiring ongoing statutory intervention. This would have included a family action plan for change, and the involvement of a more intensive family based service....rather than an early intervention service.*

56. Professor Irwin agreed with Ms Alexander. She told the Court:

> *I had the sense when I was reading the initial paperwork of the initial visit that it was in haste, really strong in haste. That was very, I thought, I will use the same word, superficial, and I thought it didn't take everything into account…... I think it was very, very superficial.*

57. Ms Alexander was of the view that the application of the safety assessment tool should have identified the dangers and that should have meant the outcome of the safety assessment would have been that the children were unsafe, or at best, "safe with plan".

58. Counsel assisting submitted that the Court could find that given the superficial nature of interactions with AS at the first home visit, there was a missed opportunity to consider a statutory response. I accept that submission without hesitation.

The information provided by SH in the Brighter Futures referral was inadequate

59. The Court had the opportunity to consider the information in the referral form dated 25 May 2015.

60. SH agreed that she should have put more information in the form.

61. In addition to the lack of detail in the form, KD gave evidence that The Benevolent Society did not receive a copy of the structured decision-making safety and risk

[23] Ex 2, Vol 1, Tab 23, Statement of Katherine Alexander dated 12 September 2023 at [61].
[24] Ibid.

assessment at any point. KD recalled making a request for this assessment from BG by telephone. Whilst the referral form included a summary of the first and second ROSH reports, KD and CT both stated that they did not receive a copy of the third ROSH report, the fourth ROSH report or the sixth ROSH report. Apparently CT did not find out about those particular ROSH reports until after DB's death at the Serious Case Review.

62. Ms Alexander agreed that the referral form was "entirely inadequate" and that The Benevolent Society was not provided with adequate information about what needed to change.

63. As CT identified, the consequence of the inadequate information provided at the time of referral meant that The Benevolent Society was ill-equipped to properly assess the dangers and risks associated with the family and properly assess whether this was an appropriate case for the Brighter Futures program to take on.

64. I find that Brighter Futures was provided with inadequate information and that it affected the work they could perform. Further I accept that KD made unsuccessful efforts to get further information by contacting BG.

The ROSH reports should not have been accepted by SH to be 'malicious' or 'vexatious'

65. I was persuaded that the characterisation of ROSH reports as "malicious" or "vexatious" resulted in inadequate consideration of the real issues which had been raised and consequently led to significant missed opportunities to provide support to DB and her brother. There is a need for caseworkers to keep an open mind and approach their work with curiosity. This was missing in the approach taken.

66. SH clearly accepted AS's claims that (at least some) of the ROSH reports were "malicious" or "vexatious". On 11 June 2015, KiDS records, relating to the assessment consultation, noted that the reports appeared to be "malicious". The file note relating to the home visit on 17 June 2015 recorded:

> *…I discussed with [AS] that even though I believe that the bulk of the reported concerns had been either malicious or mischivious [sic] in nature, it was my opinion that there were nonetheless areas of concern which I believed were steadily getting worse...* [25]

67. When questioned about this entry, SH's explained that DCJ couldn't confirm the reported information, and that there was no or minimal correlation between the reported information and observations of the home. However, there were still "enough concerns" to keep the file open.

[25] Ex 2: Vol 2, Tab 65, File note relating to home visit on 17 June 2015.

68. When questioned further, SH gave evidence that she didn't know if the bulk of the reports were malicious and vexatious. SH said she sometimes believed that, but sometimes it was difficult to "really put your finger on". SH stated that AS presented as very genuine, secure in what she was saying, and was very open, and apparently very transparent about aspects of her life. However, SH later conceded that there were no investigations (such as police checks, hospital checks) undertaken by DCJ to assist in obtaining information which might corroborate or disprove the claims. SH agreed that there should also have been inquiries made with the neighbours in relation to aspects of the reports.[26]

69. The danger of the approach taken was increased by the fact that, understandably, reliance was placed on DCJ's assessment by The Benevolent Society's caseworker. CT indicated that it stood out to her in the referral form that the reports may be vexatious.[27] She stated:

> *…it was my expectation at the time if something was deemed vexatious by DCJ that a thorough assessment would have been completed. For me, even in my role today, to say a reported allegation is - has been deemed vexatious is quite - it's quite a strong statement. I would usually look at something being alleged, and whether it's been substantiated or not substantiated, based on the information that you've gathered during an assessment period. Vexatious is quite a strong term to use, which basically would indicate to me that the reality from the reported concerns was, you know, very far from the reality that was reported.*

70. Counsel assisting submitted that the consequence of accepting that calls are "vexatious" has serious consequences. Professor Irwin stated that it can "pervade the whole practice".[28] Professor Irwin stated that best practice was to not label a report as vexatious at an early stage, but to "assess it the way they would any situation, any referral".[29] I accept her opinion.

71. Ms Alexander highlighted one of the dangers with labelling a report as "malicious" relates to evidence about decision making which indicates that when a particular view is formed, "they may keep collecting evidence that fits that view, and discard evidence that doesn't". Ms Alexander was of the view that this may have happened in this case.[30] I accept her analysis of what occurred. There is always a need to guard against confirmation bias.

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[26] Transcript 16.10.23, p47.5.
[27] Transcript 19.10.23, p165.40-166.20.
[28] Transcript 24.7.24, p49.14.
[29] Transcript 24.7.24, p58.34-43.
[30] Transcript 24.7.24, p62.11.

72. Mr Malcher's evidence also suggested that SH's apparent focus on whether the report was "malicious" was misplaced[31]:

> *…our job is not to determine whether information is false. We're just meant to determine on the balance of probabilities whether it is true, or has likely occurred, or there has been harm or risk to the child, and certainly our role is not to question the intent of the reporter, but whether the reported information is, on the balance of probabilities, true and correct.*

73. Ms Alexander stated that DCJ has now developed a guideline on malicious reports that will sit in the guidelines used when case workers are doing safety assessments.[32] Counsel assisting submitted that this is a very positive development given the role that labelling the reports as "malicious" appears to have had in this case.

74. I was particularly concerned that the characterisation of reports as "vexatious" or "malicious" meant that they were not given sufficient weight. I was concerned that staff may not have been adequately aware of the blindspot that this kind of assumption can create. However, given Ms Alexander's evidence on this issue I am satisfied it has been addressed in the guidelines that have now been created.

NSW Health and NSW Police records should have been obtained and shared

75. SH agreed that she did not obtain NSW Health or NSW Police background information but that she would "do that now".[33]

76. CT obtained information from NSW Police under chapter 16A[34] but does not believe that she shared that information with SH. Looking back, she agreed it would have been a good idea to have shared that information.[35] Counsel assisting submitted that this COPS record should have been shared with DCJ. The COPS entry relating to TW having been found wandering the streets on 19 June 2015[36] would have provided objective evidence to support allegations of neglect.

77. Ms Alexander was of the opinion that from the perspective of child safety and the issues which presented in this case, she would expect that the DCJ caseworker would seek information from NSW Health and NSW Police.[37] In my view the failure by DCJ to seek this information was a clear missed opportunity. Once The Benevolent Society correctly made the chapter 16A requests, that information should also have been shared with

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[31] Transcript 16.10.24, p11.31.
[32] Transcript 24.7.24, p61.30.
[33] Transcript 16.10.23, p63.15.
[34] Chapter 16A of the *Children and Young Persons (Care and Protection) Act 1998*.
[35] Transcript 19.10.23, p169.26-170.11.
[36] Transcript 16.10.23, p62.19; Ex 2: Vol 3, Tab 88, Email from NSWPF responding to Ch16A request.
[37] Transcript 24.7.24, p53.33.

DCJ.

DCJ should have arranged professional assessments for the children

78. I accept counsel assisting's submission that in light of the observations of bruising and the possibility of developmental delay observed at the first home visit it was necessary to arrange for the children to be professionally assessed at an early stage.

79. There appeared to be some confusion as to whose role it was to arrange medical assessments when both agencies were involved.

80. When being questioned about arranging medical assessments in the context of notes made at the second home visit (26 May 2015) and the notes made by the other DCJ caseworker of the initial home visit on 12 May 2015 which included "Discussion about paediatrician", SH said[38]:

> *The discussion that we had around that time was that we needed medical assessments, paediatrician, because of [TW]'s developmental, appearing to be behavioural issues and so forth. Maybe OT. So we needed more of a holistic kind of assessment of both kids, and this is what we were discussing with [AS] about during that visit. And we had discussed Brighter Futures and the fact that Brighter Futures would be able to access those services.*

81. CT stated that it was not "set in stone'" whose role it was to arrange medical assessments.[39] She stated:

> *…. It could have been done by DCJ, it could have been done by Brighter Futures, it could have been done by a parent. There wasn't - there wasn't, as far as I'm aware, anything that said whose responsibility it was to do that.*

82. When further pressed, she agreed that if Brighter Futures had an open case they could assist a mother to make those appointment.

83. Ms Alexander made it clear that this was an important issue.[40] She stated:

> *The observation that they appeared developmentally delayed, for me, the most pressing concern about this story was neglect. And neglect in terms of physical care, supervision, but also neglect – emotional neglect, and that is perhaps the most worrying thing which is the attachment between the children and their mother. So, it would have been really important to get an assessment of the children, and the developmental delay might not have been anything cognitive. It could just have been an environmental neglect or a parenting neglect.*

[38] Transcript 16.10.23, p47.
[39] Transcript 19.10.23, p186.29.
[40] Transcript 24.7.24, p39.30.

84. In Professor Irwin's view there should have been a referral to a paediatrician *before* there was any referral to Brighter Futures.[41] She shared Ms Alexander's opinion that developmental delay may be associated with neglect and that it should have been investigated.

85. Ms Alexander also saw a medical examination as necessary in relation to "the bruises, and an understanding of the injury of the little girl being taken by ambulance… A head injury in a 13-month-old baby. So, to me, that was the most pressing issue. ….And on top of that, we know that drug use in pregnancy, particularly methamphetamine use, can lead to developmental delays in children".[42] Ms Alexander emphasised the steps that should have been taken[43]:

> *…in a story like that, the caseworker would go out, they would do the safety assessment, and they saw bruising on this little boy, and the little girl had been presented by an ambulance unconscious, days beforehand. You could have served an order and got the family to the hospital that day.*

86. I accept evidence given by CT and KD that where medical issues are involved, DCJ has a greater capacity to obtain timely appointments. KD's experience at the time was that The Benevolent Society's recourse was to make community referrals which often had lengthy lists, whereas DCJ's referral would often be prioritised because it was coming from a statutory agency.[44]

87. I have considered all the available evidence and have come to the conclusion that while The Benevolent Society could assist a family to obtain professional assessments, in the circumstances of this case these referrals should have been commenced by DCJ *prior to* any consideration being given to making a Brighter Futures referral.

DCJ should have conducted a risk and safety assessment after the second ROSH (and every ROSH thereafter)

88. Ms Alexander stated that SH should have been doing new safety assessments or safety reassessments each time a new report came through.[45] I accept her evidence.

89. At the relevant time, DCJ's policy on safety assessments set out that open cases in which changing circumstances require safety assessments include "Change in family circumstances; Change in information known about the family; or Change in ability of

[41] Transcript 24.7.24, p40.5.
[42] Transcript 24.7.24, p40.32.
[43] Transcript 24.7.24, p42.22.
[44] Transcript 17.10.23, p140.22-29.
[45] Transcript 24.7.24, p50.

an existing safety plan to mitigate dangers."[46]

90. SH explained the reason for not conducting the assessment in her statement for the following reason[47]:

    Subsequent ROSH reports in relation to the same matter did not require additional reassessment consultation unless a significant change of circumstances was indicated in the subsequent ROSH report.

91. SH ultimately acknowledged that there was additional information in the second ROSH report and agreed a risk and safety assessment should have been done at this stage.[48]

92. I accept Ms Alexander's evidence on this issue. Each new report in the circumstances of this case should have prompted a new safety assessment or reassessment. The failure to do so represents a missed opportunity to keep the children safe.

Delay between the third ROSH report and a DCJ staff member making a home visit on 17 June 2015

93. SH agreed that after becoming aware of this ROSH report (on 31 May 2015) it was not until 17 June 2015 that a home visit was made.[49] SH's explanation was as follows[50]:

    So even though it's an open plan, it's been accepted by Brighter Futures. So it's really a Brighter Futures case. So they do the home visits and so forth. I'm only going along with Brighter Futures if they have asked me to come along with them if they're having issues, which when [CT] asked me to go with her on a visit because they were finding it difficult to get engagement from the mother, I went along with her. But once it's been transferred to an agency, really that casework, it's been given to them to do. So it's invasive for DCJ to continue to be interfering in their casework unless they have specifically said, "Look, we're finding it difficult to engage. I think there's going to be more issues. Do you want to come out on a joint home visit?"

94. SH later agreed in this context that the delayed home visit (17 June 2015) was "a problem."[51]

95. There is no doubt that SH's initial response failed to adequately reflect that there being a Brighter Futures file open did not absolve DCJ of its statutory responsibilities. Her apparent confusion in the roles of played by DCJ and The Benevolent Society is extremely concerning. While it is well known that while DCJ rely on non-government

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[46] Ex 2: Vol 4, Tab 113B, SDM Safety, Risk and Risk Reassessment, p31.
[47] Transcript 16.10.23, p39.24.
[48] Transcript 16.10.23, p42.47-43.15.
[49] Transcript 16.10.23, p53.10-53.25.
[50] Transcript 16.10.23, p53.26.
[51] Transcript 16.10.23, p57.25.

sector organisations to support families, the need to properly investigate a ROSH report and decide whether a statutory response is called for resides with DCJ. That being the case it was not appropriate for SH to just "go along" with The Benevolent Society caseworker. A statutory response was required.

AS's lack of engagement with Brighter Futures

96. On 10 June 2015 KD telephoned SH and reported AS's reluctance to engage with the program and stated that the referral may have to be closed as a result.[52] In my view this was an appropriate response at that time. After the home visit on 17 June 2015, AS verbally agreed to signed on to the program.[53]

97. A record made by SH on 21 July 2015 of her telephone conversation with CT reads[54]:

> *[CT] said she was concerned about mother's lack of engagement. During the time that [Brighter Futures] signed mother up, she has only seen mother on one occasion. Mother keeps making excuses to cancel her visits.*

98. SH gave evidence that she was aware the lack of engagement was an issue and although in her own mind it had reached a point where the referral may need to be terminated, that opinion was not shared by BG. SH stated:

> *I think, look, because I think it was minimised based on the fact that all of the reports appeared that they were coming from the same source, the same anonymous reporter, and even though they were escalating in severity, I don't think that was looked past by [BG].*

99. In my view, a careful analysis of AS's lack of engagement, along with further ROSH reports should have prompted SH to take decisive action in relation to DCJ's involvement with the family before the fifth and sixth ROSH reports. I understand and accept that she appears to have been hampered in this by a lack of support and guidance from her supervisor.

100. Counsel for DCJ made the point that this was not a matter of the case "returning" to DCJ because of lack of engagement. Under current policy there needs to be something more significant such as a ROSH report to trigger DCJ's further involvement. However counsel for DCJ also drew my attention to Mr Malcher's evidence that a proposal under the Recommissioning of Family Preservation Services work currently being considered may change this. The proposal would see DCJ keep their file open for a specified period after referral to a Family Preservation Service. In this case a "return" may occur if there

[52] Ex 1: Agreed Facts at [82] (also Annexure 1 to these findings).
[53] Ex 1: Agreed Facts at [84] (also Annexure 1 to these findings).
[54] Ex 1: Agreed Facts at [99] (also Annexure 1 to these findings).

is a lack of engagement.

101. In any event, there was more than just a “lack of engagement” in the circumstances of this case.

Risk and safety assessments should have been undertaken after the fifth and sixth ROSH

102. While in my view there was already sufficient evidence for DCJ to act, by the time of the fifth ROSH report on 20 July 2015 (which included TW's penis bleeding because of his nappy not being changed, serious examples of neglect, exposure to alcohol and assault including slapping TW) it is clear there was a pressing need for DCJ to conduct urgent risk and safety assessments. SH did not know why that was not done.[55]

103. The sixth ROSH report was made the following day on 21 July 2015. Risk and safety assessments should have been undertaken following this report.

104. Risk and safety assessments were clearly called for. Had they been done correctly and in a timely manner, the course of DCJ’s involvement in DB’s life would have changed.

Verification of the concerns raised in the fifth ROSH report

105. A record made by SH on 21 July 2015 of her telephone conversation with CT reads[56]:

> *I discussed the newest report with [CT]. We discussed whether it would be better for her to see [AS] and the children as arranged and if [CT] had concerns verifying those raised in the report, then she would make a report to the Helpline after which further action would be taken by Community Services.*

106. SH did not appear to consider this request inappropriate, responding that CT has “got eyes on the family, she's visiting the family, it's quite common practice for agencies to make reports, because they are the ones that have the direct contact”.[57]

107. Ms Alexander and Professor Irwin agreed assessing this issue was a matter for DCJ[58]:

> *MCMAHON: Yes. And of course, similar on this topic, there was the issue about TW's nappy rash that was reported, and [SH] had asked [CT] to look at that nappy rash and report back. Again, is that an issue, and bleeding penis indeed as well, where DCJ should have stepped in?*
>
> *WITNESS ALEXANDER: Yes.*
>
> *MCMAHON: No doubts about that?*
>
> *WITNESS ALEXANDER: Nope.*

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[55] Transcript 16.10.23, p62.38.
[56] Ex 1: Agreed Facts at [99] (also Annexure 1 to these findings).
[57] Transcript 16.10.23, p65.10.
[58] Transcript 24.7.24, p52.4.

MCMAHON: Professor Irwin?

WITNESS IRWIN: No. No doubts.

108. I accept the expert evidence without reservation. It is perfectly clear that it was DCJ's role to intervene, undertake risk and safety assessments and arrange a medical assessment immediately. Once again, what occurred shows a complete misunderstanding of the role which *must* be played by DCJ.

The home visit on 23 July 2015

109. In the context of serious and escalating concerns (arising from the fifth and sixth ROSH reports) and AS's lack of engagement with Brighter Futures, the home visit on 23 July 2015 should have been conducted by two DCJ child protection workers for the purpose of undertaking the risk and safety assessments. It was not appropriate for SH to go with CT.

110. SH agreed that the visit should have been with another DCJ caseworker and recalls talking to BG about this (although as counsel assisting points out, it is unclear what the content of the conversation relating to this issue was).[59]

111. Once again it was inappropriate to place responsibility for a statutory response on a worker from Brighter Futures.

The seventh ROSH report - DCJ should have attended AS's home and a risk and safety assessment should have been completed

112. Ms Alexander stated that Bankstown CSC should have undertaken a further safety and risk assessment after the report of 5 August 2015.[60]

113. The seventh ROSH report was made on 5 August 2015 by CT.[61] The content of the contact report included that DB had been injured after falling out of bed twice, concerns that AS would not seek medical assistance for any injury given she had failed to do so in the past for TW, concerns about AS's lack of understanding of her children's needs, and that the children are not "visible" and any future concerns may go unnoticed given the family has moved and Brighter Futures would not be working with her. The report also included other information about previous neglect.[62]

114. CT explained why she made this ROSH:

I was very worried for both of these children. From my interactions and comparison to the ROSH reports I did see that there was serious reasons to be worried, and that

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[59] Transcript 16.10.23, p67.45.
[60] Ex 2, Vol 1, Tab 23, Statement of Katherine Alexander dated 12 September 2023 at [58].
[61] Ex 1: Agreed Facts at [117] (also Annexure 1 to these findings).
[62] Ex 2: Vol 2, Tab 75, Contact Record – ROSH report dated 5 August 2015.

I did not believe that the initial two reports, or any - sorry, the three report - ROSH reports that I had access to during the relevant period were vexatious in any way, and I was very worried that there hadn't been any change during the relevant period. I was very worried that AS appeared to have very little empathy or attunement with either of the children, which is a huge risk factor. Yes, they had moved to another area and there was grandma there, which is often seen as a protective factor, to have another adult in the home, but there was - there was still worries and even once the family had moved there, DB had fallen out of bed, I think, on two occasions. I didn't think any of the worries had been properly addressed, and I thought the safety concerns for the children were escalating. That's why I made the report.

115. CT's report, coming as it did from a caseworker who had some knowledge of the family should have prompted immediate action. She knew the children would no longer be visible and their mother appeared to have little empathy or "attunement" to their needs. Reading this report, with the benefit of hindsight, is chilling.

116. The Court had the opportunity to hear CT and KD give evidence about their escalating concerns and their attempts to get help for DB and TW. CT ultimately made the final ROSH report and KD strongly advocated for an internal DCJ transfer, being of the view that "that would be the best way of creating a different experience for DB and TW… for there to be ongoing DCJ involvement, to address the risk and safety concerns."

117. I commend CT and KD for their attempts to keep these children safe. It is apparent that they tried to trigger DCJ to consider a statutory response. I acknowledge their efforts in this regard. I regret the trauma they have suffered in later learning what happened to the children after DCJ closed its file.

118. SH's explanation as to why the risk and safety assessments were not done were as follows[63]:

Q. Is there a reason that you did not go and see AS after this report when it had been allocated?

A. Well, so she's in a different district, so I've spoken - I spoke to [BG]. [BG]. I said, "Look, they have moved. They need to be allocated. We need to have ongoing casework. This family needs to be allocated," and she said, "Yeah, yeah, yeah. I'll do it," and she did not do it for quite some time. I spoke to [CT] prior to that report being made, and I said to her, "Look, give me a bit of time to get this matter transferred and then made a report." I don't know whether some of that was lost in translation because a report was made too soon. If the report had come through

[63] Transcript 16.10.23, p75.30; p90.10, SH confirmed this report was not investigated.

once transferred, then that would have been a trigger for Central Sydney to respond to. But because the report was made while it was still in our district, it wasn't transferred to Central Sydney.

119. The family was in the Bankstown District. DCJ knew that the family had not and was unlikely to be transferred to Central Sydney CSC. It was clear from the content of the ROSH report made by CT[64] that the children remained at risk and an immediate assessment was required. There is no excuse for the lack of action. The suggestion that transfer between districts was some kind of administrative barrier is unacceptable.

120. No adequate reason has been given for this major failing. The movement between districts is irrelevant to the concerns raised. I consider this a very significant failure.

DB's family's case should have been urgently transferred to Central Sydney CSC and a risk and safety assessment undertaken

121. SH gave evidence that she was trying to have the matter transferred but was having trouble with her manager (BG) to get it transferred.[65]

122. It was also reported to DCJ's Serious Case Review team, during its review, that when staff from Bankstown CSC contacted Central Sydney CSC and spoke to them about transferring the family to their office, Bankstown CSC were told that it was unlikely that the family would be allocated because The Benevolent Society was involved and the final risk level was "low".[66]

123. In my view Bankstown CSC had a responsibility to pressure Central Sydney CSC to take the referral or escalate the matter.

DCJ should not have closed the DB's family's case on 19 August 2015

124. Counsel assisting submitted that DCJ's decision to end its involvement with AS and her children was not an appropriate decision in all of the circumstances. She submitted that it was unsafe to close the case on 19 August 2015.

125. Counsel assisting submitted that DCJ were required to undertake a risk assessment prior to closing the case.[67] She submitted that the decision to close the file and not undertake a risk and safety assessment at this time was dangerous and left DB and TW vulnerable to serious harm.

126. Counsel for DCJ accepted that the decision to close the file was inappropriate but

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[64] Ex 2: Vol 2, Tab 75, Contact Record – ROSH report dated 5 August 2015.
[65] Transcript 17.10.23, p95.25.
[66] Ex 2: Vol 2, Tab 31, Serious Case Review/Internal Child Death Review (Office of the Senior Practitioner) dated July 2017, p49.
[67] Transcript 17.10.24, p104.29-105.19; Ex 2: Vol 4, Tab 113B, SDM Safety, Risk and Risk Reassessment, p33.

rejected the notion that it was also "unsafe" given the information available to SH at the time. DCJ submitted that even if the file had been transferred to Central Sydney CSC, it may still have been closed "a short time after that", given the children would likely have been considered safe at the grandmother's home and the fact that there were no further ROSH reports. I have considered the submission carefully, but reject it. In my view on the information known at the time of the move from Bankstown, it is correct to characterise closure as not just "inappropriate" but also unsafe. In this I place particular reliance on the concerns raised by CT and KD, the history of poor engagement and the fact that DCJ could not assume a move to the grandmother's home was safe without a proper assessment.

127. Counsel for DCJ also took issue with counsel assisting's characterisation of DCJ Policy, stating that it was not correct to say DCJ was *required* to undertake a risk assessment at this point. Counsel for DCJ noted that the last risk assessment had been undertaken on 3 June 2015 and had an outcome of "moderate". In these circumstances policy allowed closure with approval from the Manager Casework. While this may be correct, policy did require a safety assessment and risk assessment be conducted each time a ROSH report was received and clearly this had not happened. Counsel for DCJ also submitted that a closing safety assessment was not required because both prior safety assessments found the children "safe", not "safe with a plan".

128. Whatever the formal policy, I accept counsel assisting's submission that there was ample, current information available to DCJ which demonstrated that at the time of closing the case, the children were at risk of harm, including but not limited to:

    i. The history of the matter from 11 May 2015 including the content of the 7 ROSH reports;

    ii. AS's lack of engagement with the Brighter Futures program;

    iii. Brighter Futures' concerns about the family (including those raised in the ROSH report on 5 August 2015);

    iv. The email from KD to SH raising further concerns about the risks to the family and the fact that they would be closing their file[68];

    v. It was known to Bankstown CSC that the children were not "visible" in the community;

    vi. It was known to Bankstown CSC that the case was not going to be transferred to Central Sydney and Brighter Futures would no longer be involved and therefore there would be no one to check on the welfare of the children.

[68] Ex 1: Agreed Facts at [128]-[129] (also Annexure 1 to these findings).

129. SH's evidence demonstrates the inappropriate handling of the transfer. SH requested that the case be closed on 19 August 2015. SH could not remember if she contacted AS then or at any stage but imagined that she "would have". SH gave evidence that the matter would have been closed by DCJ by then. She stated that by late August, BG had contacted Central Sydney CSC and they had advised that because AS had been in Lilyfield and there hadn't been any further reports, they likely would not accept the transfer. SH recalls BG telling her that she had called Central Sydney CSC, but there is no documentation of this [69]:

130. In relation to the receipt of the email from KD and the closure of the file, SH gave evidence that:

> *Q. You'd got the email from [KD]. You had the background. When you requested the case was closed, to your manager--*
>
> *A. Yes.*
>
> *Q. --on 19 August, and that's when it looks like it happened from the paperwork, what did you think was going to happen?*
>
> *A. That the matter would be closed. What I was hoping was that another report would come through, which would re-open it in Central Sydney.*
>
> *Q. So you just had a hope that there'd be, what, another anonymous hotline complaint? Is that what you were hoping?*
>
> *A. She was in another district, where if there were concerns, they would be reported, and this was - during my discussion [BG] about her having had a conversation with Central Sydney, regarding the transfer. She said look, if concerns continue, Central Sydney isn't accepting, because they'd been - there hasn't been any further reports since that time, but if there are concerns and another report is made while they are there, they'll - it will get looked at.*

131. KD gave evidence that he tried to have a meeting with DCJ prior to the closure of their file (on 13 August 2015) without success.[70] KD's evidence was that as part of the Memorandum of Understanding, it was considered appropriate to have a meeting between DCJ and Brighter Futures prior to closing a matter. KD gave evidence that he requested a meeting by leaving a message with BG, and they had one brief interaction where he was to get a call back. There were also other unsuccessful attempts to contact BG.

132. It should be noted that BG was not available to give evidence in these proceedings.

[69] Transcript 17.10.24, p94.15.
[70] Transcript 17.10.24, p146.23.

However, I had the opportunity to hear KD give evidence and I accept his account. He impressed the Court as a witness of truth and I accept his recollection of these events.

133. SH also gave the following evidence[71]:

> *Q. So the situation, as at 19 August 2025 (as said) is that really, for this family to reconnect, a community member or the police, or something happening in terms of neglect and abuse to those children, had to occur for DCJ to be involved again?*
>
> *A. Yes, unfortunately. Yes.*

134. SH's evidence demonstrates a disturbing passivity and a lack of robust support at the Bankstown CSC. This is shockingly evident given the concerns SH had about the family at the time the case was closed[72]:

> *Q. Is it your evidence, and maybe danger's too high a word, but was it your evidence that at the time you closed this or DCJ closed this, it was approved by [BG], that you felt there was a danger present.*
>
> *A. I felt there was a danger present, yes.*

135. Ms Alexander clearly stated that DCJ should not have been considering closure. In her view the case should have been open, and there should have been active assessment work.[73] I accept her opinion on this issue.

136. Counsel assisting submitted that the manner in which the case was abruptly closed meant that DB and TW were at risk of serious harm. They were vulnerable and without oversight. I accept DCJ's submission that it cannot be known what would have occurred if DCJ had remained involved once AS moved in with her grandmother. However, in my view, given the known volatility of her family relationships, it was naïve at best to assume the move itself provided stability and safety. A period of intensive support and contact was clearly required. No medical assessments had taken place, no meaningful engagement or rapport had been developed, and issues raised in the ROSH reports remained largely unexamined.

137. Counsel for AM submitted that the Court should not accept counsel assisting's "veiled suggestion" that DB should have been removed from her mother's care prior to her departure from the Bankstown catchment area. This submission misses the point that it was because there was inadequate work done with the family, that the opportunity to properly consider an appropriate statutory response was lost. While I cannot know what might have happened had a DCJ file remained open, I can be certain that DB would

[71] Transcript 17.10.23, p99.41.
[72] Transcript 17.10.23, p105.21.
[73] Transcript 24.7.24, p69.18.

have been more visible and that alone would have increased her chance to avoid the horror which was to ensue.

Other matters impacting the care DB received

138. Counsel assisting raised a number of contextual matters which emerged at the hearing which had a detrimental impact upon the decisions made in relation to DB's family during the relevant period. In particular, consideration was given to the lack of supervision and support SH received as caseworker, the culture of the Bankstown CSC and the confusion in relation to the roles of DCJ and The Benevolent Society whilst the two agencies had open files. Counsel assisting also raised a question about whether having access to the audio recordings of the calls made to the Helpline would have been of assistance in this case.

Supervision and support

139. It was submitted that SH was inadequately supported and supervised. I accept that. As noted by Ms Alexander, "[AM]….was not involved in the case, but should have been".[74] Further it was submitted that the lack of supervision by BG seriously impacted SH's capacity to make appropriate decisions in respect of DB's family.

140. Professor Irwin and Ms Alexander emphasised the importance of supervision and agreed that SH received minimal supervision.[75] Ms Alexander agreed supervision is an important safeguard for a caseworker who may form a view that a report is "malicious"[76]:

> *…supervision helps people hold competing hypotheses, and you should always be able to understand things from different points of view, and not get stuck in one way of thinking. And the research about decision making highlights errors that are made when people maybe have an unconscious … bias towards something. So, this perhaps was a bias, which is if I just say it's malicious reports, and it could be unconscious. The caseworker might not even know she is doing it. It's malicious, it's malicious, then I don't have to worry about these children*.

141. SH agreed that supervision is essential to support caseworkers to make good decisions.[77] SH stated[78]:

> *Well, just to have a look at their practice, where they are with their caseloads. We, where we are with our caseloads; whether there's any supports required where the decision making has been sound; if there are holes in practice to address those*

[74] Ex 2: Vol 1, Tab 23, Statement of Katherine Susan Alexander of 12 September 2023 at [57].
[75] Transcript 24.7.24, p60.9.
[76] Transcript 24.7.24, p59.32.
[77] Transcript 16.10.23, p13.24.
[78] Transcript 16.10.23, p13.25.

holes; if there are any emotional issues that are arising from any particular case, then to address that, but mainly around caseloads, casework practice and supporting caseworkers to actually manage their work.

BG

142. The Court did not hear directly from BG who was deceased at the time of the inquest, but there was a significant amount of direct evidence about her work practices which was largely corroborated by her concessions to the ICDR and the findings of an independent report.

143. On the evidence before me, I am satisfied that BG failed to supervise SH adequately, leaving her unsupported in the context of a difficult case. SH required structured opportunities to debrief and to be guided in relation to issues arising in her contact with the family. I accept counsel assisting's submission that she did not receive this critical support.

144. SH recalled that she was required to have one supervision session with her manager per month but that she did not recall ever having a supervision session with her manager.[79] She could not remember any group supervision at that time[80] and the group supervision described in the Assessing Safety and Risk Mandate[81] was not practiced.[82] SH also stated that it could take weeks or months to get approvals, including for assessments.[83]

145. SH reported that BG's supervision generally was inadequate[84]:

    [BG] was very rarely - she had - she was very rarely in the office before 11. She had a very, I suppose, casual approach to coming to work. She would stay late, but the times that the team required her was through, during the day. She was rarely available for us to consult with.

146. With respect to DB's case, SH recalled the type of supervision she received as follows[85]:

    So when we went out to do home visits we would - prior to the home visit we would have a PAC, pre-assessment consultation, so [BG] was involved in that. After the visit we would have an assessment consultation, which happened after a visit, to let her know what our observations were of the visit, and of the family. Then we would

[79] Transcript 16.10.23, p14.48.
[80] Transcript 16.10.23, p15.22.
[81] Ex 2: Vol 5, Tab 114G, Assessing Safety and Risk Mandate, p7.
[82] Transcript 16.10.23, p15.39.
[83] Transcript 16.10.23, p16.40.
[84] Transcript 16.10.23, p15.45.
[85] Transcript 16.10.23, p16.6.

discuss what steps to take. So within that context that was her input into the casework.

147. The support BG offered in pre-assessment and assessment consultations was not adequate. BG, herself, told the team preparing the Serious Case Review that she did not provide SH regular supervision and support.[86]

148. The poor supervision provided by BG, as reported by SH, is corroborated by the findings of the investigation report dated June 2017 into BG's conduct[87] which found, amongst other things that:

    A. BG failed to carry out her responsibilities efficiently and professionally;

    Cases have been literally unmanaged, sometimes for many months. Some cases were identified with almost total lack of MCW oversight or input;

    B. Casework staff were frustrated, overburdened and stressed by BG's lack of management, supervision and availability;

    C. BG was sometimes known to react adversely or indifferently to criticism.

149. While I have no problem with accepting BG modelled poor work practices at Bankstown CSC during the relevant period, I remain disturbed that so many people must have known about the dysfunction and yet it continued for an extended period.

AM

150. Counsel for AM was concerned that she had not been provided procedural fairness, given the Court had regard to reports and reviews to which she had not been given the opportunity to be involved. Further it was suggested that unfairness lay in the fact that BG, and AM's superior, Patricia Moffat (Director Community Services, DCJ) were not called. I reject the submission, noting that AM was given every opportunity to respond to concerns about the relevant events. She was legally represented and as far as I am aware made no requests for other witnesses to be called or other documents considered.

151. SH stated that she did not have any day-to-day involvement with AM and never spoke to AM about DB's case.[88] AM stated that to the best of her recollection she was not involved with the case management of DB or her family.[89]

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[86] Ex 2: Vol 2, Tab 31, Serious Case Review/Internal Child Death Review (Office of the Senior Practitioner) dated July 2017, p 62.
[87] Ex 3, Tab 1: Report from the Fact-Finding Investigation into [BG], Manager Casework at Bankstown Community Services dated June 2017 (pages 3-6).
[88] Transcript 16.10.23, p14.35-14.44.
[89] Exhibit 3: Tab 3, Statement of AM of 12 October 2023, p2, Q1/A1.

152. Ms Alexander noted AM's absence and important role at the point of closure[90]:

There is no information that [AM] had any oversight of the decision for DCJ to end its involvement in this matter…… The role of MCS was critical at this point as practise leader for the unit, as was the manager case work, to support and guide a strong casework response, through practise leadership and supervision.

153. Further, Ms Alexander stated that "it was evident that there was no oversight of casework decisions [in relation to DB] by [AM], as Manager Client Services. This was later confirmed after [DB's] death when the District undertook an extensive independent investigation of the management of the office".[91]

154. On 16 October 2023, AM gave evidence acknowledging that she was asked to address in her statement: "the level of support provided to [SH] by [BG], yourself, or other persons who had supervisory or management roles in relation to [SH]" and that her answer was: "[BG] was a very experienced manager caseworker, MCW". AM said she had nothing further to add to that answer.[92]

155. In relation to any circumstances at the relevant time including staff levels and other issues which may have impacted on the capacity of SH or BG to perform their roles, AM could not recall the numbers and information on staffing and allocation rates at the time.[93]

156. AM confirmed there was an informal complaint made against BG by some of the members of BG's team which related to "BG's timeliness in processing Court work and Court matters, the time she was arriving at work and the fact that there was often frequent late-night consultations".[94] AM gave evidence that prior to the informal complaint being made, she was aware that BG's team did not have formal supervision times.[95]

157. In response to various findings arising from the investigation into BG's conduct, AM said that she did not observe failures to carry out responsibilities efficiently and professionally or cases being "unmanaged" in relation to BG.[96]

158. When AM was recalled to give evidence on 24 July 2024, she initially confirmed that the only issues she was aware of with regards to BG's supervision of caseworkers over the relevant period was that the supervision was occurring at irregular hours and "it

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[90] Ex 2: Vol 1, Tab 23, Statement of Katherine Susan Alexander of 12 September 2023 at [59].
[91] Ex 2: Vol 1, Tab 23, Statement of Katherine Susan Alexander of 12 September 2023 at [57].
[92] Transcript 19.10.23, p197.37-198.9.
[93] Ex 3: Tab 3, Statement of AM dated 12 October 2023, p3; Transcript 19.10.23, p198.5.
[94] Transcript 19.10.23, p198.50.
[95] Transcript 19.10.23, p200.14-30.
[96] Transcript 19.10.23, p202.48.

wasn't happening enough."[97] AM confirmed that in her view the supervision BG was providing was "adequate".[98]

159. AM was taken to a number of documents in exhibit 5, including email exchanges with BG and Ms Moffat relating to issues with case reviews, including "a lack of case reviews and reporting". AM agreed that completing case reviews was a factor relevant to quality or capacity to supervise caseworkers. She stated that she did not mention this in evidence on 19 October 2023 because she did not recall it.[99]

160. Later, in response to an email dated 14 August 2015 which related to the completion of work including case reviews, supervision and SARA timeframes, AM accepted that those matters would have been relevant to the sort of support that DB's family was receiving.[100]

161. AM agreed that part of her role was to identify crucial gaps in practice.[101] AM believed her processes to identify gaps were adequate[102] but also accepted that her processes did not identify the gaps which were identified by those undertaking the audit for "accreditation with the Children's Guardian at Homecare"[103]. Counsel assisting submitted that based on this evidence, AM was being guarded about aspects of her own work which could be open to criticism.

162. I considered AM's demeanour and participation in these proceedings very carefully and came to the conclusion that she was defensive on this and other issues. Her evidence in relation to BG is at odds with other accounts and fails to identify the toxic culture that developed at Bankstown CSC. AM appeared to downplay her responsibilities for managing BG.

163. When she was recalled to give evidence on 24 July 2024, AM accepted that BG had more outstanding work than other managers, at least in the weeks (or possibly months) leading up to 11 August 2015.[104] She also told the Court that she had some difficulties in recalling that period.[105]

164. AM agreed that there was an accumulation of issues (relating to BG) and it was getting worse.[106]

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[97] Transcript 24.7.24, p5.10.
[98] Transcript 24.7.24, p5.36.
[99] Ex 5: Tab 18 (Email dated 20 November 2014); Transcript 24.7.24, p7.25-8.5; Ex 5, Tab 29 (Email dated 9 June 2015); Transcript 24.7.24, p9.
[100] Transcript 24.7.24, p12.15.
[101] Transcript 24.7.24, p10.25.
[102] Transcript 24.7.24, p10.34.
[103] Transcript, 24.7.24, p9.26-10.37.
[104] Transcript 24.7.24, p11.45.
[105] Transcript 24.7.24, p11.48-12.2.
[106] Transcript 24.7.24, p12.40.

165. AM gave evidence that she was shocked to receive an email on 18 August 2015 from BG, which set out the pressures BG was experiencing and indicating she would call the 'PSA' to complain that she was receiving a lack of practical support.[107] AM said that she was starting to be worried about BG's mental health, was worried about her in terms of stress and was concerned about her emotional wellbeing.[108] AM gave evidence that BG would get very angry at her whenever she asked her about her performance. AM recalled that about this time,[109] she started talking to her Director Community Services about the issue going down a formal process of monitoring.[110] AM also recalled that BG was very unwell and having a lot of pain and she encouraged her to have a medical evaluation.[111] AM recalled offering for BG to see an EAP[112] counsellor in mid-August.[113]

166. AM gave evidence that those sort of difficult conversations and emails from BG had been increasing gradually in the lead up to this email of 18 August 2015.

167. In an email between Ms Moffat and AM dated 18 August 2015, AM wrote "I know you have experience managing chaotic and underperforming individuals, and I would certainly appreciate any strategies you can offer". AM agreed that she used those words "chaotic and underperforming" because that was her opinion of BG as at 18 August 2015 as she was not performing well.[114]

168. Counsel assisting acknowledged the passing of time may have affected AM's memory in relation to the detail of the issues she was having with BG in 2015. She drew attention to AM's evidence that it was difficult for her with BG being "chaotic"[115] and that she may have supressed how difficult it was.[116]

169. However, counsel assisting submitted that given the extent of the problems, how worried AM was about BG and that she was required to escalate the matter to Ms Moffat, it is not reasonable to believe that AM was trying her best on 16 October 2023 to give a full account of her understanding of BG's capacity to supervise SH.

170. Towards the end of AM's evidence, she maintained that she was of the opinion that her oversight of the casework decisions at the relevant time was adequate.[117] However, AM agreed that it was her role at the critical point when the case was being closed to

[107] Transcript 24.7.24, p16.18; Ex 5: Tab 40 (Emails dated 18 August 2015).
[108] Transcript 24.7.24, p16.
[109] This date is by reference to the email that AM was being questioned about at Transcript 24.7.24, p13-14.
[110] Transcript 24.7.24, p14.28.
[111] Transcript 24.7.24, p14.43.
[112] Employee Assistance Program
[113] Transcript 24.7.24, p17.19.
[114] Transcript 24.7.24, p18.44.
[115] Transcript 24.7.24, p19.15.
[116] Transcript 24.7.24, p19.11.
[117] Transcript 24.7.24, p20.48.

support and guide a strong casework response[118] but that she did not have oversight of DCJ's decision to end its involvement in the case.[119]

171. I have considered the evidence carefully and made allowances for the possibility that AM's memory may have been impacted by the passing of time, but I do not accept that she was committed to participating in the inquest process with honesty and openness. Her evidence was defensive and partial. She was a senior employee at the relevant time and she demonstrated little ability to assess with hindsight what had happened.

172. Having reviewed the material before me, I accept Ms Alexander's evidence that clearly indicates that AM did not have adequate oversight of the quality of supervision that that was provided to caseworkers at Bankstown CSC and was not adequately involved in the decisions that were being made.

Impact of lack of supervision

173. In response to the lack of supervision by BG, SH stated she did not go to AM. She said that AM and BG were friends and that there had been repercussions for caseworkers who had made complaints about BG.[120] Initially SH said she did not know if the supervision issues impacted her work with DB's family. She thought she was acting in an appropriate manner at the time, but she now recognises that she should have gone above BG's head to put more pressure on DCJ to transfer DB's family to the new CSC.[121] SH later accepted that the lack of supervision support did impact her decision making.[122]

174. Counsel assisting submitted that the lack of support and supervision received by SH whilst working with DB's family had a significant, negative impact on her decision making and capacity to manage the safety risks in relation to DB's family, which were obviously present. I accept that submission.

Pathways for support

175. SH was questioned about why she did not seek support elsewhere when she was receiving inadequate supervision from BG[123]:

Q. --that perhaps maybe it would've been appropriate to go above--

A. [BG].

Q. --[BG] at that time?

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[118] Transcript 24.7.24, p20.30.
[119] Transcript 24.7.24, p21.5.
[120] Transcript 16.10.23, p17.48-18.5.
[121] Transcript 16.10.23, p18.19.
[122] Transcript 16.10.23, p18.44.
[123] Transcript 16.10.23, p69.1.

A. Looking back on it now, I should have, yes. If I didn't - looking back on it now, if I did not feel comfortable going to the manager client services, but there were other manager caseworkers that I should have approached with my concerns, and if I could do it again, that's what I would have done. Yeah.

176. The Serious Case Review was critical of the leadership team at Bankstown CSC and highlighted the importance of strong leadership and strong systems to keep children safe [124]

> *A critical but missing piece of the response to [DB] and [TW] was the lack of strong practice leadership from the manager client services and other District leaders to ensure that systems designed to keep children like [DB] and [TW] safe were in place. The review encourages the reader to ponder the question about where responsibility for practice starts and ends. The nature and seriousness of the reported issues, and the disparity between them and the casework response, highlights not only the inadequacy of the practice but an absence of strong leadership and systems. To this end, recommendations are made for the District that aim to strengthen practice leadership and monitoring of decision-making at Bankstown CSC.*

177. At the time Ms Alexander was giving evidence (24 July 2024), she indicated that DCJ was due to launch an updated supervision policy at the end of 2024 (initially brought in in 2019,[125] which was monitored and reported on in DCJ) which will make clear that caseworkers can expect a weekly compulsory group supervision session, and up to nine individual supervision sessions a year. Ms Alexander said that this "gives caseworkers the gravitas if you like, to say I am not getting my needs met, because here is a policy".[126] Mr Malcher was unsure as to the status of the availability of that updated policy when he gave evidence on 16 October 2024.[127]

178. Counsel for DCJ advised the Court that after the closure of evidence, further internal policy shifts have confirmed that group supervision of Helpline staff will remain after the new policy is finalised.

The Bankstown CSC workplace culture

179. On 16 October 2017, an investigator was engaged to conduct an independent fact-finding investigation into matters including the broader culture and operations at the

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[124] Ex 2: Vol 2, Tab 31, Serious Case Review/Internal Child Death Review (Office of the Senior Practitioner) dated July 2017, p6.
[125] Transcript, 24.7.24, p60.25 – noting that the supervision police was approved in 2018 (see Ex 2: Vol 5, tab 114J, Supervision Policy for Child Protection Practitioners).
[126] Transcript, 24.7.24, p60.29-30.
[127] Transcript, 16.10.24, p22.25.

child protection unit at Bankstown CSC.[128] The investigation involved the interview of 19 staff members and a review of a considerable amount of written and other material which included transcripts of interviews, correspondence, emails, social media posts. The investigation took eight weeks to complete. The investigation concluded that[129]:

> *…the Child Protection Unit at Bankstown CSC is experiencing many serious problems which are having a significant impact on staff morale and the efficiency of the business unit. Most of the issues are systemic and relate to habitual behaviours that have been continuing for several years. The major cause of the dysfunction would appear to stem from a general lack of boundaries between personal and professional relationships, the large group of staff and ineffective leadership.*

180. This conclusion was read to SH in Court and she agreed that during the time she was working with DB's family, that the above assessment of Bankstown CSC was accurate.[130]

181. KD's impressions of the Bankstown CSC also raised culture issues[131]:

> *….it was, in my experience, very challenging to work in a collaborative way with that particular office. Rather, I previously had access to manager caseworks direct lines and mobile phone numbers, and vice versa. At that time I was required to go through the switchboard, so reception, and I found that often my calls may not get put through, or I may not receive a call back. My - I had limited experience at the relevant time, being physically inside that office for - not related to DB and her family, but for other matters, and it did feel quite toxic*

182. AM, on the other hand, did not consider that there were culture issues at the Bankstown CSC during the relevant period[132]:

> *Q. Just to be clear, is it your evidence that as far as you were concerned there were no culture problems at Bankstown CSC--*
>
> *A. Yes.*

183. Counsel assisting submitted that I should not accept AM's evidence on this issue.

184. In my view the reliable evidence supports a finding that there were significant internal issues which created a poor workplace culture at Bankstown CSC at the relevant time. I specifically rely on the evidence of SH and KD in this regard. AM's evidence outlining

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[128] Ex 3, Tab 2, Investigation Report – Concerns, culture and operation of the Child Protection Unit, Bankstown Community Services Centre dated 2- December 2017 (pages 3, 241-244).
[129] Ibid, p1 at 5.1 [sic].
[130] Transcript 16.10.23, p18.30.
[131] Transcript, 17.10.23, p131.10.
[132] Transcript, 19.10.23, p206.39.

the difficulties she was having managing BG at the relevant time was also persuasive in coming to a finding that the Bankstown CSC was a workplace that did not function appropriately.

185. There were also the findings of the independent investigation. Whilst the investigation commenced in October 2017, approximately 2 years after the time DCJ was involved with DB's family, the report refers to "the fact that a large number of staff have behaved inappropriately *over a number of years"*[133]. In that context I can safely accept the possibility that serious cultural issues existed at the relevant time.

186. Mr Stuart Malcher, who held the position of Director Community Services for the South Western Sydney Districts between 5 December 2016 and 30 July 2021,[134] was responsible for engaging Ms Kathy Thane to conduct the fact finding investigation into Bankstown CSC. It is noted that this report did not make any findings against SH, BG or AM and they were not interviewed, as none of them were working at Bankstown CSC during the investigation period.[135] Mr Malcher stated that many of the recommendations made by Ms Thane in relation to improving the office were adopted.[136]

187. Mr Malcher confirmed there had been a significant change in leadership of the office[137]:

> *The district appointed a high performing MCS in early 2018, undertook extensive work on identifying and implementing clear systems, processes and expectations for Bankstown CSC, which have greatly aided role clarity, performance and responses to children and families and office cohesion.*

188. In evidence, Mr Malcher appeared proud of the work that had been achieved at Bankstown CSC following the implementation of a number of the recommendations from the report. He reported that there has been a significant culture shift and he described the work done to improve the office had been "transformative"[138]:

> *It was just a night and day kind of environment to work within. You know - so certainly their performance went from being poor, to below average, to being one of the best performing units in the district at the time.*

189. SH gave evidence that the toxic environment she experienced at Bankstown CSC is not her experience now (though it is unknown where SH currently works):

> *Q. What would you do now?*

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[133] Ex 3, Tab 2, Investigation Report – Concerns, culture and operation of the Child Protection Unit, Bankstown Community Services Centre dated 2- December 2017, p2 at 7.1.2.
[134] Ex 5: Tab 2, Statement of Stuart Malcher of 20 February 2024 at [10].
[135] Ibid [34].
[136] Ibid [48].
[137] Ibid [50].
[138] Transcript, 16.10.24, p27.42-28.8.

A. I would go to my manager client services. Can I just say - just make one point? That sort of scenario doesn't happen often. It's the first time that - I've been with DCJ now for, what, 24 odd years, and that's the first time I was faced with a scenario like that where the environment was so toxic that you really didn't know where to turn. I've never faced that before in the 24 years that I've been with DCJ. So, with regards what I would do now, absolutely, but it's not a scenario that happens often enough for me to go, okay, I need to do this because it just doesn't happen. DCJ generally is a fairly - especially now, it's very equality-based and there are report instructors and there are checks and measures. Yeah.

190. Counsel assisting submitted that significant efforts were made to improve the workplace culture at Bankstown CSC, commencing with the engagement of an independent investigator by Mr Malcher to properly identify the issues underpinning the problems at Bankstown CSC. Further, the implementation of the recommendations and changes in leadership are likely to have produced positive results. I accept this submission.

191. Counsel for SH drew my attention to her evidence that suggested she had reflected intensely on what had occurred and that she would now do things differently. She stated:[139]

Would I do things differently now? Absolutely. Would I go above [BG]'s head, in relation to what my concerns were at the time? Absolutely. I think this needs to be a lesson in exploring other avenues, and keeping that child at the focus, rather than the politics of the environment that you might be working in, and letting that impact on your practice.

192. The real dangers of a dysfunctional work environment are well illustrated in this case. Workers doubted their own instincts, were inadequately supervised and ended up losing sight of their responsibilities. I accept counsel's submission that SH is devastated when she looks back at what occurred. She understands that she should have gone above BG's head and clearly recognises the toxic work environment she found herself a part of.

Roles and responsibilities

193. SH and CT's understanding of each of their roles whilst they were both working with DB's family lacked clarity. At times this led to confusion as to who was responsible for particular tasks.

194. CT told the Court that she assumed that SH was undertaking all aspects of her role at DCJ. CT explained that her understanding of SH's role at that time was "different" to

[139] Transcript 17.10.23 p100.21-25.

what CT has since come to understand.[140] CT believed at the relevant time that SH's role was "to assess the immediate safety of the children and respond to any ROSH reports that were received"; that when a fresh ROSH report came in, it would be SH's responsibility to investigate that report; that SH had "lead over the case as the statutory body"; that CT would take her lead from DCJ and follow DCJ's direction if DCJ had an open case.[141] CT gave evidence that there was never a discussion or time put aside to discuss allocation of roles and responsibilities.[142]

195. KD was of the view that there was ambiguity in relation to whose role it was to arrange medical or disability assessments[143]:

> *Q. Was it Brighter Futures' responsibility in this case, whilst ever Brighter Futures had carriage of it, or had accepted the referral, I should say, to arrange and make those assessments?*
>
> *A. I think with DCJ remaining open that occasionally complicated the boundaries of the roles, and certainly in the - at that relevant time, the recourse that The Benevolent Society lead agency had in Brighter Futures' program was to seek community referral, like, so community health options, which often were lengthy delay lists; where if DCJ were to make a referral it would often be prioritised because it was coming from a statutory agency. That was my experience at the time.*

196. However, given the pattern of engagement with AS, he was of the view that it is unlikely Brighter Futures would have arranged the assessments.[144]

197. KD agreed that DCJ keeping an open file created ambiguities[145]:

> *Q. With respect to DB's case, can you elaborate any further on ambiguities and responsibilities that were unclear?*
>
> *A. It was my perspective or understanding at the time that because of – during the relevant period when we - when the ROSH report came in on 20 July, that lead - the case management responsibility for DB and TW transferred back to [SH].*
>
> *Q. Did it create some ambiguity for you, in your role as case worker, for Brighter Futures to have an open file working with the family and your own case file open too?*
>
> *A. Yes, there was because it's - once you have transferred a file to a non-government*

[141] Transcript 19.10.23, p173.7.
[141] Transcript 19.10.23, p173.7.
[142] Transcript 19.10.23, p173.7.
[143] Transcript 17.10.23, p140.20.
[144] Transcript 17.10.23, p140.40.
[145] Transcript 17.10.23, p149.48.

agency it's expected that they're managing the case. So, if it's open with them, and it's an ongoing case work that is being required, then the expectation is the non-government agency that the file sits with are the ones that should be doing the casework. So, it does create some ambiguity.

198. KD stated that there was no process for defining the caseworkers' respective roles in a document but agreed that that would have been something useful for SH and CT.[146]

199. Professor Irwin agreed that their roles were unclear because they did not sit down and "work it out"[147] and that best practice required them to be clear about what each of you have got to do, and that will vary in different situations.[148]

200. Ms Alexander clearly stated that it was SH's role to have been doing new safety assessments or safety reassessments each time new ROSH report came through.[149]

201. Counsel assisting submitted there appears to be work to be done to improve the guidance available to support caseworkers from DCJ and other agencies to clearly define their roles when working with the same family. DCJ appears to accept this. Mr Malcher confirmed that there will be practical tools or requirements for two caseworkers (working in different agencies) to sit down together and have clarity about their roles. The detail is still to be worked out but DCJ appears to recognise that this is an important area to clarify.[150]

202. Counsel for DCJ ultimately conceded that by keeping the DCJ file open after the premature referral to Brighter Futures significant role ambiguity was created in the minds of both SH and CT. In my view, it should always have been clear that DCJ retained responsibility to investigate the ROSH reports, but it is easy to understand how DCJ's open file was confusing to CT. And clearly an explicit discussion about their roles would have assisted.

Access to audio recordings of helpline reports

203. SH appeared to assume that the majority of the Helpline calls were being made by the same person. She stated[151]:

I think, look, because I think it was minimised based on the fact that all of the reports appeared that they were coming from the same source, the same anonymous reporter, and even though they were escalating in severity, I don't think that was looked past by [BG].

[146] Transcript 17.10.23, p151.7.
[147] Transcript 24.7.24, p50.18.
[148] Transcript 24.7.24, p50.21.
[149] Transcript 24.7.24, p50.31.
[150] Transcript 16.10.24, p18.36-50.
[151] Transcript 16.10.24, p49.42-45.

204. SH was not aware that she could have asked the Helpline to verify whether the reports were in fact from the same person. She agreed that it would be helpful for caseworkers and their managers to be able to verify whether the reports are being made by the same person, or not.[152]

205. In preparation for the hearing, Ms Alexander's team went back and listened to the Helpline calls and was able to identify that there were five different voices who made the calls.[153] In reflecting on the calls, Ms Alexander stated:

> *The fact that five young, young women, and that was the thing that stood out most to me when I listened to those calls, and I won't forget them. They were young, and they sounded so worried. The fact that young women, many of them had some drug problems, some homelessness problems themselves, had the courage to make those calls as anonymous reporters, and the fact that five of them did it, I think was very compelling.*
>
> *But I'm not sure it would have been less compelling if the same woman had reported five times. What they said was powerful, and spot on about the children, and they were very child focused in the choices they made to make those calls. So, yes, I agree that it would have been useful, but there was enough there. There was enough there without knowing whether they were different or not.*

206. Professor Irwin stated that it would be helpful for caseworkers to have the opportunity to listen to Helpline calls in complex cases.[154] Ms Alexander agreed with Professor Irwin but raised practical concerns about enabling caseworkers to have access to the recordings including time, privacy and resourcing.[155] Ms Alexander stated that caseworkers are aware that they may be able to listen to the Helpline calls. Professor Irwin did not know that the calls were "readily available".[156]

207. Mr Malcher agreed that there could be a benefit in making caseworkers and their supervisors aware of the ability to access audio calls[157] but that advice should not sit in advice relating to "malicious" reporting, it should be separate. He was of the view that the calls should only be accessed rarely, where there is a real need[158] as caseworkers should be relying on the information in front of them to conduct a holistic assessment.

208. Counsel assisting submitted that had SH been aware of the option of listening to the calls and had taken up that opportunity, this may have cast doubt upon her acceptance

[152] Transcript 16.10.24, p41.21.
[153] Transcript 24.7.24, p64.9.
[154] Transcript, 24.7.24, p64.48.
[155] Transcript, 24.7.24, p65.19.
[156] Transcript, 24.7.24, p66.
[157] Transcript 16.10.24, p13.3.
[158] Transcript 16.10.24, p13.15.

on AS's claim that the calls were "malicious". This is because she would have been made aware that the reports were being made by more than one person and the young women who were making the reports sounded worried, as described by Ms Alexander. Given SH and Professor Irwin were not aware that the Helpline calls are available to listen to, it may not be "common knowledge"[159] that caseworkers can do that.

209. While counsel assisting accepted that there are resourcing issues associated with making Helpline calls available to caseworkers and their managers, she submitted that consideration should be given to making a recommendation that DCJ develop guidance for child protection workers which:

    A. informs caseworkers and their managers of the availability of the audio Helpline reports; and

    B. provides managers with assistance to make decisions about when it may be appropriate for audio Helpline reports to be made available to support decision making.

210. It is an issue to which I will return.

Adequacy of other specific policies and guidelines

211. Finally, an issue to be examined at this hearing was "whether DCJ's policy and guidelines provided adequate guidance to staff for the purpose of supporting AS and her children". Counsel assisting submitted that DCJ's work with this family fell well below the expected standards, noting that the decisions being made were likely to have been detrimentally impacted by BG's lack of supervision, the absence of appropriate leadership from AM and the existence of a dysfunctional workplace culture. I accept that submission.

212. I also accept counsel assisting's submission that within this context, it is difficult to isolate particular policies or guidelines that should be reformed. That is not to say that change is not required. In this context my attention was drawn to the reforms and changes that have taken place since DB's death and which are ongoing.

Serious Case Review: findings and recommendations

213. An Internal Child Death Review[160] dated July 2017 into the death of DB was conducted by DCJ's Office of the Senior Practitioner. The ICDR made three findings[161]:

    1. The Child Protection Helpline did not include all contextual information in the

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[159] Transcript, 24.7.24, p76.31
[160] Ex 2: Vol 2, Tab 31, Serious Case Review/Internal Child Death Review (Office of the Senior Practitioner) dated July 2017
[161] Ibid, p 8

records created about reports received. This information was crucial for caseworkers at the CSC to better understand [DB] and [TW]'s experiences in their mother's care and to inform safety and risk assessments.

2. In the context of the information obtained by the Helpline, the screening and recommended response time was sound, appropriate and mostly reflected the urgency of risk accurately.

3. [DCJ], via South Western Sydney District, missed numerous opportunities to protect [DB] and [TW]; did not use its people well; did not respond with appropriate urgency and skill to consistent information that the children were in danger and ended its involvement abruptly and with no justification, leaving them without safety, defences or advocates.

214. The Serious Case Review process was a rigorous examination of what had occurred. Professor Irwin and Ms Alexander both agreed with the findings and recommendations of the Serious Case Review, Ms Alexander stating[162]:

I agree, wholeheartedly. It was - that report was my responsibility. I am responsible for the team, and I actually wrote aspects of the report myself. I am very familiar with the report, so I wholeheartedly agree with it.

215. The Serious Case Review made seven recommendations relating to practice and staffing. I have included counsel assisting's useful table below. It sets out the seven recommendations and the evidence by Ms Alexander addressing DCJ's response to the recommendations.

Recommendation	DCJ Response
Recommendations for practice	
1. That this review be referred to the Serious Case Review Panel to consider the practice and system issues identified, and where applicable, to make recommendations in light of these.	Ms Alexander confirmed that the implementation of this recommendation is complete. No further recommendations were made by the panel but insights from the serious case review could be shared with teams within DCJ that were leading broader reviews.[163]
2. That this review be referred to the Executive Director, Statewide Services to consider the practice and system issues	Ms Alexander confirmed that the implementation of this recommendation is complete.

[162] Transcript 24.7.24, p30.30
[163] Ex 2, Vol 1, Tab 23, Statement of Katherine Alexander dated 12 September 2023 at [31]-[33]

identified in Helpline practice, and where applicable, to respond accordingly in light of these.	The Director Helpline informed the Serious Review Panel that the review had led to immediate steps being taken to address issues raised including: • Work with Helpline staff to review the language used in reports from the Helpline • The Helpline was prioritising building better relationships with districts to encourage feedback from the districts • Leadership - changing the focus of managers meetings to practise meetings • The relevant department was to review a number of the Helpline reports to provide advice on improving documentation in reports • The crisis response team (CRT) were to be included in the Serious Case Review process in the future • A helpline casework specialist was being assigned to support the CRT[164]
3. That the OSP review team facilitates a reflective session with relevant [DCJ] and Brighter Futures staff to reflect on the inter-agency work with this family.	Ms Alexander confirmed that the implementation of this recommendation is complete. A meeting took place with the Director of the Serious Case review, Ms Alexander, Executive District Director of South Western Sydney, Directors Community Services and Manage Client Services from each of the CSC's in the South Western Sydney District in Relation to the Serious Case Review in November 2017.[165] Ms Alexander stated that KD declined the offer to read and reflect on the learning from the review because of the impact that DB's death had had up on him.[166] KD stated that he was not offered the opportunity to participate in a reflective session in November 2017

[164] Ibid at [35]-[37]
[165] Ibid at [41]
[166] Ibid at [40]

	and it is not known how the misunderstanding has come about.[167] Ms Alexander stated that CT had left The Benevolent Society and could not be located.[168] CT stated that she did not recall receiving an email inviting her for a reflective session.[169] KD and CT's participation at the inquest was very important to understand the issues at the relevant time.
4. That Auburn CSC arranges a paediatric and psychological assessment for [TW] to inform a tailored and long-term treatment plan. A suitably qualified expert should complete any assessment undertaken so that [TW] has the best opportunity to heal from the abuse and neglect he has experienced.	Ms Alexander confirmed that the implementation of this recommendation is complete. On 9 June 2017 a meeting occurred between a DCJ representative and the director of a support service associated with TW. TW commenced counselling in July 2017 and 'continues to receive this counselling'. On 13 January 2017 primary health screen referral was made for TW and the assessment was completed by a paediatrician on 21 April 2017. Areas in native support were identified and my health management plan was developed including (initially) 6 monthly review. [170]
5. That Auburn CSC work with [DCJ] Legal Services to ensure an application for victim's compensation is made for [TW].	Ms Alexander confirmed that the implementation of this recommendation is complete. TW's claim for victim's compensation was approved on 9 June 2020, having been submitted by 'FACS Legal' on TW's behalf.[171]
Recommendations for staffing	
6. That this review is referred to the Deputy Secretary Northern and Executive District Director South Western Sydney for consideration of staffing issues in light of the concerns identified about practice, with the aim of	Ms Alexander confirmed that the implementation of this recommendation is complete. An independent investigation was undertaken in relation to the operation and culture of Bankstown CSC[172].

[167] Ex 12: Letter from Pinsent Masons to the Crown Solicitor's Office on 1 November 2024; Transcript 17.10.23 p156.45-157.20
[168] Ex 2, Vol 1, Tab 23, Statement of Katherine Alexander dated 12 September 2023 at [40]
[169] Transcript 19.10.23 p168.4-19 and p190.40
[170] Ex 2, Vol 1, Tab 23, Statement of Katherine Alexander dated 12 September 2023 at [43]-[45]
[171] Ex 2, Vol 1, Tab 23, Statement of Katherine Alexander dated 12 September 2023 at [46]-[47]
[172] Ex 3: Tab 2, Investigation Report – Concerns, culture and operation of the Child Protection Unit, Bankstown Community Services Centre dated 20 December 2017 (pages 3, 241-244)

strengthening practice leadership and monitoring of management decision-making at Bankstown CSC	An investigation was also undertaken in relation to the conduct of BG.[173] These investigations are referred to above.
7. That the OSP Director Practice Support, Southern Cluster completes a CSC review for Bankstown to determine the adequacy and quality of practice. The terms of reference of the review are to be decided with the Executive District Director South Western Sydney. On completion, the review is to be provided to the Deputy Secretary Northern to respond accordingly.	Ms Alexander confirmed that the implementation of this recommendation is complete. As per response to recommendation 6.[174]

216. This inquest identified as a key issue "the extent to which DCJ have assessed and implemented recommendations identified in the Serious Case Review". Based on the steps taken as identified above by Ms Alexander, counsel assisting submitted that DCJ has responded directly to each recommendation and has done so adequately. I accept that submission.

217. Counsel assisting drew my attention to Ms Alexander's statement which sets out other relevant changes to DCJ policies and procedures following DB's death in relation to[175]:

   A. Child Protection Helpline

   B. The Practice Framework Implementation and evaluation

   C. Practice Kits and Advice

   D. Developing Practice Leadership

   E. Improved training and the Better Decisions for Children Project

   F. Collaborative Practice in Child Wellbeing and protection

[173] Ex 3: Tab 1, Report from the Fact-Finding Investigation into [BG], Manager Casework at Bankstown Community Services Centre dated June 2017 (pages3-6)
[174] Ex 2, Vol 1, Tab 23, Statement of Katherine Alexander dated 12 September 2023 at [53]-[54]
[175] Ibid at [64]-[139]

G. Improvements in the Brighter Futures Programs

H. Improvements to practices to enhance engagement with families.

218. Each of the above initiatives and areas of change touch upon issues relevant to issues arising in DB's case. There was inadequate time to examine the nature and impact of the extensive changes which Ms Alexander outlined in her statement.

The need for Recommendations

219. Navigating the detail of DCJ policies and procedures as an outsider is always difficult when it comes to considering the need for recommendations.

220. Given the significant reform processes that are currently underway in relation to DCJ's policy and practice, including reform in relation to areas which are specifically relevant to the issues arising in this inquest (DCJ assessment tools to improve decision making[176], supervision policy[177], defining roles and responsibilities when working with third party agencies[178]) counsel assisting submitted that there may be limited utility in making specific recommendations in relation to those contextual issues. I accept that submission.

221. The issue of caseworkers labelling ROSH as "malicious" or "vexatious" has already received some attention by DCJ.[179] For this reason I do not consider it necessary to make a specific recommendation in relation to this issue.

222. Counsel assisting submitted a single recommendation for consideration:

That DCJ develop guidance for child protection workers which:

A. informs caseworkers and their managers of the availability of the audio Helpline reports; and

B. provides managers with assistance to make decisions about when it may be appropriate for audio Helpline reports to be made available to support decision making.

223. DCJ did not support the recommendation. It submitted that the purpose of the recommendation, which in the context of this inquest relates primarily to the identification of suspected malicious or vexatious complaints has already been addressed by the work done by the Practice Quality Unit developing a guideline on malicious complaints. Ms Alexander's evidence was that the focus should be on "constantly holding an open mind, constantly testing evidence, constantly holding

[176] Ex 2, Vol 1, Tab 23, Statement of Katherine Alexander dated 12 September 2023 at [114]-[119]
[177] Transcript, 24.7.24, p60.27
[178] Transcript 16.10.24, p18.36-50
[179] [37(C)], p13 above

competing hypotheses and constantly reflecting on your response to information. That's the most important bit, and if you get that right, we shouldn't even be talking about malicious reports".[180] Ms Alexander made it clear that a report may be both malicious and true, and in any case an open mind must be maintained while further investigations take place. She gave the example of reports given during family separations where the purpose of the report may be malicious, but where the information provided is actually correct and worthy of investigation.

224. Counsel for DCJ submitted that there may be a risk that focussing attention on listening to the calls to check whether they are malicious might tend to over-emphasise the issue or act as a distraction. While an issue in this case, counsel for DCJ submitted that there is no evidence that the problem is widespread or systemic. Further, as Professor Irwin pointed out the specifics in this case were such that other objective evidence existed which should have already prompted further action, for example the fact that TW was found wandering the street, the state of the house and other factors. Professor Irwin thought the ability to listen to calls might be good in complex cases but it would be time consuming and one would need to be careful about how it was done.

225. Having considered all the evidence I accept that it would be the very rare case that would require a caseworker to go back to listen to the Helpline calls. I also accept that to do so just to determine whether the report is "malicious" has the potential to encourage an approach to a ROSH report that is flawed. Nevertheless, in my view it is useful for caseworkers to know that the calls are available and to provide a process where they *could* approach their manager for guidance to identify the unusual situation where it may assist them to listen to a call.

226. Noting the advice that DCJ do not support the recommendation, I nevertheless intend to make it and ask that it is given further consideration.

Findings and Recommendations

227. For reasons stated above I make the following formal findings pursuant to section 81 of the *Coroners Act 2009*:

Identity

The person who died was DB.

Date of death

DB died on 20 December 2016 at approximately 9.12pm.

Place of death

[180] Transcript 24.7.24 p62.46-49

DB died at Westmead Children's Hospital, Westmead NSW.

Cause of death

DB died as a direct result of sequalae of blunt force head and spinal cord injuries.

Manner of death

DB's death was the result of the fatal injuries resulting from deliberate assaults inflicted upon DB on 18 and 19 December 2016.

Recommendations pursuant to section 82 *Coroners Act 2009*

228. For reasons stated above I make the following recommendations pursuant to section 82 of the *Coroners Act 2009*:

DCJ consider developing guidance for child protection workers which:

a. **informs caseworkers and their managers of the availability of the audio Helpline reports; and**

b. **provides managers with assistance to make decisions about when it may be appropriate for audio Helpline reports to be made available to support decision making.**

Conclusion

229. I offer my sincere thanks to counsel assisting Ms Rebecca McMahon and her instructing solicitor Ms Elizabeth Leung. Their dedication to understanding what occurred was extraordinary. They approached these difficult proceedings with the necessary combination of compassion and tenacity.

230. I thank the OIC, Sergeant William Freeman, and the previous OIC, former Detective Sergeant Adam Wharfe, for their assistance in these proceedings.

231. I thank CT and KD in particular for their attempts to keep DB safe. The decision to close The Benevolent Society file and make the final ROSH report was driven by very real safety concerns that should have been listened to.

232. I also thank TW's caseworker who attended each day of the inquest and assisted with providing the Court with a family statement from TW.

233. I recognise the trauma involved for some of the participants in these proceedings. I hope that being part of explaining what happened in public has not increased their trauma.

234. Finally, once again I offer my sincere condolences to TW.

235. I close this inquest.

Magistrate Harriet Grahame

Deputy State Coroner,

NSW State Coroner’s Court, Lidcombe

1 May 2025

Annexure – Agreed facts (see following pages)

CORONIAL INVESTIGATION INTO THE DEATH OF DB

Agreed facts

10 October 2023

NOTE: Sensitive content warning

Manner and cause of death

1. DB died on 20 December 2016 at Westmead Children's Hospital. DB died as a result of a sequelae of blunt force head and spinal cord injuries.[1] The fatal injuries resulted from deliberate physical assaults inflicted upon DB on 19 (and possibly 18) December 2016 by Mohammed Khazma.

Background

Immediate Family

2. DB was born on [redacted] at the Royal Prince Alfred Hospital, Camperdown, NSW.

3. DB was the daughter of AS and AF. AS was 19 years old and AF 24 years old, at the time of DB's birth. TW was DB's half-brother.

TW

4. TW was born on [redacted]. He was 4 years old when DB died and is now 11 years old. AS was 17 years old at the time of TW's birth.

5. TW's father is [redacted] [redacted]. [redacted] passed away on [redacted] 2023.

6. TW was removed from his mother's care by his father about six weeks before DB died.[2]

AS

7. AS was born on [redacted]. She was 17 years old when TW was born and 19 years old when DB was born.

[1] Vol 1, Tab 6, Autopsy Report of Dr Lorraine Du Toit-Prinsloo dated 21 June 2017, p1&6

[2] [redacted]

8. AS first came to the attention of FACS when she was nine years old.[3] FACS records indicate that AS experienced significant disadvantage in her childhood including[4]:

   a.

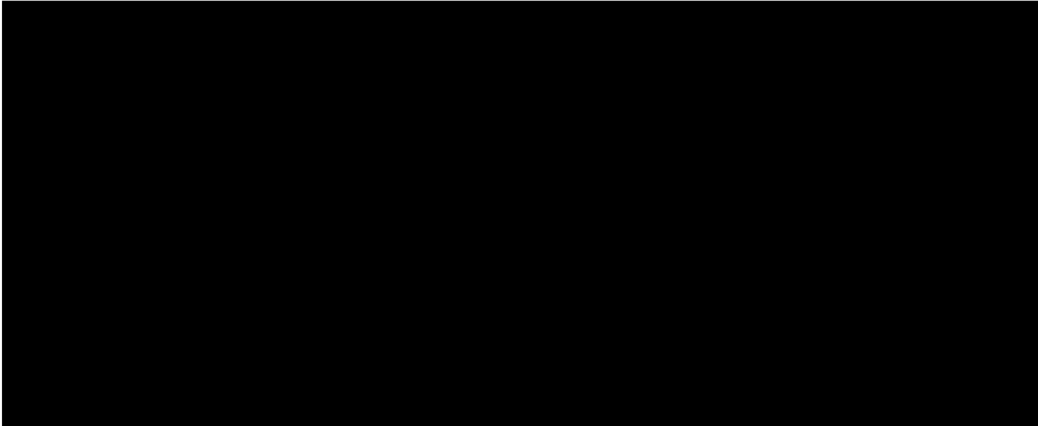
   b.

   c.

   d.

   e.

   f.



   g. In February 2012, AS (17 years old) reported that she had been 'kicked out of home' and was renting with a friend. She was 20 weeks pregnant (with TW).

AF

9. AF was DB's father.

10. FACS records reveal 28 reports relating to AF and his brothers and sisters being physically abused and neglected as children.[5]

AS's relationship with Mohammed Khazma

11. Mr Khazma was AS's boyfriend. They met on Facebook approximately 2 months before DB's death.[6]

12. On 28 November 2016, AS, Mr Khazma and DB moved into a granny flat at the back of Guilford NSW. TW did not move into the granny flat as his father had removed him from AS's care.

Prosecution of AS and Mr Khazma

***R v AS* [2018] NSWSC 930**

13. On 2 March 2018, AS entered a plea of not guilty to murder but guilty to the manslaughter (criminal negligence) of DB.

14. On 15 June 2018, the prosecution formally accepted the plea of guilty to manslaughter in full satisfaction at the commencement of the sentence proceedings. On 20 June 2018, AS was sentenced to imprisonment for 3 years, with a non-parole period of 16 months to date from 10 February 2017. The sentence expired on 9 February 2020.

[3] Vol 2, Tab 34, FACS Person History for AS;

[4]

[5]

[6] *Not in BOE*: NSW Police record of interview with AS dated 19 December 2016, Q&A 22-25, p5

***R v Khazma* [2019] NSWSC 416**

15. Mr Khazma pleaded not guilty to murder. Fullerton J presided over Mr Khazma's trial. He was convicted by a jury in the NSW Supreme Court on 4 March 2019 of the murder of DB.[7] Mr Khazma was also convicted of two further counts of assault occasioning actual bodily harm relating to DB.

16. Mr Khazma was sentenced to an aggregate sentence of 44 years with a non-parole period of 33 years. He is eligible for release to parole on 18 December 2049.[8] His sentence will expire on 18 December 2060.

Events leading up to 19 December 2016

17. AS reported to the FACS Critical Response Team (CRT) caseworkers and police that Mr Khazma started abusing DB one to two weeks before her death.

18. In relation to the ongoing abuse leading up to 19 December 2016, the findings of Fullerton J are adopted as follows [9]:

> [37] …..[DB] was slapped, punched, whipped with a mobile phone charger cord, pulled by the hair, held upside down over a garbage bin, thrown against the wall so she would land in the bed and held off the ground by the throat as examples of the offender's systematic and unrelenting abuse of the child – a course of conduct which AS said commenced within a short time of her moving in with the offender. She gave evidence that despite her entreaties that the offender use other methods to discipline the child, the beatings and the physical punishments did not abate for any significant period of time before they resumed with increased frequency and intensity when the child was disobedient by refusing to eat, when she made a mess or when she refused to submit to the offender's rules, including that she only move when he permitted her to and only displayed affection to her mother when he allowed it."

Events on 18 and 19 December 2016

19. In relation to the facts relating to the events on 18 and 19 December 2016, the findings of Fullerton J are adopted as follows[10]:

> [4] It was the Crown's primary case at trial that on either or both of 18 and 19 December 2016 the offender deliberately inflicted the injuries that were causative of death and that when he did those acts (on both occasions involving the application of considerable blunt force to DB's head) he acted with the intention of causing her grievous bodily harm.

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[7] Vol 1, Tab 20, *R v Khazma* [2019] NSWSC 416 at [1]

[8] Indicative sentences: Murder: 40 years, NPP 30 years; count 1 AOABH, 3 years; count 3 AOABH 5 years

[9] Vol 1, Tab 20, *R v Khazma* [2019] NSWSC 416 at [37]

[10] Vol 1, Tab 20, *R v Khazma* [2019] NSWSC 416 at [4]-[7]

> [5] The head injuries inflicted on 18 December 2016 were alleged to have resulted from the offender grabbing the child's head and "slamming it into the wall". The head injuries inflicted the following day (when the child was clearly suffering compromise to her neurological function from the assault the previous day) resulted from the offender slapping the back of the child's head under sufficient force that she fell forward and struck her forehead on the kitchen floor of the flat where she was living with the offender and her mother. It was also the Crown case that the child lost consciousness on 18 December 2016 for an hour and lost consciousness when she was assaulted on 19 December 2016. She did not regain consciousness before she was pronounced deceased on 20 December 2016.
>
> [6] For sentencing purposes, and consistently with the jury's verdict, I am satisfied that it was the combined effect of the assaults on 18 and 19 December 2016 which were causative of DB's death and that both assaults were committed with the intention of causing her grievous bodily harm.
>
> [7] Having regard to the medical evidence to which I will refer presently, I am also satisfied that when the child did not regain consciousness on 19 December 2016, the offender grabbed her by the shoulders and shook her with such force that it caused multi-layered retinal haemorrhages in both eyes and was also likely to have exacerbated the intercranial bleeding the child had sustained during the assaults on both 18 and 19 December 2016.

Events following the assaults

20. Mr Khazma's parents, [redacted] lived at [redacted] Guildford West, NSW with their two younger children.[11]

21. Shortly after 3:00pm on 19 December 2016, AS arrived at the offender's parent's home in Guildford West. DB was unconscious and unresponsive, lying on the back seat of the car.

22. When AS arrived, [redacted] heard her say the words "Mohammed killed my baby".[12] Mr Khazma called triple 0.[13]

23. DB was observed lying on the back seat of the car by various witnesses. They described seeing significant areas of obvious bruising to her face and forehead with dried blood and mucous around her nose and mouth.[14]

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[11] *Not in BOE*: Statement of [redacted] dated 10 December 2-16 at [3]

[12] *Not in BOE*: Statement of [redacted] dated 10 December 2-16 at [15]

[13] *Not in BOE*: Statement of [redacted] dated 10 December 2-16 at [16]

[14] Vol 1, Tab 20, *R v Khazma* [2019] NSWSC 416 at [12]

24. At about 3:27pm, Constable Russo, who was on duty with Constable Bernhardson, responded to a VKG message indicating that someone had been murdered at [redacted] [redacted] Guildford West.[15] Constable Russo was the first officer on the scene.

25. Constable Russo was the first to look inside the car where DB's body was and saw "the shins of an infant in the backseat under a black coloured jacket. The jacket was covering the entire body bar the shins of the legs. The shins were covered in bruises, black, purple and yellow in colour."[16]

26. When Constable Russo pulled back the jacket, she observed:

> "……She had no shoes on. The deceased's face was extremely swollen and she had bruising over her face. The bruising was blue and purple in colour, with red markings near on her cheeks and down her neck. I observed dried blood also coming from the deceased's nose. The deceased had what looked like dried vomit around her mouth. The deceased's t-shirt was pulled up around her chest and I saw dark cola red purple bruising to her lower abdomen. The deceased's arms were visible and were also covered in purple and blue bruises. The deceased's white leggings were rolled up half way up her shins where I observed more bruising that was purple and blue in colour."[17]

27. Constable Russo checked for a pulse but could not find one.[18] DB was unresponsive and her eyes were closed.[19] Police administered CPR. Constable Claxton commenced chest compressions and Constable Russo commenced breaths between compressions until paramedics arrived on the scene.[20]

28. Inspector Jennine Kiely (Auburn Ambulance station) was the first paramedic on the scene.[21] Upon attending the address she observed[22]:

> "….. the body of a female child, approximately 4 years old, lying supine on the grass, unconscious and not breathing, laying next to the left hand side of a silver sedan parked in the yard. A female police officer was giving the child mouth to mouth resuscitation with a disposable face mask and a male police officer performing cardiac chest compressions…... I saw that the child had extensive bruising to her chest and abdomen. Some of these bruises seemed to be about a week or so old. I originally thought that dependent lividity had set in owing to the extensive bruising on the child's body and thought she was dead. I checked the child's pupils which were fixed and dilated. I lifted up the child's legs which were limp and warm to touch."

29. Inspector Kiely applied the defibrillator to DB and noticed further injuries including burns to her feet.[23]

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[15] *Not in BOE*: Statement of Constable Russo dated 23 January 2017 at [4]-[5]

[16] *Not in BOE*: Statement of Constable Russo dated 23 January 2017 at [7]

[17] *Not in BOE*: Statement of Constable Russo dated 23 January 2017 at [9]

[18] *Not in BOE*: Statement of Constable Russo dated 23 January 2017 at [10]

[19] *Not in BOE*: Statement of Constable Russo dated 23 January 2017 at [11]]

[20] *Not in BOE*: Statement of Constable Russo dated 23 January 2017 at [12]

[21] *Not in BOE*: Statement of Jennine Kiely dated 20 December 2016 at [5]

[22] *Not in BOE*: Statement of Jennine Kiely dated 20 December 2016 at [8]-[9]

[23] *Not in BOE*: Statement of Jennine Kiely dated 20 December 2016 at [10]

30. Paramedic Inspector Kevin McSweeney moved DB to the ambulance vehicle. Officer Ronan commenced CPR on DB in the back of the ambulance. Officers Ibrahim and McPherson assisted to treat DB.[24] DB still did not have a pulse and was not breathing.[25]

31. While officers were attending to DB, Inspector McSweeney spoke to AS. After conferring with police, Inspector McSweeney drove her to Westmead Children's Hospital.

32. Ambulance officers left the scene at 3:44pm and continued CPR. Officer McPherson administered adrenalin and shortly after this at 3:48pm a pulse was detected but there was still no breathing. CPR continued and they arrived at the hospital at 3:54pm. [26]

Westmead Children's Hospital

33. The Westmead Children's Hospital discharge summary records DB arriving at the hospital at 3:58pm on 19 December 2016 presenting with 'cardio/respiratory arrest' and severe head injury. The following assessment was made at emergency:[27]

> Airway has been assessed as being at risk. Intubated, collar insitu. Child is assessed as having breathing difficulty requiring respiratory support. Child' s circulation has been assessed as abnormal. Bruising over body

34. DB was admitted to the Intensive Care Unit (ICU).

35. At 5:01pm on 19 December 2016, a CT scan of DB's brain was performed which identified an acute subdural haematoma on the right side of the brain and a smaller subdural haemorrhage on the left side. An area of haemorrhage was also identified in the corpus callosum.[28]

36. The ICU notes indicate that at 6pm on 19 December 2016, a Sexual Assault Investigation Kit (SAIK) was collected. Hospital notes indicate the peri-anal area was recorded as 'red, broken skin, scabs/sores, some discharge, yellow in colour'.[29]

37. At 3:00pm on 20 December 2016, a further CT scan was performed which identified a tonsillar herniation.[30]

38. Brainstem testing was performed by Dr Cavazzoni and Dr Harmner.[31] DB was pronounced deceased at 9:12pm on 20 December 2016 by Dr Elena Cavazzoni following disconnection of life support.[32]

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[24] *Not in BOE*: Statement of Jennine Kiely dated 20 December 2016 at [11]-[12]

[25] *Not in BOE*: Statement of Jennine Kiely dated 20 December 2016 at [15]

[26] *Not in BOE*: Statement of Jennine Kiely dated 20 December 2016 at [16]-[17]; Summary of Ambulance management and treatment between 3:33pm and 3:49pm on 19 December 2016 contained in Ambulance Electronic medical records, p5

[27] *Not in BOE*: The Children's Hospital at Westmead discharge summary

[28] *Not in BOE*: The Children's Hospital at Westmead, CT final report, p926-927

[29] *Not in BOE*: The Children's Hospital at Westmead discharge summary, p829

[30] *Not in BOE*: The Children's Hospital at Westmead, CT final report, p925

[31] *Not in BOE*: The Children's Hospital at Westmead, CT final report, p845-846, Vol 2

[32] Vol 1, Tab 3, Certification of brain death, p861, Vol 2]

Post-mortem

Autopsy

39. Dr Du Toit-Prinsloo performed an autopsy on 21 and 22 December 2016.[33] Dr Du Toit-Prinsloo's opined that the cause of death '<u>is most likely sequelae of blunt force head and spinal cord injuries</u>.'[34]

40. During the autopsy, Dr Du Toit-Prinsloo identified extensive injuries including:

External examination

a. Approximately 114 inflicted injuries including 45 bruises on the face, neck, arms, chest, abdomen, back, arms, legs, hands, soles of the feet and behind the ears. 28 probable bite marks and 17 thermal injuries. [35] The variation in colour suggested the injuries were inflicted over a period of time. The thermal injuries were present on various parts of the body including the genital area and soles of the feet. The thermal injuries appear to have been occasioned by a heated lighter being pressed firmly on the skin to cause a contact burn wound.[36] The probable bite marks on various parts of the body including the buttocks. Presuming the bruise to be bite marks, they were consistent with dental arches of an adult. [37]

Examination of genital region – features of sexual assault

b. Injuries were present on the genital region in the peri-anal region and anal canal. These included thermal injuries. In view of the extensive injury and haemorrhage noted in the rectum/anal canal, Dr Du Toit-Prinsloo opined that the features are in keeping with blunt force penetrative injury to the anus.

Internal injuries

c. Significant internal injures included subdural and subarachnoid haemorrhage, injury to the lower frenulum and bronchopneumonia.[38]

Opthalmology

41. Extensive bilateral retinal haemorrhages were revealed on ophthalmologic examination conducted as part of the post-mortem.[39]

42. Dr Du Toit-Prinsloo opined that the severity and location of haemorrhages indicate non-accidental head trauma.[40]

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[33]Autopsy Report of Dr Lorraine Du Toit-Prinsloo dated 21 June 2017
[34] Vol 1, Tab 6, Autopsy Report of Dr Lorraine Du Toit-Prinsloo dated 21 June 2017, p2&6
[35] Vol 1, Tab 6, Autopsy Report of Dr Lorraine Du Toit-Prinsloo dated 21 June 2017, p4
[36] Vol 1, Tab 6, Autopsy Report of Dr Lorraine Du Toit-Prinsloo dated 21 June 2017, p4
[37] Vol 1, Tab 6, Autopsy Report of Dr Lorraine Du Toit-Prinsloo dated 21 June 2017, p5
[38] Vol 1, Tab 6, Autopsy Report of Dr Lorraine Du Toit-Prinsloo dated 21 June 2017, p7
[39] Vol 1, Tab 15, Surgical Pathology Report of Dr Svetlana Cherepanoff dated 10 March 2017, p4
[40] Vol 1, Tab 6, Autopsy Report of Dr Lorraine Du Toit-Prinsloo dated 21 June 2017, p9

Neuropathology

43. On 11 January 2017, specimens of the child's brain and spinal cord were received by Associate Professor Buckland, neuropathologist.[41]

44. Associate Professor Buckland's report identified evidence of blunt force head and spinal column injury and its sequelae including the presence of spinal nerve root haemorrhages and hypoxic and ischaemic changes in the spinal cord.[42]

45. Professor Buckland also gave the following evidence at Mr Khazma's trial:

> [33]……He was unable to identify any particular injury or injuries to the head and spinal cord which were causative of death. He did give evidence however that the amount of blood adhering to the dura and descending into the arachnoid indicated the application of significant blunt force, associated with an inevitable loss of consciousness and a potential compromise of neurological function. While he gave evidence that a <u>vigorous shaking of a child, and the accompanying accelerant, decelerant and rotational forces acting on the brain was also comprehended by the concept of blunt force injury</u>, the amount of blood in the dura was inconsistent with having been caused by vigorous shaking alone. He also gave evidence that from his examination of the brain and neck and the results of the CT scans there were <u>at least two traumatic events which resulted in the head and neck injuries, with the subdural haemorrhage being the older of the two injuries</u> because of the healing process that he was able to discern by changes in the haemoglobin. He also gave evidence that the subdural bleeding from the first traumatic event may have commenced slowly and then increased in intensity as a result of a subsequent traumatic incident. <u>He also gave evidence that a vigorous shaking of the child could also exacerbate a pre-existing subdural haemorrhage, and that this would occur irrespective of the child's state of unconsciousness</u>. (underline added)

FACS Involvement

<u>Helpline Reports</u>

Previous ROSH report - 22 February 2012

46. On 22 February 2012 AS [redacted][43] stating that[44]:

- she was staying with a friend and two days ago the friend 'kicked her out'
- she had an AVO with her family and so couldn't stay with them
- there had been previous domestic violence
- she was 20 weeks pregnant (with TW)

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[41] Vol 1, Tab 7, Neuropathology Report of Associate Professor Michael Buckland dated 25 May 2017, p1

[42] Vol 1, Tab 7, Neuropathology Report of Associate Professor Michael Buckland dated 25 May 2017, p4

[43] *Not in BOE*: [redacted]

[44] *Not in BOE*: [redacted]

- she was paid $240 by Centrelink on Monday and went to the doctor on Monday and the other money went on food and transport.

47. FACS allocated a response priority of within 10 days.[45]

48. The Helpline referred this report to the after hours Crisis Response Team (CRT) for immediate response.

49. The CRT called AS and she said that she and her boyfriend could stay with a friend for the night and her grandmother the next day (23 February 2012). AS said that she would call the Helpline if she required assistance. Central Sydney Community Services Centre (CSC) closed the report.[46]

First ROSH Report – 11 May 2015

50. A Risk of Significant Harm (ROSH) report (the first) was made on 11 May 2015.[47] The reporter was anonymous.

Actions by FACS following this report

51. The Joint Investigation Response Team's (JIRT) Joint Referral Unit (JRU) recommended a response in less than 24 hours.[48]

52. The JRU decision report[49] recorded details of the ROSH report from 11 May 2015 and concluded with 'Neglect:– Rejected'.

53. Police records state:

> 'This referral has been REJECTED as it does not meet the following JIRT criteria for neglect:
>
> - Further assessment required before a JIRT investigation can be initiated.
>
> - Further information obtained by the JRU has confirmed DB received a minor injury following a fall and was treated and discharged from Bankstown Hospital on the same day.
>
> There was nothing noted by the hospital that would confirm the presence of severe neglect. Further assessments required before a JIRT investigation can be initiated.
>
> - The reported child/young person has not suffered from extreme neglect resulting in physical harm ,
>
> This matter has been referred to Bankstown Community Services Centre (CSC) for further assessment/intervention.'[50]

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[45] *Not in BOE*: FACS contact record dated 22 February 2012; FACS Screening and Priority Response Tool

[46] *Not in BOE*: FACS assessment record dated 24 February 2012, p2; FACS Assessment Record dated 23 February 2012

[47] Vol 2, Tab 36, Contact Record – ROSH report dated 11 May 2015

[48] Vol 2, Tab 36, Contact Record — ROSH report dated 11 May 2015

[49] Vol 2, Tab 41, JRU Decision Report (48358) completed on 12 May 2015

[50] Vol 3 Part B, Tab 113, COPS Event E57876807

54. Upon being rejected by JIRT, the case was referred to Bankstown CSC. [51]

55. On 12 May 2015, Bankstown CSC was allocated the report.[52]

56. On 12 May 2015, at 3:30pm BG (Manager Casework, Bankstown CSC) convened a Pre-Assessment Consultation meeting with FACS Caseworkers SH and . At the meeting the report was discussed and several actions agreed to be taken in response to the report.[53]

57. On 12 May 2015, SH and attended AS's home (a granny flat at the rear of) and conducted a home visit.[54]

58. At an assessment consultation meeting at 6:45pm on 12 May 2015, attended by SH, and BG (Manager Casework, Bankstown CSC), it was determined that a referral to the Brighter Futures program was appropriate.[55]

59. A risk assessment was completed on 15 May 2015 by SH assessing the risk level as 'moderate'.[56]

60. On 25 May 2015, FACS referred AS to the Brighter Futures program.

61. Brighter Futures is a voluntary targeted program funded by FACS that provides targeted intervention services to families, where consent is required from the family and families can chose to exit the program at any time. Brighter Futures is administered by various service providers (also referred to as Lead Agencies) who are responsible for discrete planning areas and work with families within their service area, including providing structured home visiting for a period of up to 18 months.

62. The Benevolent Society was the Lead Agency for the area (Bankstown) where AS was living at the time of the referral to Brighter Futures.

63. On 25 May 2015 at 11:21am, SH emailed a Brighter Futures referral for AS and the children to KD, Team Leader Brighter Futures, Bankstown, at The Benevolent Society.[57] The referral form, completed by SH included reference to AS's prior homelessness and domestic violence background.[58] SH provided the following information in answer to the question "please outline the referring agency's involvement with the child/family":[59]

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[51] Vol 2, Tab 41, JRU Decision Report (48358) completed on 12 May 2025

[52] Vol 2, Tab 38, Assessment Record – Secondary Assessment Stage 1 dated 11 May 2015; Vol 2, Tab 42, the SDM Safety Assessment Decision Report dated 12 May 2015 indicates the CSC as Bankstown CSC.

[53] Vol 2, Tab 59, FACS Assessment Record: Secondary Assessment Stage 2, prepared on 12 May 2015 and submitted for approval on 9 June 2015; Vol 2, Tab 40, Secondary Assessment Stage 2 assessment record dated 31 May to 31 July 2015

[54] Vol 2, Tab 39, Handwritten notes of home visit (made by , caseworker) dated 12 May 2015

[55] Vol 2, Tab 40, Secondary Assessment Record Stage 2 assessment record dated 12 May 2015

[56]

[57] Vol 3 Part A, Tab 85, Brighter Futures Referral; Vol 2, Tab 48 Email chain between SH and KD dated 25 May 2015; Vol 2, Tab 49, Brighter Futures referral form (from SH Community Services Bankstown) dated 25 May 2015

[58] Vol 3 Part A, Tab 85, Brighter Futures Referral

[59] Vol 3 Part A, Tab 85, Brighter Futures Referral

> 'Family referred to c.s. as there were concerns of physical abuse. Interview/assessment done. No abuse apparent though mother requires parenting skills. Older child in particular is developing behavioural issues'.

64. The Serious Case Review reported that[60]:

> 'Brighter Futures staff told the review team that when the family was first referred to their service, FACS [Brighter Futures Assessment Unit] said the reports were 'vexatious' and the main concern for the children was inadequate supervision. However, Brighter Futures staff said FACS did not provide a safety or risk assessment to guide Brighter Futures' work and because of this the service did its own assessment for guidance around its interventions with the family'.

65. At the time that the referral was made the *Brighter Futures – Service Provision Guidelines May 2015* were in operation. Page 30 of those guidelines said that for children who had been identified at ROSH prior to entry into the program and who had been the subject of a safety and risk assessment (SARA) by FACS, the narrative and assessment outcome could be exchanged in accordance with Chapter 16A. The outcome of the assessment was provided to the Benevolent Society by the FACS Brighter Futures Assessment Unit on 29 May 2015.[61] Also, Page 36 of the Brighter Futures Service Provision Guidelines (May 2015) also required the Benevolent Society to undertake an initial strengths and needs assessment when a family had been allocated, as soon as practicable to inform the development of a case plan.[62]

Second ROSH Report – 25 May 2015

66. A second ROSH report was made on 25 May 2015.[63] The reporter was anonymous.

Actions taken by FACS

67. The Helpline screened the report as ROSH and recommended a response in less than 24 hours. The date and time on which this ROSH report was received by FACS caseworkers at the Bankstown CSC is not recorded.

68. On 26 May 2015, FACS caseworkers SH and , attended AS's home to conduct a home visit.[64] made some hand-written notes of the home visit.[65] On 27 May 2015 SH recorded an Assessment Record: Secondary Assessment Stage 1.[66]

69. On 29 May 2015 at 11:44am, , Acting Manager Casework for FACS' Brighter Futures Assessment Unit (BFAU), emailed KD a Summary of Child Protection History and KD forwarded it by email to CT, Brighter

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61 Vol 3 Part A, Tab 86, Email from on behalf of the Brighter Futures Assessment Unit dated 29 May 2015

62 Vol 4, Tab 113D, Brighter Futures – Service Provision Guidelines dated May 2015

63 Vol 2, Tab 44, Contact Record – ROSH report dated 25 May 2015

64 Vol 2, Tab 51, Handwritten Caseworker notes) dated 26 May 2015

65 Vol 2, Tab 51, Handwritten Caseworker notes) dated 26 May 2015

66 Vol 2, Tab 52, Assessment Record – Secondary Assessment Stage 1

Futures caseworker at the Benevolent Society, the same day asking her to 'print and review Monday'.[67]

70. On 29 May 2015 at 12:27pm, KD emailed Natasha Jordan (NSW Police) requesting information under Chapter 16A regarding AS, DB and TW.[68]

71. On 29 May 2015 SH recorded the following File Note Record:

> 'Plan is due to be closed once tasks are completed.
> Discussion with KD at Brighter Futures – they are happy to pick up the case.
> Discussion with [AS] – mother. She is keen to work with Brighter Futures to address her parenting needs and [TW]'s child care needs.'[69]

Third ROSH report – 31 May 2015

72. A (third) ROSH report was made on 31 May 2015.[70] The reporter was anonymous.

Actions taken by FACS

73. The Helpline screened the report as ROSH and recommended a response within 24 hours.[71] The date and time on which this ROSH report was received by FACS caseworkers at the Bankstown CSC is not recorded.

74. Later on 31 May 2015, CRT caseworkers (and attended AS's home.[72] This was an afterhours response.

75. A Secondary Assessment Stage 2 record prepared on 31 May 2015 for the CRT call-out[73] recorded that the CRT had telephoned NSW Police on 31 May 2015 (prior to the home visit). The record also noted that a pre-assessment consultation had been carried out by (Acting Manager Casework CRT), (CRT Caseworker) and (CRT Caseworker) on 31 May 2015 at 6.30pm. A telephone call from the CRT Caseworkers (who were at the home) at 7.49pm on 31 May 2015 is recorded:

> 'The mother and the children were at the home as was the mother's flatmate and some friends. The children appeared healthy and clean. The mother was very engaging, very open. The allegations were posed to the mother and she denied that she locks the children in the bedroom. There were the usual locks on the doors ie the door knob has those locks that you can push in. Mother denies using this. The house overall appeared fine and both children have their own beds. The mother was preparing the children to go to bed. The mother denied going out clubbing last night but stated that at 2am she went out for cigarettes but her flatmate was at

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[67] Vol 3 Part A, Tab 86, Email chain, top email from KD (Brighter Futures) to CT dated 29 May 2015

[68] Vol 3 Part A, Tab 87, Benevolent Society letter requesting information under Chapter 16A (From CT to Bankstown Police) dated 29 May 2015 ; Vol 3 Part A, Tab 88, Email chain, top email from Natasha Jordan (NSWPF) to KD Copying in CT , re 16A request between 29 May and 10 June 2015Vol 3 Part A, Tab 89, Police Information

[69] Vol 2, Tab 55, File Note Record – General File Note dated 29 May 2015

[70] Vol 2, Tab 56, Contact Record – ROSH report dated 31 May 2015

[71] Vol 2, Tab 56, Contact Record – ROSH report dated 31 May 2015

[72] Vol 2, Tab 59, Secondary Assessment Stage 2 record dated 31 May to 31 July 2015

[73] Vol 2, Tab 59, Secondary Assessment Stage 2 assessment record dated 31 May to 31 July 2015

the home while the children were in bed. The mother and her friends stated that the reports are malicious. Mother thinks it might be a friend who they reported to the police after they found out she was going overseas to join ISIS and that friend was stopped by Federal Police at the airport. Mother advised that she has had discussions with her caseworker SH who has suggested that TW may require some developmental assessment as he may have autism. The family have been referred to eferred to EI (sic). No dangers were identified.'

76. A FACS SDM Safety Decision Report dated 31 May 2015 (and prepared by [redacted]) assessed TW and DB as 'safe'.[74]

77. On 11 June 2015, KiDS records, relating to the assessment consultation, noted that the reports appeared to be 'malicious'. The record also noted that it would end its involvement with the family and that the Brighter Futures referral had been accepted.[75]

78. The Brighter Futures Service Provision Guidelines (2015) provide that when a new ROSH Report is received by the Helpline that meets the ROSH threshold:[76]

    a. the local FACS CSC will inform the Lead Agency that the family is subject to a ROSH report and exchange relevant information

    b. working in partnership, Lead Agency and FACS caseworkers will ensure that Brighter Futures services and support continue as appropriate while CS completes the child protection investigation. FACS has lead responsibility for case management throughout a child protection investigation

    c. where a child and their family will not receive ongoing statutory child protection services and the family remains eligible for Brighter Futures – FACS should provide Lead Agency caseworkers with advice and support to improve the safety for children at home

    d. if the child and family will receive ongoing statutory child protection services, FACS and the Lead Agency will determine whether a family will continue to participate in Brighter Futures and how services will be managed, including roles and responsibilities to ensure against service duplication and inefficiency

    e. Consideration of whether a family remains suitable for Brighter Futures should focus on whether Brighter Futures is able to provide services and support necessary to adequately maintain a child/ren's safety in the home.

79. A FACS' SDM Family Risk Assessment Decision Report dated 11 June 2015 (and prepared by SH) assessed the family risk level as 'low'.[77]

80. There are no records to support that the Benevolent Society was ever notified of this ROSH Report.

[74] Vol 2, Tab 58, SDM Safety Assessment Decision Report of 31 May 2015

[75] [redacted]

[76] Vol 4, Tab 113D, Brighter Futures – Service Provision Guidelines dated May 2015, p49

[77] Vol 2, Tab 61, SDM Family Risk Assessment Decision Report dated 11 June 2015

The Benevolent Society commence work with AS and her children

81. On 1 June 2015 KD and CT conducted their first home visit to AS and the children. The visit was about 20 minutes because AS was not interested in speaking with Brighter Futures staff. AS said the reports to FACS were 'vexatious' and that she didn't need help, other than with childcare for TW.[78]

82. On 10 June 2015 KD telephoned SH and reported AS's reluctance to engage with the program and that the referral may have to be closed as a result. SH offered to visit AS with a Benevolent Society Caseworker.[79] A record of that telephone conversation made by SH reads:

> '[AS] appeared to be keen to get involved initially when BF contacted her over the phone. However during the initial home visit she appeared to be reluctant. KD believes this may have something to do with the flatmate who appeared to be speaking for [AS].
>
> [AS] could not identify any areas that she felt she needed help with other than child care for [TW] and stopping the malicious reports being made by her ex friend.
>
> KD was quite concerned about [TW]'s attachment which was indiscriminate.
>
> [AS] didn't attend to [TW] during the visit. Her friend was more involved in attending to [TW].
>
> [AS] didn't appear to be uneasy about the presence of Brighter Futures.
>
> KD believes [AS] is perfect for Brighter Futures but is concerned that [AS] may not engage.
>
> I have suggested that I go with the caseworker for a joint visit to which he had agreed.'[80]

83. On 10 June 2015, KD (and CT copied) received an email from Natasha Jordan from NSW Police responding to their Chapter 16A request of Bankstown Police dated 29 May 2015.[81]

84. On 17 June 2015 CT and SH conducted an unannounced home visit to AS and the children at 10am. Both CT and SH made written records of this home visit (SH file note is dated 18 June 2015).[82] At the conclusion of this home visit, AS verbally agreed to sign onto the program.[83]

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78 [redacted]

79 [redacted]

80 Vol 2, Tab 60, File Note Record – General File Note dated 10 June 2015

81 Vol 3 Part A, Tab 88, Email chain, top email from Natasha Jordan (NSWPF) to KD Copying in CT re 16A request between 29 May and 10 June 2015; Vol 3 Part A, Tab 89, Police Information

82 Vol 2, Tab 65, File Note Record – Home Visit dated 18 June 2015; Vol 3 Part A, Tab 92, Benevolent Society file note by CT dated 17 June 2015; Vol 3 Part A, Tab 93, Email chain between CT and SH on 19 and 23 June 2015

83 Vol 3 Part A, Tab 90, Agreement to participate, Brighter Futures program dated 17 June 2015; Vol 3 Part A, Tab 91, Brighter Futures consent to exchange information

Fourth ROSH report – 18 June 2015

85. A (fourth) ROSH report was made on 18 June 2015.[84] The reporter was anonymous.

Actions taken by FACS

86. Helpline screened the report as ROSH and recommended that caseworkers respond within 72 hours.[85]

87. There are no records indicating that the Benevolent Society was notified of this ROSH report.

88. The ROSH report recorded by the Helpline on 18 June 2015 includes the following information in relation to the KiDS History Check:

> "*A very thorough history search was conducted considering the reporter stated the children had been reported before and were known to CS. However there were no matches on the database. Please note the following searches were conducted: Phonetic, first and last names, suburbs and DOB.*
>
> *Therefore, all parties were created on the database and a person merge will need to be requested when the parties are found.*"

89. This matter was presented to a WAM meeting on 23 June 2015, and the Assessment Record indicated "Person Merge forms to be completed".[86] A summary of this ROSH report on 18 June 2015 was contained in the KiDS History Check in the next two ROSH reports of 20 and 21 July 2015.[87]

90. On 19 June 2015, CT emailed SH as follows:

> 'Hi SH Thanks again for the joint visit on Wednesday morning. I think we got a good outcome. Just to confirm that [AS] did verbally sign on to the program on Wednesday. I have been in contact with [AS] and I will be booking her in for a home visit early next week. I will keep you up dated if anything changes.' [88]

91. SH replied, 'Hi CT, I agree. I think our joint visit went well. I'll leave the plan open for until your visit next week. Let me know how it goes. I'll close the plan at that time.'[89]

June 2015 – Information held by Police

92. The Benevolent Society sought information from NSW Police (Bankstown) on 29 May 2015.[90] NSW Police responded to the Benevolent Society on 23 June 2015 with a report that

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[84] Vol 2, Tab 63, Contact Record – ROSH report dated 18 June 2015

[85] Vol 2, Tab 63, Contact Record – ROSH report dated 18 June 2015

[86] Vol 2, Tab 66, Assessment Record Secondary Assessment Stage 1 of 23 June 2015

[87] Vol 2, Tab 67, Contact Record – ROSH report dated 20 July 2015; Vol 2, Tab 69, Contact Record – ROSH report dated 21 July 2015

[88] Vol 3 Part A, Tab 93, Email chain, top email from SH to CT dated between 19 June 2015 and 23 June 2015

[89] Vol 3 Part A, Tab 93, Email chain, top email from SH to CT dated between 19 June 2015 and 23 June 2015

[90] Vol 3 Part A, Tab 87, Benevolent Society letter dated 29 May 2015 requesting information under Chapter 16A to Bankstown Police

TW had been found wandering the streets on 19 June 2015 by a member of the public, he had smelled strongly of faeces and given his age and limited language, police sent out patrols to find his parents.[91] AS flagged the police down and said her son was missing because she had gone to the shops and left him with a friend who had fallen asleep and he had left the house. AS later admitted to police this was not true but that DB had kept her up all night. Police advised her to arrange childcare so the children were not left unsupervised. Police records also contained a report about the children being neglected by AS, left in soiled nappies and unsupervised.[92] Police noted that a 'children at risk incident' had been created and that a referral to JIRT would be made.

93. There is a question about whether this incident was reported to FACS by NSW Police. The Serious Case Review reports that police confirmed to the OSP team that no report was made by Police to FACS.[93] This is a matter which will be addressed at the hearing.

23 June 2015 – Chapter 16A request of Bankstown Hospital

94. On 23 June 2015 CT sent a Chapter 16A request to Bankstown Hospital.[94] There is no record of any material being produced in response to this Chapter 16A request.

The Benevolent Society home visits

95. From 3 July to 19 July 2015 KD was on annual leave. During that time CT reported to Ms Ashton Hayes, Manager, Brighter Futures SW Sydney at the Benevolent Society.

96. On 9 July 2015 CT visited AS and the children at her home.[95]

Fifth ROSH report – 20 July 2015

97. A (fifth) ROSH report was made on 20 July 2015.[96] The reporter was anonymous.

Actions taken by FACS

98. The Helpline screened the report as ROSH and recommended a response within 24 hours.[97]

99. On 20 July 2015, SH called CT to discuss the report.[98] The Benevolent Society caseworker CT advised that she had only seen AS once and was concerned about her engagement. SH suggested that the Benevolent Society caseworker check in on AS,

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91

[92] Vol 3 Part B, Tab 112 COPS Event E58314357 record dated 19 June 2015

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[94] Vol 3 Part A, Tab 94, Benevolent Society letter requesting information under Chapter 16A (from CT to NSW Health, Bankstown Hospital) dated 23 June 2015

[95] Vol 3 Part A, Tab 95, Benevolent Society file note made by CT 9 July 2015

[96] Vol 2, Tab 67, Contact Record – ROSH report dated 20 July 2015

[97] Vol 2, Tab 67, Contact Record – ROSH report dated 20 July 2015

[98] Vol 2, Tab 71, File Note Record – Phone Call dated 21 July 2015; Vol 3 Part A, Tab 84, Chronological Index

visiting unannounced and outside scheduled visits.[99] A record made by SH of her telephone conversation with CT reads:

> 'CT said she was concerned about mothers lack of engagement. During the time that BF signed mother up, she has only seen mother on one occasion. Mother keeps making excuses to cancel her visits. Brighter Futures is supposed to be seeing mother on Tuesday as she is booked in for playgroup. CT is supposed to pick mom and the 2 children up and take them there.
>
> I discussed the newest report with CT. We discussed whether it would be better for her to see [AS] and the children as arranged and if CT had concerns verifying those raised in the report, then she would make a report to the Helpline after which further action would be taken by Community Services.'[100]

100. On 20 July 2015 at 11.37am, SH sent CT an email, with subject '[DB] – New ROSH'. It opens with, 'Hi CT, Here's the report regarding [DB] – again from anonymous. Let me know what KD says.'[101]

101. Neither FACS nor the Benevolent Society visited AS and her children between the fifth Helpline report and the sixth Helpline report that was received on the next day on 21 July 2015.

102. On 21 July 2015, SH telephoned CT and recorded a note of the call as follows:

> 'CT said she had spoken to [AS]. [AS] has cancelled the play group for today claiming that she is not feeling well and is currently staying at her aunts place. I advised CT that I would call [AS] then give CT a call back.'[102]

103. SH then telephoned AS (still on 21 July 2015) and recorded a note of the call as follows:

> 'I asked [AS] how things were going. She said everything is fine. I said to [AS] that we had received another report and I had to see her to talk about the concerns.
>
> I asked her about [TW] and how he was doing. I said there were concerns in the report that he had severe nappy rash and his penis was bleeding. She said that was not the case and that [TW] was absolutely fine. I said that I would still need to see him. I asked [AS] whether she was at home.
>
> [AS] said she was currently at her aunt's house in Campbelltown due to EID. She said she would be back at her house either later this afternoon/evening or tomorrow.
>
> I advised her that I wanted her to take [TW] to the doctor for him to be examined regarding his nappy rash. I told her I wanted a report from the doctor regarding the outcome of his examination. [AS] said she would do this.

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[99]

[100] Vol 2, Tab 71, File Note Record – Phone Call dated 21 July 2015

[101] Vol 3 Part A, Tab 98, Email from SH to CT dated 20 July 2015

[102] Vol 2, Tab 71, File Note Record – Phone Call dated 21 July 2015

[AS] said she would call me this afternoon or tomorrow morning as soon as she returned home.

I told her I would speak with her then.'[103]

104. After this call, SH telephoned CT back (still on 21 July 2015) and recorded a note of the call as follows:

> 'Discussed my conversation with [AS]. I advised CT that I would speak with my manager first before deciding whether I would visit [AS] with CT or with a CP caseworker.'[104]

Sixth ROSH report – 21 July 2015

105. A (sixth) ROSH report was made on 21 July 2015.[105] The reporter was anonymous.

Actions taken by FACS

106. The Helpline screened the report as ROSH, recorded the primary reported issue as 'Physical: hit, kick, strike' and recommended a response within 72 hours.[106] The date and time on which this ROSH report was received and came to the attention of FACS caseworkers at the Bankstown CSC is not recorded.

107. There are no records indicating that The Benevolent Society was notified of this ROSH report.

108. On 23 July 2015, SH and CT conducted an unplanned home visit together to AS and her children.[107] SH recorded notes of the home visit,[108] as did CT.[109] During the visit SH raised the report about TW having severe nappy rash and a bleeding penis with AS again, and she asked if she and CT could check TW. AS took TW's nappy off and SH observed redness on his thighs and 3 or 4 blisters on his scrotum. SH asked AS if she had taken TW to the doctor the day before as she said she was going to. When she said she hadn't, SH informed her that she must take TW to a doctor that day (23 July 2015) and send through a medical report confirming she had done so. AS agreed she would.

109. SH's notes also included:

> '[AS] said that she knew who was making all these reports and that it was the same person. She said she knew this because this person had told her she was going to keep making these reports until her kids were taken from her. I said to her that this was all the more reason to keep working with Brighter Futures

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[103] Vol 2, Tab 71, File Note Record – Phone Call dated 21 July 2015

[104] Vol 2, Tab 71, File Note Record – Phone Call dated 21 July 2015

[105] Vol 2, Tab 69, Contact Record – ROSH report dated 21 July 2015

[106] Vol 2, Tab 69, Contact Record – ROSH report dated 21 July 2015

[107] Vol 2, Tab 72, File Note Record – Interview dated 23 July 2015; Vol 3 Part A, Tab 99, Benevolent Society file note made by CT on 23 July 2015

[108] Vol 2, Tab 72, File Note Record – Interview dated 23 July 2015

[109] Vol 3 Part A, Tab 99, Benevolent Society file made by CT 23 July 2015

because if the reports are vexatious, then her BF caseworker is there to let FACS know that everything is going fine with her and her children.

[AS] said she was happy to do whatever we suggested. She said that her grandmother returns from Italy on the 1st of August and [AS] will be moving in with her upon her return. [AS] said she was happy for her case to be transferred to a Brighter Futures team in that area.

CT said that there was a playgroup happening tomorrow and that [AS] could join in with the kids if she wanted. [AS] said she would like to come along and asked how long it was for – 2 hours. A BF caseworker will be picking her and the 2 children up at 9:30am.

I re-iterated the importance of taking [TW] to the doctor for a medical and that I needed the doctor to write a report on the rash. I also re-iterated the importance of [AS] engaging effectively with Brighter Futures with tomorrow's play group being the first step.

I advised [AS] that I would need to discuss our meeting with my manager before any further decisions were made and arranged to speak to her again on Friday.'[110]

The Benevolent Society records

110. CT's notes of the home visit with SH on 23 July 2015 indicated that SH told AS to engage with the Brighter Futures program or risk having her children removed.[111] Supervisory notes made after this visit by CT and KD (the notes are dated 23 July 2015 but signed on 7 and 4 September 2015 respectively) also record that AS was demonstrating 'disguised compliance' and was unwilling to actively engage in their program.[112] It was noted that The Benevolent Society would advise FACS that DB and TW were in need of a 'thorough statutory response to ensure their safety and wellbeing'.[113]

FACS response on 24 July 2015

111. On 24 July 2015, SH called AS to find out if she had taken TW to the doctor. AS said she had and he had given her cream to apply.[114] SH then called CT, who confirmed she had seen a medical certificate from the doctor and that he had prescribed cream, although the report did not make reference to concerns about TW's penis. CT said she 'still has serious concerns about AS's parenting and ability to care for the children'.[115] SH also recorded that CT had told her that AS said 'her grandmother will be returning soon and she will be living with her after her return in early August'.[116]

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110 Vol 2, Tab 72, File Note Record – Interview dated 23 July 2015

111 Vol 3 Part A, Tab 99, Benevolent Society file made by CT 23 July 2015

112 ; Vol 3 Part A, Tab 100, Benevolent Society supervisory notes made by KD dated 23 July 2015 (signed 4 and 7 September 2015)

113 ; Vol 3 Part A, Tab 100, Benevolent Society supervisory notes made by KD, dated 23 July 2015 (and signed 4 and 7 September 2015)

114 Vol 2, Tab 73, File Note Record – General File Note dated 24 July 2015

115 Vol 2, Tab 73, File Note Record – General File Note dated 24 July 2015

116 Vol 2, Tab 73, File Note Record – General File Note dated 24 July 2015

112. On the same day CT emailed SH a copy of a medical certificate from Dr M Sella Thurai (Bass Hill Plaza Medical Centre).[117] The certificate from Dr M Sella Thurai certified that '[TW]' attended the Bass Hill Plaza Medical Centre on 23 July 2015 because of 'extensive nappy rash require resinol cream to be applied 3 x 1 day & frequent nappy change.'[118]

The Benevolent Society home visit on 27 July 2015

113. On 27 July 2015, CT and another caseworker from The Benevolent Society, , attended AS's home and conducted a home visit.[119]

114. During the visit AS told CT that TW 'drives me insane' and 'doesn't follow directions'. CT formed the view that AS did not appear to have a bond with either child, was not observed to engage in play with either of them, appeared very abrupt with the children and had unrealistic expectations of both children. CT concluded her file note of the visit as follows:

> '<u>Analysis</u>
>
> CW is concerned for the current state of the home in terms of cleanliness and safety. CW observed [DB] to be sucking on old bottle of milk and eating food from a plastic bag. There were also numerous objects that were on the floor that [DB] could put in her mouth. CW in concerned that both children as when CW arrived both children were in dirty nappies and [AS] needed prompting to change them both. [AS] does not appear bothered by the state of the home. [AS] does not have a bond with either child. [AS] has not been observed to engage in play with either child. [AS] has been observed to be very abrupt with her children and have unrealistic expectations of both [DB] and [TW]. [AS] appears to need support tuning into her children's needs and following their lead and requests.' [120].

31 July 2015 – AS attends 'Bringing Up Great Kids' session

115. On 31 July 2015 CT and , a Benevolent Society Caseworker, picked up AS and her children at their home and drove them to The Benevolent Society's Bankstown office to attend a 'Bringing Up Great Kids' parenting program session. CT 's notes on that day quote , a Child and Family Worker who observed AS during the sessions, as follows:

> 'I observed that she ([AS]) was engaging with the group and offered some reflective feedback in terms of the discussions we were having. I understand from conversations with yourself and others in the team however that she is service savvy and this may be superficial participation.'

AS and the children move to Lilyfield and AS requests assistance to buy a cot

116. On 5 August 2015, by which time AS and the children had moved into AS's maternal grandmother's () house at , AS called SH

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[117] Vol 2, Tab 24, Statement of SH , at [114]

[118] Vol 3 Part A, Tab 101, Medical Certificate re TW dated 23 July 2015

[119] Vol 3 Part A, Tab 103, Benevolent Society file note made by CT dated 27 July 2015

[120] Vol 3 Part A, Tab 103, Benevolent Society file made by CT dated 27 July 2015

SH and asked for help to buy a new cot.[121] SH's record of the call included that AS said she had moved to Leichhardt and was now living with her grandmother. It also included the following:

> '[AS] has said she wants to remain involved with Brighter Futures who will be visiting her at her grandmothers house on Monday.
>
> [AS] said that when she went to the Chester Hill address to pick up the rest of her belongings, the landlady had thrown away some of the furniture – including the baby's cot.
>
> [AS] said she can't afford to buy a new cot and wanted assistance to do so.
>
> I advised her to contact charity organisations to see whether they were able to assist. I also advised her to contact her local CSC to request assistance.'[122]

Seventh ROSH report – 5 August 2015

117. A (seventh) ROSH report was made to the Helpline on 5 August 2015.[123] This report was made by CT.

Actions taken by FACS

118. The Helpline screened the report as ROSH and recommended a response within 24 hours.[124] There are no documents which indicate that The Benevolent society was informed of any outcome by FACS.

119. On 6 August 2015, , A/Manager Casework, Triage Assessment, Bankstown CSC, prepared a 'Report Acknowledgment and Triage Status', on behalf of BG, noting the report had been allocated to SH.[125]

Other matters around this time reported to FACS Serious Case Review team

120. It was reported to FACS Serious Case Review team, when it was conducting its review following DB's death, that a FACS caseworker told a staff member at The Benevolent Society to make a report to the Helpline if they had continued concerns, which would be sent to the local office where AS and the children were living. However, there are no contemporaneous records that evidence this advice being given.[126]

121. At the time CT made the ROSH report (on 5 August 2015) Bankstown CSC had not closed the case and so that ROSH report went back to Bankstown CSC and was not sent on to the FACS local office, whose catchment included Lilyfield, where AS and the children were now living.[127]

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[121] Vol 2, Tab 74, File Note Record – General File Note dated 5 August

[122] Vol 2, Tab 74, File Note Record – General File Note dated 5 August 2015

[123] Vol 2, Tab 75, Contact Record – ROSH report dated 5 August 2015

[124] Vol 2, Tab 75, Contact Record – ROSH report dated 5 August 2015

[125] Vol 2, Tab 79, Report Acknowledgement and triage status dated 6 August 2015

[126]

[127]

122. It was also reported to FACS' Serious Case Review team, during its review, that when staff from Bankstown CSC contacted Central Sydney CSC and spoke to them about transferring the family to their office, Bankstown CSC were told that it was unlikely that the family would be allocated because the Benevolent Society was involved and the final risk level was 'low'.[128]

Actions taken by FACS

123. At 6.13pm on 5 August 2015 a CRT after hours call was made by (CRT caseworker) to AS. She informed AS who she was and where she was calling from and asked her what arrangements she had made for DB that night. AS said she had spoken with her Benevolent Society caseworker 'and the allocated worker at Bankstown' and had 'requested assistance and neither provided assistance'. She said she 'has pushed her bed up against the wall, and will put pillows and blankets as a divider between herself and DB'. The CRT caseworker told AS to call Bankstown CSC the next day 'for assistance as the plan will be sent there as there is an open plan with that office'. A note of the call reads, 'Consultation with MCW , she confirmed that the plan will be sent to Bankstown and that [AS] should contact that office. Decision made that the issue of [DB] falling out of the bed has been addressed for the night.'[129]

124. On 7 August 2015 BG, Manager Casework, Bankstown CSC, called AS and informed her that she had purchased a portable cot for her and arranged for a FACS support worker to deliver it to her home. A record of the call made by BG reads:

> 'P/Call to [AS], mother of [DB] & [TW]. [AS] advised that she had attempted to obtain assistance to obtain a cot today without success. I advised [AS] that I would arrange for the purchase of a portable cot for [DB] as an interim measure for over the week-end & have it delivered to her home @ Lilyfield this afternoon. I further advised [AS] that SH, her CPCW, would follow up with her next week.
> Arranged for , CWSO, to purchase portable cot from K-Mart.
> Arranged for , CPCW, to deliver cot to [AS] @ Lilyfield address'[130]

125. This was the last contact Bankstown CSC had with the family.[131]

126. From 8 August 2015 to 19 December 2016 there is no record of any contact between FACS and the family and no record of any Helpline call or report.[132]

The Benevolent Society Home Visit – 10 August 2015

127. On 10 August 2015, The Benevolent Society caseworkers, CT and , visited AS and the children at AS's maternal grandmother's house at where they were now living.[133] (DB's great-grandmother and AS's maternal grandmother) was present. The Benevolent Society caseworkers noted

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[128]

[129] Vol 2, Tabs 77 & 78, Assessment Record – Secondary Assessment Stage 1 dated 5 August 2015

[130] Vol 2, Tab 80, Assessment Record – Secondary Assessment Stage 1 dated 7 to 25 August 2015

[131]

[132]

[133] Vol 3 Part A, Tab 107, Benevolent Society file note made by CT dated 10 August 2015

concerns about AS's attachment to DB and TW, the children's physical health, possible developmental delays and previous reports of neglect. The Benevolent Society caseworkers were of the view that AS found it difficult to notice her children and their cues. A file note of the visit made by CT concludes:

> 'Analysis
>
> It is CW assessment that [AS] has only been engaging with BF in a minimal sense and has cancelled a number of visits. CW is seriously concerned for [TW] and [DB] given the most recent and ongoing reports in regards to medical neglect, in adequate supervision.
>
> Plan of Action
>
> CW to contact SH at Bankstown FACS to update her on the home environment and request a transfer to Central CS given the open plan that currently exists in Bankstown. [AS] stated that she would continue to come to the parenting group on Fridays.'

The Benevolent Society end their involvement with the family

128. On 13 August 2015, the family was assessed as no longer eligible for the Brighter Futures program as the risk was beyond the remit of Brighter Futures and they had moved out of area for The Benevolent Society Brighter Futures Program in South Western Sydney.

129. KD, Brighter Futures Team Leader at the Benevolent Society, emailed SH, at 1.02pm, copying CT and Ms Hayes in. The email read:

> 'Hi SH,
>
> I'm just following up on your conversation with CT regarding the above family who have a current open plan with Bankstown CSC. As you're aware, the family have recently relocated out of the Bankstown LGA and are no longer eligible to receive the service from Bankstown Brighter Futures. I understand from your call this morning that you feel a transfer to Central and Eastern CSC would not be appropriate given the process associated with this and your concern regarding there being a delay in continuity of care for [TW] and [DB].
>
> My preference would be for the matter to be picked up by Central and Eastern CSC given the limited changes we have seen in [AS]'s ability and willingness to promote the safety and wellbeing of [TW] and [DB], however if this is not possible then I think the best way forward for [DB] and [TW] is for a ROSH level referral to be made by Bankstown CSC to reflect the current (and repeated) open plan status and the unresolved and indeed escalating concerns we have seen regarding [AS]'s ability to care for [TW] and [DB] over a period of several months. I am very concerned for the welfare of [TW] and [DB] and believe that this needs to be acknowledged through a ROSH referral from Bankstown CSC pertaining to the recent ROSH reports and open-plan as opposed to a case transfer between Brighter Futures Lead Agencies. This is due to the fact that [AS] has not demonstrated sufficient capacity to engage around these concerns in the voluntary context of Brighter Futures, despite encouragement from yourself and the collaborative approach you and CT have taken to engage [AS]. If Central and Eastern CSC aren't able to take on the transfer then a ROSH level referral to SDN Brighter

Futures Redfern based on the current open-plan will ensure that the seriousness of the concerns for [TW] and [DB] are captured on the KiDS system.

In light of the above and considering the current open-plan with Bankstown CSC I have closed [TW] and [DB's] file today and will not be taking any further action.

Thanks

KD '[134]

130. There are no electronic records in KIDS to reflect that FACS responded to the email from the Benevolent Society.[135]

[134] Vol 2, Tab 82, Email from KD to SH, copying in Ashton Hayes and CT re transfer and referral of DB's family dated 13 August 2015; Vol 3 Part A, Tab 108, Email chain top email from KD to SH

[135]