CORONERS COURT

OF NEW SOUTH WALES

Inquest:	Inquest into the death of KP
Hearing dates:	9 December 2024 – 11 December 2024
Date of findings:	30 May 2025
Place of findings:	Coroners Court of New South Wales, Lidcombe
Findings of:	Magistrate Kasey Pearce, Deputy State Coroner
Catchwords:	CORONIAL LAW – death of 3-month-old baby – family known to Department of Communities and Justice – cause and manner of death
File number:	2022/00017352
Representation:	Mr J Harris, Counsel Assisting the Coroner, instructed by S Ellicott and C Hill of the Crown Solicitors Office Ms J Chapman instructed by S Watson of Lander and Watson for Albury Wodonga Health Mr P Rooney, instructed by R Cooke of Hicksons Lawyers for Murrumbidgee Local Health District Ms E Sullivan, instructed by S Young of Department of Communities and Justice Legal for the Department of Communities and Justice
Non publication order:	A non-publication order has been made pursuant to section 74(1)(b) of the Coroners Act 2009 (NSW) in relation to the name of the deceased and members of his family, as well as the names of employees of the Department of Communities and Justice. A copy of this order is on the Registry file

Findings:	**Identity** The person who died was KP **Date of death** KP died between 12 January 2022 and 19 January 2022 **Place of death** The available evidence does not allow for any finding to be made as to KP's place of death. **Cause of death** The available evidence does not allow for any finding to be made as to the cause of KP's death. **Manner of death** The available evidence does not allow for any finding to be made as to the manner of KP's death.
Recommendations	To the Chief Executive Officer, Albury Wodonga Health, Murrumbidgee Local Health District 1. That AWH and MLHD consult with a view to formalising the administration and governance of the SAFE START Program for the Murrumbidgee Local Health District and the Albury Wodonga Health catchment, which is networked with Victoria. This consultation should consider formalising: (a) a clear and documented allocation of roles and shared distribution of responsibility for the administration of the SAFE START program between each health Service; (b) which agencies will be responsible for the administration of the program; (c) expectations for participation by the agencies in case management meetings; (d) minute taking and distribution of minutes; and (e) a process to identify and track agreed action.

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1 Introduction

1.1 This is an inquest into the death of KP. KP was 3 months old when he died in January 2022.

1.2 At the time of his death, KP was in the care of his mother. They were living in a granny flat at the rear of a property owned by KP's maternal grandparents in Corowa.

1.3 Unfortunately, the court knows nothing about KP's emerging personality, and only a little about what he looked like. We know that he had blond hair and blue eyes and that he seemed to have overcome the difficult start he received in life due to health complications he suffered before his birth. We know also that his extended family loved him.

1.4 In making these findings, I acknowledge the profound impact that KP's death has had, and will continue to have, on both his immediate and extended family and on behalf of the Coroners Court of NSW I extend my sympathies for their loss.

2 Why was an inquest held?

2.1 Under the *Coroners Act 2009* ('the Act') a coroner is responsible for investigating all reportable deaths. This investigation is conducted primarily so that a coroner can answer questions that are required to be answered pursuant to section 81 of the Act, namely, the identity of the person who died, when and where they died, and the cause and the manner of that person's death. A secondary function of a coroner is to make recommendations, arising from the evidence, in relation to any matter connected with the death.

2.2 Section 27 of the Act provides that an inquest is mandatory where it appears to the coroner that a person died, or might have died, as a result of a homicide (that is, an unlawful death) or where the manner and cause of the person's death have not been sufficiently disclosed.

2.3 Section 24(1)(c) of the Act provides that only a senior coroner has jurisdiction to hold an inquest concerning a death or suspected death if it appears to the coroner that the person was a child, or the sibling of a child, in respect of whom a report was made under Part 2 of Chapter 3 of the *Children and Young Persons (Care and Protection) Act 1998* within the period of 3 years immediately preceding the child's death. KP falls into this category. In such cases, there is a clear public interest in ensuring that the death of a vulnerable child,

who has previously been reported to the Department of Communities and Justice (**DCJ**),[1] is fully investigated to ascertain whether the state should have provided greater assistance to the child's family or whether missed opportunities for care and support can be identified and rectified.

3 The inquest

3.1 The Court received ten volumes of extensive documentary evidence and heard oral evidence over the three days of the inquest from the following witnesses:

1. Dr Bernard I'Ons, the forensic pathologist who conducted the autopsy on KP's remains;
2. Dr David Christie, KP's paediatrician;
3. Child and Family Health Nurse (**CFHN**) Bernice Nardino;
4. Detective Senior Constable Matthew Kelly, the Detective in charge of the investigation into KP's death;
5. CFHN Debbie Sanger, coordinator of the Albury SAFE START program;
6. Ms Kate Alexander, the Senior Practitioner of the Office of the Senior Practitioner (**OSP**) in DCJ;
7. Dr Andrew Ellis, a forensic psychiatrist, who provided an expert report regarding the mother's mental health;
8. Dr Susan Marks, a child protection paediatrician, who provided an expert report for the court.

3.2 A list of issues was prepared before the proceedings commenced. These issues guided the coronial investigation and shaped the conduct of the inquest. These issues were:

1. Did the Department of Communities and Justice conduct an adequate safety assessment? If not, what factors contributed to the inadequacy?
2. Why was no risk assessment performed?
3. How was information regarding risk shared between stakeholders, including through the SAFE Start meetings? Was this process adequate?

[1] I have used the acronym 'DCJ' throughout this document to refer to the organisation with primary responsibility for child protection in New South Wales, although it has been known by several different names and acronyms throughout its history.

4. Was there an adequate response when [the mother] failed to keep appointments with health practitioners and caseworkers? Should caseworkers have attended the home?
5. Was there an adequate and timely response to the risk of significant harm report received on 17 January 2022?
6. What were the circumstances of [KP's] death?
7. What factors may have caused or contributed to [KP's] death?
8. What statutory findings are available, pursuant to s81 of the *Coroners Act 2009*, regarding:
    a. the identity of the deceased
    b. the date and place of death, and
    c. the manner and cause of death?
9. Is it necessary or desirable to make any recommendations in relation to any matter connected with the death?

4 KP's life

KP's family background

4.1 KP's mother is known to have had three other children prior to KP's birth with a man, JK, that she met in 1999. The relationship between KP's mother and JK appears to have deteriorated in about 2012. After the end of this relationship, the eldest child (**the first sibling**), initially lived with her father, but returned to live with her mother, and later moved in with a boyfriend. Of the younger two children, (**the second and third siblings**), the second sibling appears to have lived with his father, while the third sibling remained with the mother. Between about 2015 and 2017 nine reports were made to DCJ about the care the mother provided to the first and third siblings. These reports raised concerns about missed medical appointments for the children, poor school attendance, neglect, and the mother's mental health and drug use. Although DCJ referred the mother to Brighter Futures, she failed to engage.

4.2 In September 2017, the third sibling moved to live with his father pursuant to a family arrangement, that is, without any formal decision having been made as to his placement. A safety plan was agreed to in December 2017 which provided that the mother could have

contact with the second and third siblings for 2-3 hours once a week, supervised by the maternal grandmother. There were no further reports about the family until KP's birth.

4.3 Shortly after the third sibling moved in with his father in September 2017, the mother appears to have suffered a deterioration in her mental health. On 17 October 2017 she called police claiming there were robbers in her home. Although police attended, they were unable to find anything out of the ordinary. Later the same day the first sibling, then 15 years old, contacted police alleging that her mother had stripped half naked and was threatening to self-harm by ingesting rat poison. Police arrived and restrained the mother. She was sedated and taken to Wangaratta Hospital pursuant to s 20 of the Mental Health Act. She was detained as a mentally ill person at Wagga Wagga Base Hospital for a week before she was discharged on 23 October 2017. During this admission she was diagnosed with drug induced psychosis and was prescribed Olanzapine. Although it was intended that the mother follow up with her General Practitioner on her release, there is no evidence that this occurred.

4.4 A further incident occurred on 20 October 2020, when staff at Woolworths in Corowa asked to search the mother's bag. She allegedly became aggressive, and staff called police. Police found nothing in the bag and issued the mother with a move on direction. They arrested her when she refused to comply. When police were escorting the mother to a police vehicle, she allegedly assaulted a police officer, leading to police charging her with further offences. She appeared at court and was sent to Albury Hospital for a mental health assessment. She was not found to be either mentally ill or disordered and was returned to court where she was convicted and fined.

4.5 In about November 2020 the mother met a man, D, on Facebook. They commenced a casual relationship in about January 2021. Around this time, the mother became pregnant with KP. The mother and other members of her family appear to have thought that D was KP's father, although subsequent DNA testing proved that this was not the case. The identity of KP's father remains unknown.

4.6 The mother attended a doctor in April 2021 who confirmed that she was pregnant. She attended for a 14-week scan, which was normal. She also attended a 'booking in' appointment on 21 July 2021. This appears to be the total of the ante-natal care accessed by the mother. The mother was a regular smoker of cannabis. She continued to smoke during her pregnancy with KP.

4.7 The mother moved into a granny flat out the back of her parents' house in Corowa shortly before KP's birth.

KP's birth

4.8 KP was born by spontaneous vaginal delivery on 18 October 2021 at Wodonga Hospital. Although he was born at 38 weeks and 1 day gestation, almost full term, KP was very small. He weighed just 1.42 kgs at birth and had a head circumference of 29.5 cms, placing him below the third percentile in both weight and height. Despite this, he had an APGAR score of 9 at both 1 minute and 5 minutes. Doctors later diagnosed KP with a severe form of intrauterine growth restriction, due to what was thought to have been abnormalities in the functioning of his mother's placenta. KP was also born with a congenital deformity affecting three of the fingers on his left hand due to an 'amniotic band sequence' that had restricted growth during the pregnancy.

4.9 Because of his condition at birth, KP was transferred to the special care nursery and remained in hospital for five weeks. He was initially treated for hypoglycaemia and hypothermia and was fed with a nasogastric tube. Cannabis was detected in samples of meconium and urine taken from KP after his birth.

4.10 For the first couple of weeks that KP was in hospital he was fed with expressed breast milk with human milk fortifier and when the supply of expressed breast milk was running out, he was changed across to Nan Comfort formula, although made in a more concentrated way based on calculations from the hospital dietician.

4.11 Aspects of the mother's behaviour after KP's birth were unusual. On 19 October she reported blurred vision to a nurse, although she said that this was normal. The following day, another nurse recorded that the mother appeared to be disoriented, although she had just woken up. On 21 October, she said to a nurse, without any context that '*she doesn't want to be burnt again*.' On the day of her discharge, 22 October, the mother saw a social worker. She was reported to be hostile, avoiding eye contact and turning her back. At one point she said she was going outside to '*calm the F down*.'

4.12 The hospital discharged the mother on the afternoon of 22 October. The same day, a Risk of Significant Harm (**ROSH**) report was made to DCJ in relation to KP. This report outlined concerns about KP and his mother, that cannabis had been detected in KP's system, that his mother had only attended a couple of antenatal appointments, and that she had

declined social work support. There was concern about how the mother was going to cope in caring for KP.

4.13 The mother returned to the hospital to visit KP in the special care nursery most days after her discharge. Some of the other parents who were also visiting children in the special care nursery recall that some of KP's mother's behaviour was odd. There is evidence that the mother mentioned to other patients at one point that she had put dead kittens in the freezer.

4.14 While KP remained in the nursery, the mother expressed consistent reluctance to engage with support services offered including social work, physiotherapy, lactation consultant, and a dietitian.

5 DCJ involvement with KP

5.1 The DCJ Helpline assessed the ROSH report made on 22 October 2021 and referred it to the local Community Service Centre (**CSC**) at Albury. About ten days later, on 2 November 2021, it was discussed at the Albury CSC Weekly Allocation Meeting (**WAM**). At that meeting, KP's case was allocated to a caseworker, DCJ practitioner G. G had been in that role since March 2021, that is, about 8 months.

5.2 On being allocated the report, G reviewed DCJ's records about the family, contacted Wodonga Hospital, spoke to a social worker there, and made attempts to contact the mother, which were unsuccessful.

5.3 On 10 November 2021 G participated in a 'pre-assessment consultation' (**PAC**) with DCJ practitioners, B, C, and H. The purpose of the consultation was to plan for a face-to-face meeting with KP's mother.

5.4 On 15 November, practitioners G and H met the mother at the hospital, where KP remained in the nursery. This was the first of two occasions when caseworkers met with the mother prior to KP's death. During the meeting, which lasted for an hour, G told the mother about the concerns DCJ had for KP, which were: lack of antenatal care, the mother's mental health history and drug use, KP's low birth weight and his deformity, and also cannabis being found in his system. The mother disclosed to the caseworker during this meeting that she had previously been scheduled, and she also said she had been prescribed medication for schizophrenia for a couple of nights, although not diagnosed with any mental health condition.

5.5 Following the meeting, DCJ practitioner G spoke to her manager, and informed the mother that representatives of DCJ intended to visit her at her home the following day to assess the living conditions. The mother is recorded as having been upset at this prospect.

5.6 On 16 November, DCJ practitioner G did attempt to visit the mother at her home, along with DCJ practitioner F. The mother was not there, although KP's maternal grandparents were present. They advised that the mother was staying in a hotel in Wodonga for the night. KP's maternal grandfather showed the caseworkers through the granny flat. Caseworkers described it as a converted corrugated iron shed. There were a number of cats present within the granny flat at the time. It smelled of urine and faeces, was dark, had no hot water and no oven. DCJ practitioner G contacted the hospital for advice about this and was advised that it would be preferable if KP was living in the main house and not in the granny flat. It appears that although the maternal grandfather was initially reluctant to agree to the mother and KP living in the main house and did not understand why the granny flat needed to be repaired, the maternal grandparents agreed that KP and his mother could stay in the main house for a few weeks until repairs to the granny flat had been completed.

5.7 On 19 November 2021, G conducted a Safety Assessment. This is a structured decision-making tool used by DCJ caseworkers to identify immediate dangers, and identify actions which can mitigate those dangers, as recorded in a Safety Plan. DCJ practitioner G determined that most of the dangers identified at the initial safety assessment conducted on 10 November 'did not meet the threshold.' G identified one remaining danger, that KP was a 'drug exposed infant.' DCJ practitioner G assessed KP as 'safe with plan.' A Safety Plan was prepared involving three interventions:

'1. Intervention or direct service by caseworker. CW will be planning a return visit within the next 72 hours.

2. Use of family or neighbours or other individuals in the community as safety resources. The mother's mother and father are safety resources for the family.

3. Use of community agencies or services as safety resources. [KP] is currently in the nursery at the hospital.'

6 Safe Start

6.1 On 27 October 2021, KP and his mother were referred to the Albury SAFE START Program, a NSW Health program involving interagency collaboration, and aimed at families who are at risk of adverse outcomes in the perinatal period. In KP's local area it involved collaboration between Murrumbidgee Local Health District (**MLHD**), Albury Wodonga Health (**AWH**) (which includes drug and alcohol and mental health services), and DCJ. It was, at this time, coordinated by AWH CFHN, Debbie Sanger.

6.2 The SAFE START meetings are intended to facilitate the sharing of information between relevant agencies and identify relevant avenues for support for 'at risk' families. KP was discussed at four SAFE START meetings between his birth and death: 10 November 2021, 24 November 2021, 8 December 2021, and 12 January 2022.

6.3 At the meeting held on 10 November 2021, it was noted that KP was going to remain in hospital until he gained enough weight and that DCJ had become involved with the family. It was also noted at the SAFE START meeting that, at that stage, KP's mother was refusing to engage with a dietician or social worker. It is unclear from the SAFE START records, what of this information was conveyed to DCJ.

7 Events after KP was released from hospital

7.1 KP was discharged from hospital on 22 November 2021, after a stay of thirty-six days. By that time, he had gained weight and weighed 2.352 kgs. The paediatric team (including medical, nursing, and allied health) made detailed discharge plans prior to discharge. The discharge plan included:

- Hospital in the Home visits to the home on 24 and 26 November 2021;
- Review with the General Practitioner the following week after discharge;
- Weekly weight checks with the local Maternal and Child Health nurse;
- Review at the Royal children's Hospital Plastic surgery outpatients;
- Review at the Albury-Wodonga Paediatric Group 22 December 2021.

7.2 KP and his mother moved into the home of the maternal grandparents. It is unclear how long they remained there before they relocated to the granny flat out the back of the main building once improvements had been made by KP's maternal grandfather. DCJ

caseworkers did not attend the home during the first few weeks following KP's discharge from hospital.

7.3 There were two visits by health staff from Hospital in the Home, on 24 and 26 November. KP was weighed and found to be putting on weight and no significant issues were identified.

7.4 The second SAFE START meeting was held on 24 November 2021. DCJ practitioner E attended the meeting. The SAFE START minutes from that meeting note that '*mother stated baby has gained weight and they don't need Dietician Service*' and further, in relation to the involvement of DCJ *'(e)arly stages of risk assessment starting now baby discharged*' and further, *'(c)ase worker did home visit and is doing another one this week'*. According to DCJ practitioner E, she informed the meeting that DCJ had previously worked with KP's mother in relation to substance abuse, mental health, and intellectual disability, and that DCJ would be completing a further Safety Assessment. She also advised that KP's mother used cannabis daily, that she used it for migraines, and that it made her feel angry the next day. According to DCJ practitioner E, Drug and Alcohol services said they would like to speak to the mother about reducing her cannabis use. The SAFE START minutes note '*Action: DCJ to refer to D & A.*' It is not clear whether this ever occurred.

7.5 On 29 November 2021, CFHN Bernice Nardino, with a colleague, CFHN Van Leeuwen, visited KP and his mother at home. CFHN Nardino's role was to conduct mother and baby screening, surveillance, support, and referrals if required. This was the first of four home visits by the CFHN.

7.6 At the time of this visit, KP and his mother were still living in the main house with the maternal grandparents. Screening tests were performed, including the Edinburgh post-natal depression scale. KP's mother scored eight, which is in the normal range. KP's mother provided details about her background, including that her older children had been removed from her care and resided with their father, and that DCJ had contacted her in hospital. CFHN Nardino's impression of KP's mother at this home visit was that '*she appeared well*', '*handled the baby confidently*' and '*was receptive to the information we provided*.' A further appointment was made for 6 December 2021.

7.7 A second home visit was conducted on 6 December, by CFHN Van Leeuwen. KP was continuing to gain weight.

7.8 A third SAFE START meeting took place on 8 December. DCJ practitioner E again attended the meeting and stated that KP's mother had been assessed by DCJ and deemed to be safe. It was noted, however, that there had been difficulties contacting her, and that she was not linked with any service. It was said that DCJ were assessing the mother's living arrangements. The minutes note *'attending all apts, going well.'*

7.9 On 9 December 2021, DCJ practitioner G visited the mother with DCJ practitioner F. By this stage, KP and his mother were living in the granny flat. Caseworkers noted that conditions had improved. KP's mother was smiling and engaging with them. KP was asleep in a cot, and no dangers were identified. They discussed accommodation with KP's mother who said she was open to moving to other housing, with the Department of Housing, or Yes Housing, or with the first sibling. KP's mother also said she was not present at the last DCJ home visit, on 16 November, because she felt DCJ's approach to her in hospital had been '*invasive*'. She also declined to give a drug sample, saying she did not like peeing into a cup. She said she had reduced her cannabis use to ½ gram a day. She was given a SUDI information pack and offered a Christmas hamper.

7.10 That was the last time G, or any DCJ practitioner, saw KP prior to his death, nearly six weeks later.

7.11 On 13 December 2021, CFHN Van Leeuwen attempted to visit KP and his mother. She did not answer the door. KP's maternal grandmother said the mother was sleeping.

7.12 The next day, 14 December 2021, CFHN Nardino again visited KP's mother. She saw the mother on the enclosed veranda to the granny flat. KP appeared well and had put on weight (3.18 kg). According to CFHN Nardino, KP's mother was engaged and showed appropriate attachment to KP. The mother reported that KP had opened his bowels frequently the day prior. She said she had changed KP's formula preparation, and he appeared much more settled (recorded as 25mls to 1 scoop at discharge, now 30mls to 1 scoop). KP's mother was given advice about pets and sleeping.

7.13 CFHN Nardino again attempted to visit the mother on 20 December 2021. She did not open the door or respond to phone or text messages. CFHN Nardino called DCJ practitioner G about this and left a message. They spoke the following day, on 21 December 2021.

7.14 DCJ practitioner G said she would try to contact the mother. G then called KP's maternal grandfather and then the mother, who answered the phone. She said she had missed the appointment with CFHN Nardino because she was asleep. She was told to arrange another appointment.

7.15 On 22 December 2021, paediatrician, Dr David Christie, reviewed KP at the Albury-Wodonga Paediatric Group. He had been part of the team that had reviewed KP in hospital and was reviewing KP as part of planned follow up post-discharge.

7.16 According to Dr Christie, KP looked well and had gained weight (3.35 kg). KP's mother reported that KP had loose stools. Dr Christie thought KP had developed a cow's milk allergy. Although he would ordinarily have proposed a hypoallergenic formula, at that time there was a nationwide shortage. He instead prescribed KP an amino acid formula called EleCare, a box of 8 tins with 5 repeats. He also contacted Chemist Warehouse at Birralee, who confirmed they had the formula in stock.

7.17 Dr Christie advised KP's mother to be careful to only use the scoop that came with the EleCare formula, and not the other formula, due to the difference between the sizes. He also discussed with KP's mother a plan about what to do if things were not going well, given the upcoming Christmas break. He advised she should speak to a nurse, contact the Special Care Nursery, or call triple zero. A further appointment for Dr Christie to see KP was made for 17 January 2022.

7.18 Each tin of EleCare formula was expected to last 3-4 days. However, KP's mother only filled one prescription, on 23 December 2021, and did not finish the first tin prior to KP's death.

7.19 As KP's mother had missed the home visit with CFHN Nardino on 20 December, it was re-scheduled for 23 December 2021.

7.20 On 23 December CFHN Nardino attended the home, but the mother did not come to the door. The mother's brother and father both knocked on her door. The mother responded that she was okay but *'did not want to see anyone that day.'* CFHN Nardino spoke with the maternal grandparents who told her that the mother had taken KP to see the doctor the day before and obtained a prescription for a special formula.

7.21 CFHN Nardino left a message on the phone of DCJ practitioner G and then emailed her to report this missed appointment. The next home visit from the CFHN was booked for 4 January 2022. Caseworker G said she would meet with KP's mother after Christmas. In

fact, after the office shutdown over Christmas, on 13 January 2022 G went on leave and did not see KP's mother or contact her again.

7.22 On 29 December 2021, the previous Safety Assessment that had been conducted by DCJ on 19 November 2021 was reconsidered by DCJ. DCJ practitioner G deemed the previous danger, 'drug-exposed infant', to no longer to be relevant. However, no further face-to-face meeting with KP's mother took place, and the assessment did not address information about her changed circumstances, including her living conditions and the missed appointments. A new outcome was recorded as 'safe'.

7.23 CFHN Nardino met with KP's mother as planned on 4 January 2022. KP's mother invited her into her home. CFHN Nardino recorded that KP appeared '*vigorous and alert*.' KP's mother told CFHN Nardino that she was '*slowly getting [KP] to take the formula (currently 50 percent hydrolysed formulae and 50 percent NAN comfort).'* According to CFHN Nardino, KP's mother engaged well during the visit and '*was handling [KP] appropriately*'. The mother said she did not want CFHN Nardino to attend the following week, because '*everything was going so well'.* CFHN Nardino agreed and scheduled the next appointment for 17 January 2022.

7.24 That was the last time any service sighted KP prior to his death.

8 Events leading up to KP's death

7 January 2022

8.1 On Friday, 7 January 2022, the mother exchanged messages with her friend NB. She asked him to pick her up at 8.35pm, and her phone records suggest she left the home between 9pm and 11pm. NB does not recall this, although he believes he last saw KP with the mother a couple of weeks prior to the discovery of KP's death when he drove KP and his mother to see the first sibling. It is possible that this occurred on Saturday 8 January 2022.

12 January 2022

8.2 On Wednesday, 12 January 2022, the mother failed to attend a video appointment with a plastic surgeon at the Royal Children's Hospital, Melbourne, regarding KP's fingers. It was also the third sibling's birthday, yet she did not see him.

8.3 Between 3pm and 5pm that day, NB brought the mother some items from Safeway. He recalled attending the granny flat where the mother told him KP was asleep. The door was closed, however, and he did not see KP. The maternal grandmother says she believes she last saw the mother carrying KP to NB's car that day, or the day before, although that is not consistent with NB's account.

8.4 Messages on the first sibling's phone suggest she visited her mother on the evening, of 12 January between about 7.10 pm and 9.00 pm. The first sibling recalls going to see her mother at some stage to bring her nappies or cat food, entering the flat and being told that KP was asleep in his cot. Although she did not see him, she says she could hear baby '*cooing noises*.'

14 January 2022 – 16 January 2022

8.5 The maternal grandfather believes he last saw the mother on Friday, 14 January 2022, although he was not sure if he had seen KP.

8.6 There was no activity on the mother's phone from 14 to 17 January 2022. Her phone was connected to phone towers at Corowa between 15 and 19 January, suggesting she (or at least her phone) remained at home or nearby throughout that period.

8.7 On Saturday, 15 January 2022, the maternal uncle saw a blow-up pool in the backyard behind the main house. The mother had bought the pool at Christmas for herself and KP and had bought another one for the first sibling. The maternal uncle said the pool was usually full, but on this occasion, it was nearly empty. He also saw a dirty nappy and baby's bottle next to the pool. He thought this was unusual, and took a photo, timed at 7.22 pm. He told his parents about this.

8.8 At 5:00 am the following morning, Sunday 16 January 2022, the maternal grandmother observed a light on in the granny flat. She asked the mother if she was okay, and the mother replied "*Yeah, we are right*." The maternal grandmother did not hear KP.

17 January 2022

8.9 On Monday, 17 January 2022, the mother failed to attend a scheduled appointment with Dr Christie and staff were unable to contact her. Dr Christie advised DCJ of this, via the DCJ Helpline. This was because he was concerned about the reluctance of KP's mother to engage with medical and allied health professionals at the hospital, and he did not want KP '*lost to follow-up*.'

8.10 On Monday 17 January 2022 at 11:00 am, CFHN Nardino attempted to visit the mother. The mother did not come to the door, answer her phone, or respond to messages.

8.11 At about 12.00pm, CFHN Nardino called DCJ practitioner F as DCJ practitioner G was on leave. She told him that the mother had not been available for the visit and said '*something is not right. I feel something isn't right.'* DCJ practitioner F asked to put her concerns in an email, which she did. Although DCJ practitioner F tried to call the mother he could not get through.

8.12 The maternal grandparents were becoming concerned, as they had not seen the mother or KP for days. At about 8.20 pm that evening, the maternal grandfather contacted the first sibling, asking if she had seen the mother. She suggested he knock on the door of the granny flat, which he did. He told the mother that he '*just wanted to make sure you're not dead*.' She replied '*yes*', in an abrupt tone. He did not hear KP.

18 January 2022

8.13 On Tuesday, 18 January 2022, DCJ practitioner H became aware of the ROSH report about the mother that the Helpline had received the previous day. She asked DCJ practitioner F to follow up with the mother. At 2.30pm, F tried to call the mother again. There was no answer, and he left a message.

19 January 2022

8.14 On Wednesday 19 January 2022, CFHN Nardino sent the mother a text message, arranging an appointment for the following day. She received no reply.

8.15 DCJ practitioner F tried to call the mother again at 2.25 pm. There was no answer, and he left a message. He obtained a number for the maternal grandmother and called her, saying the mother had missed an appointment with CFHN Nardino. The maternal grandmother said the mother had been staying with the first sibling in Rutherglen and had limited phone reception. She said she would speak to the mother and pass the message on.

8.16 The maternal grandmother went to the granny flat and knocked on the door, but there was no reply. She saw the air conditioning was on. She went to get the maternal grandfather and called the first sibling. The first sibling texted the mother, but there was no immediate response. She also texted the mother's friend, NB, asking him to go round to check on the mother. NB attended the premises.

8.17 At about 3.30 pm, NB and the maternal grandparents went to the granny flat and knocked on the door again. There was mumbling in response. They tried to locate a key to open the door but were unable to gain access. After knocking again, the mother said she was not well, had taken pills, and asked them to come back in six hours, as she needed sleep. They asked her about KP, and she said she had given him to her friend to look after in Albury, who had come over the night before. She declined to give any details of her friend, claiming her parents would hassle him. The maternal grandparents decided to wait and return later.

8.18 The first sibling continued texting the mother. At 4.41 pm, the mother sent the first sibling a text stating, '*we are OK, just can't risk seeing anyone for the rest of the week.'* The first sibling texted, '*Where's [KP]. Who has [KP] mum."* The mother replied, '*My mate toke him (only until I get better) I'm shitting n puking up I couldn't take care of him, so I asked for help. He is fine.'*

8.19 The first sibling asked for details of the friend, but these were not supplied. She also contacted D, who she believed was KP's father, via Facebook Messenger. He had no knowledge of KP but offered to help and asked to be kept informed.

8.20 At 9.30 pm, the maternal grandparents returned to the granny flat with a sledgehammer, intending to break the door down. They told the mother she must open the door, but she refused, saying she had '*shit everywhere.'*

8.21 The maternal grandfather decided against breaking in and just prior to 10:00 pm he called triple 0. The details of the call were broadcast to police at 9.56 pm. Two police officers, Constable Kutti and Senior Constable Morris, acknowledged the job and attended the mother's address at about 10.10 pm. They banged on the door of the granny flat and tried to gain access. They asked the mother where KP was and she replied, '*he's with a friend, he's sick.'* When asked for the friend's name and address she said, '*I'm sorry sweetheart, I'm not giving out those details.'* The mother again stated the friend was in Albury.

8.22 Senior Constable Morris obtained written permission from the maternal grandfather to force entry, and Constable Kutti then kicked the door in. The mother was inside, alone, sitting in darkness on the bed, with the TV on. There was a bucket on the floor nearby, and the empty pram was in front of the fridge. The room was quite cluttered and dark.

8.23 Senior Constable Morris commenced searching the property. He opened the fridge, and then the freezer, and he saw something wrapped in what looked like a blanket on the top shelf. Constable Kutti then went to look inside the freezer, moved the blanket and realised that the bundle in the freezer was KP. He screamed in shock and told his colleague to arrest the mother.

8.24 These events are captured on body worn video. The mother appears unemotional in the footage. She asked police, '*What am I under arrest for?*' and '*What's in the freezer?*'

9 Police investigations after KP's death

9.1 Police took the mother to Albury police station and placed her in custody. They interviewed her that night, conducted a forensic procedure, and then released her the following morning at about 11.40am. The mother subsequently participated in two further interviews.

9.2 Crime scene officers processed and photographed the scene. KP was wrapped in a blanket or play mat and was otherwise naked. The play mat had grass clippings on it, and hair. Police also obtained a sample of the grass from near the pool. KP had a small superficial wound on the left side of his head and what appeared to be blood around his left nostril.

9.3 An investigative search was conducted on 21 January 2022, with various items seized, including the fridge and the tins of baby formula. The mother's DNA was found on the blanket, and only her DNA was found on the freezer handle. Samples of water were taken from the pool, bucket, and bottle. No DNA or other substance was detected.

9.4 Police also conducted a review of the mother's phone, computer, and Facebook account.

10 Interviews with the mother

10.1 Police interviewed the mother under caution three times. The first two interviews were recorded, and the third interview was not. Her conduct during the interviews was unusual and may suggest she has a mental health or cognitive issue. Although she appeared content to answer general questions about her background and KP, she ceased answering questions when asked about the circumstances of KP's death.

First interview – 20 January 2022

10.2 The mother's first interview was conducted at about 4.30 am on 20 January 2022. When asked if she had any mental impairment, she said '*just normal blocks.'* She added *'if people, normal people, if people were to, just to see, you know, a bird, in the gutter, playing, they'd go, oh, just, it's just a bird. And it, and they go... what was underneath it, that sort of stuff.'* She later said she had '*memory relapse issues.'*

10.3 Regarding the events of the previous few days, the mother said she missed the third sibling's birthday on Friday, and had been home since then, although had been to Albury once. When asked about Albury, she said she went with a man whose nickname was '*Only*,' that she had known for about three years. She said, '*that's what they call themselves, Only…it's not him or her, it's both of them*'. She said they picked her up when she was in the street in Corowa, going to do shopping. She said she must have spoken to them. It may have been Monday or Tuesday, as she does not go anywhere at the weekend. She said she was picked up in a blue four door sedan. She said she ended up in Albury, although did not know how long she stayed, when she came back, or how she came back. She said she must have fallen asleep. She said KP wasn't with her when she got back, although later said she didn't know if he was, and did not know when KP came back.

10.4 The mother was also asked about her general circumstances, background, and KP's health. She noted that he had been unwell and '*pooing*' and that she had changed his formula.

10.5 When asked what clothes KP was wearing that day, she stopped responding to questions. She asked police, '*If I'm found guilty, what happens then?*'

Second interview – 23 January 2022

10.6 The second interview was conducted on 23 January 2022. The mother had left the property of the maternal grandparents and had moved to a local caravan park.

10.7 She was asked about KP's health. She said KP had diarrhoea while in hospital. About two weeks after he was discharged, he had loose stools. He had been on NAN formula. The doctor (Dr Christie) gave KP a script for a '*hypoengenic*' formula. She said KP '*got … food as well*, *which I'm not meant to be doing*.' She said she mixed Rafferty's apple puree into KP's formula once during the day and that she was giving him a mix of three quarters NAN formula to one quarter hypoallergenic formula. She advised that she did not tell the

doctor about this. She said she had tried the hypoallergenic formula at full strength, but KP ended up with a pain in the stomach. She also noted that the doctor had warned her to be very careful when mixing the hypoallergenic formula with NAN formula.

10.8 The mother said she had been unwell for about four days before KP's death was discovered. She was vomiting and had diarrhoea. She did not contact a doctor. She said KP was unwell too, but she was not sure when. She said he was getting '*really hot*', that his bed was saturated with sweat, that he did not eat much, and was getting very lethargic. She said she would usually cool a baby down with an ice bath, but she wasn't able to do this.

10.9 The mother said she got a prescription for the hypoallergenic formula on the same day she went to the doctor and got it from Wodonga Chemist Warehouse. She said she had five repeats but had not finished the first tin. She said she had a box full of tins. She also said she bought a cow's milk formula from the Reject Shop, which she had also given to KP, putting '*the tiniest sprinkle'* in his bottle. She alleged that the doctor had told her not to use full strength formula, and to mix it with NAN formula.

10.10 She was also asked about KP's birth, the involvement of nurses and other services. She accepted she had missed appointments and people had banged on the door, but said she did not know who it was. She denied using alternative medicines for KP. She said she had not reached out to KP's father since the birth.

10.11 When the mother was asked about how KP came to be in the freezer, she stopped responding to questions.

Third interview – 4 May 2022

10.12 The mother was interviewed for a final time on 4 May 2022. She declined to allow the interview to be recorded.

10.13 The mother again described how KP had developed diarrhoea after leaving hospital and had gone to the doctor who had prescribed hypoallergenic formula. She said he had advised her not to give full strength, and to mix it with NAN formula, initially ¼ hypoallergenic to ¾ NAN, and then increasing the proportion of hypoallergenic formula. She said she had also added a baby spoon of pumpkin or vegetable food to the bottle.

10.14 The mother admitted smoking during her pregnancy but said she had now stopped.

10.15 She said she bought two inflatable pools for Christmas, one for her and one for the first sibling. She said KP never went into the pool, as every time it was hot enough, he was asleep.

10.16 She said KP's father was D. She had messaged him after KP's death, saying she was sorry D had never met him.

10.17 The mother said that she did not want to be friends with NB anymore, and that she was not sure if he was involved (in KP's death) because his car was out the front of the house on the night KP was found.

10.18 She maintained that KP had been with her friend 'Only.' She described Only as younger than her, 30s (under 35), short hair, darker skin but 'not ethnic,' Caucasian, black hair but bald, unsure of his height, fat but not obese. She had first met him 3-4 years ago through a friend, at Lavington McDonalds. She did not have his number. The mother said she next saw him when going for a walk with KP on River Street, Corowa. He pulled up in a car, although she could not describe the car. She said she got in, holding KP in her arms and putting the stroller in the boot. She said she fell asleep in the back seat, and next remembered being at home. Only said he could look after KP and bring him home after a couple of days. According to the mother, this occurred on 13, 14 or 15 January. She next recalls her parents knocking on her door.

10.19 The mother also made comments which allude to a possible manner of KP's death. She said she did not know how KP got in the freezer. She said, *'I could have dropped [KP] in my sleep. That could be a possibility. But I've never dropped him before.'* She said, *'I remember seeing black on the top shelf.'*

10.20 She also confirmed information given by the witnesses from the special care nursery, that she had previously placed a dead kitten into the freezer. She said a cat had given birth to a still born kitten, and that cats usually eat them, but on this occasion it did not. She said she removed it and put it in a bag and put it in the freezer. She did this to see what was wrong with it, as she thought it had been poisoned. She said this occurred a few years ago. When asked if she thought it was possible she had placed KP in the freezer to preserve him, like a cat, she said, *'I can't see myself doing that after he died. I see myself calling the ambulance.'*

10.21 On 13 April 2022, there was an article in the *Daily Mail*, which provided detail about KP's death and included some messages the mother purportedly exchanged with an acquaintance. The mother said, *'I know whom was at my place that night, I've already told the police who put me in handcuffs that night. No one can do anything without further evidence.'* She said this person had *'scored for us and later gave me a lift to Albury.'* She suggested the person's parents were covering for him. The mother was asked about this article in her third interview. She said she was confused about it.

10.22 Police have attempted to identify the person the mother calls 'Only.' Police were unable to find any evidence that he existed.

11 The cause of KP's death

The evidence of Dr l'Ons

11.1 On 21 January 2022 Dr Bernard l'Ons conducted an autopsy on KP's remains. Dr l'Ons observed that both KP's weight (3633 g) and height were well below that expected for his age. He noted that KP was unclothed, there was grass on his back and that KP's body was frozen.

11.2 A postmortem computed tomography (CT) scan and X-ray were conducted on KP's remains. These did not show any fractures. Although time for defrosting of KP's body was allowed for prior to the autopsy examination taking place, the time available was insufficient to allow for a full normal examination to take place, and the effects of freezing (artefact) impeded the assessment. Despite this, Dr l'Ons was confident that there were no major injuries to KP and despite the technical difficulties due to the freezing, he was confident that there were no minor injuries either. Although paracetamol was detected in low levels on toxicology, microbiology and virology were unremarkable.

11.3 A forensic ophthalmologist, Associate Professor Svetlana Cherepanoff, examined the eyes. She did not identify any haemorrhage or other significant finding, although there was autolysis (damaged tissue from freezing).

11.4 A neuropathologist, Associate Professor Michael Buckland, examined the brain. There was again widespread artefact from freezing, but no evidence of trauma or significant pathology.

11.5 In his oral evidence Dr I'Ons commented on the presence of ice aggregates in the skin folds of the front of KP's neck, in the armpits, and in the cleft between the buttocks. In his oral evidence, he suggested that the presence of the ice aggregates could arise from several scenarios:

1. a warm body is placed in the freezer - although ice aggregates would have formed elsewhere, they may have been rubbed off by the blanket in which KP was wrapped;
2. the body was placed into the freezer when wet - the blanket would have absorbed the water on the body except for the areas in the skin folds; or
3. the freezer was faulty or had been turned on and off, in which case the body warms up a little bit and water trickles into the skin folds and then refreezes.

11.6 Dr l'Ons did not observe any significant decompositional changes on the body. He agreed that it was a reasonable proposition that if KP died before being placed in a freezer, he would have been placed in the freezer either soon after or at the time of death. He was unable to give an estimate of time between death and the body being placed in the freezer, nor was he able to conclude one way or the other whether KP was alive or deceased when placed into the freezer. He observed that intrauterine growth retardation and failure to thrive are risk factors for sudden unexpected death in infants.

11.7 Ultimately Dr I'Ons recommended KP's cause of death be recorded as '*unascertained*.'

The evidence of Dr Susan Marks

11.8 Dr Marks considered possible causes of KP's death to include:

1. sudden unexplained death in infancy (SUDI);
2. suffocation/asphyxia, either intentional or unintentional;
3. drowning; and
4. consequences of inadequate nutrition

11.9 Dr Marks was unable to determine the cause of KP's death. In her oral evidence she commented:

'I don't think it's a sudden unexplained death. But beyond that, I don't really know.'

12 Consideration of issues

12.1 I wish to make clear, that although in my view, there were shortcomings in the compliance by DCJ practitioners with various policies and processes, and that in some

respects, things could have been done better, the comments I make in relation to the issues considered at the inquest are offered with the benefit of hindsight. By my comments, I do not intend to suggest in any way, had the identified deficiencies not occurred, that KP's death could, or would, have been avoided. In addition, nothing in my comments should be taken to indicate criticism of any individual involved in the care of KP or his mother. On the contrary, I was impressed with the care and professionalism of all who dealt with KP and his family.

1. Did the Department of Communities and Justice conduct an adequate safety assessment? If not, what factors contributed to the inadequacy?

12.2 The DCJ Safety Assessment commenced with the Pre-Assessment Consultation (**PAC**) participated in by DCJ practitioner G with practitioners B, C and H on 10 November 2021. The document recording this process evidences a comprehensive consideration of the reported risks associated with KP's family, the current circumstances of KP and his mother, as well as details of the family's child protection history.

12.3 DCJ practitioners met with the mother at the hospital on 15 November 2021, while KP was still in the special care nursery, and attended the mother's home on 16 November 2021. Although the mother was not present, they spoke with the maternal grandparents and assessed the granny flat where the mother intended to live with KP after his discharge from hospital.

12.4 The documents reflecting the DCJ Safety Assessment evidence a thoughtful process where the caseworker analysed the information given by the mother at the hospital, the visit to KP's intended accommodation, and the content of the child protection and other records. This analysis identified potential dangers that included the mother's mental health/cognitive functioning, her drug (cannabis) use, and her ability to care for KP given her history of neglect of at least one of her older children. Ultimately, DCJ practitioner G identified only 'drug exposed infant' as a danger for KP, one which, on the caseworker's assessment, could be overcome.

12.5 DCJ practitioner G completed the Safety Assessment on 19 November 2021. It was approved by DCJ practitioner B on 31 December 2021. KP was assessed as 'safe with plan.' In her oral evidence, Ms Alexander, who appeared as an institutional witness for DCJ, characterised the Safety Assessment of 19 November 2021 as 'a good start.' I agreed with this assessment.

12.6 The DCJ practitioners appropriately identified the need for significant changes to the granny flat for it to be suitable for KP and successfully negotiated for KP and his mother to stay in the main house with the maternal grandparents for the first few weeks after KP's discharge from hospital until the granny flat could be made more suitable.

12.7 However, in retrospect, as Ms Alexander pointed out in her evidence, the proposal that the maternal grandparents be used as 'safety resources' was problematic. Although DCJ practitioners spoke with the maternal grandparents to confirm they would be able to look after KP when the mother needed, the intention was that this would occur in the context of the mother smoking cannabis. However, the mother's drug use was not discussed with the maternal grandparents, nor does it appear that there was any real engagement with them as to what might otherwise be expected of them in terms of their role as a safety resource for KP.

12.8 DCJ's SDM Safety Assessment Policy and Procedures Manual requires that a review Safety Assessment occurs when a family's circumstances change. KP's discharge from hospital on 22 November 2021 was a change in circumstances that warranted a review Safety Assessment. Although there was a home visit on 9 December, there was otherwise no structured review of the initial Safety Assessment.

12.9 In December 2021, the initial Safety Assessment outcome was reconsidered, and it was decided that KP's circumstances did not meet the definition for the danger of 'drug exposed infant'. A new outcome was recorded as 'safe'. It is unclear what the purpose of this document was, given that it replicated the information included in the Safety Assessment of 19 November and made no changes to reflect the fact that KP was no longer in hospital.

12.10 I agree with Ms Alexander that the failure to review the initial Safey Assessment was a missed opportunity to review, reconsider, and engage with KP's family and other service providers who were supporting KP and his mother after KP's discharge from hospital. A clear and measurable family action plan, developed in partnership with KP's family and the services supporting them, would have ensured that all stakeholders knew DCJ's concerns and understood that there was a coordinated plan to address any risk of harm. An effective family-led case plan could have helped to create a sense of urgency which may have supported the mother to achieve goals and could have ensured a continuing focus on KP's safety.

12.11 That said, KP and his mother were living close to the maternal grandparents who were seeing KP regularly, and up until 4 January 2022 the family was in contact with other services, such as Hospital in the Home, CFHNs, and paediatrician, Dr Christie. They observed the mother to be interacting appropriately with KP and that he was well and putting on weight. It appeared to those who saw KP with his mother, that KP was safe in his mother's care.

2. Why was no risk assessment performed?

12.12 In her oral evidence Ms Alexander explained that the difference between a Safety Assessment and a Risk Assessment is that the Safety Assessment targets immediate dangers, and the Risk Assessment is an actuarial tool that predicts the likelihood of a child being re-reported to the child protection system. It tends to be focused on longer term risks rather than immediate dangers. A risk assessment was required thirty days after the initial Safety Assessment was conducted but was not undertaken in KP's case. The reasons why this did not happen is a function of several factors. DCJ practitioner G, who had primary carriage of KP's case, was a relatively inexperienced practitioner. She took on KP's case in the period leading up to Christmas 2021. This is period when staff are taking leave, including DCJ practitioner G and her manager. Also, this all occurred in 2021, when the Omicron COVID variant had emerged in the community. Because of the COVID protocols, staff were split up in Albury CSC, so DCJ practitioner G who was the caseworker responsible for KP's case was not in the office at the same time as her manager, DCJ practitioner B which probably resulted in less supervision, support, and oversight than perhaps would otherwise have occurred.

12.13 In retrospect, there were aspects of KP's case that evidenced a degree of ongoing risk. For example, aspects of the mother's interview on 15 November indicated that she had an only superficial understanding of why DCJ had become involved with her family between October 2016 and August 2017 and the reasons that the third sibling had effectively been placed with his father in September 2017. Similarly, the mother's documented mental health history might have prompted further exploration, particularly as on 15 November the mother indicated that she had been scheduled in the past, treated with medication, and yet apparently not diagnosed with a mental health condition. No inquiries were made as to what, if any, mental health, or other support services the mother was linked with. No discussion appears to have taken place with the

maternal grandparents as to their knowledge or understanding of their daughter's mental health issues.

12.14 There were also early signs that maternal grandparents may not be able to provide adequate support for the mother in her care of KP. When DCJ practitioners visited the home on 16 November 2021 the maternal grandmother opened the door. When the DCJ practitioner introduced themselves, she closed the door and walked away. When they knocked again the maternal grandfather opened the door. It was also clear that the maternal grandparents were reluctant to allow KP and his mother to stay in the main house, despite being aware of the parlous state of the granny flat. The maternal grandfather did not appear to appreciate the inappropriateness of a new baby living in the granny flat as it was.

12.15 There were certainly signs in the DCJ and health records, even before KP was released from hospital, of the mother's ambivalence towards accessing support services – a reluctance to engage with staff, the mother declining physiotherapist follow up which was offered due to KP's low birth weight, not engaging with maternity staff or the social worker, the mother declining a lactation consultant, and the mother declining dietitian follow up and advising hospital staff that she wouldn't need services when she returned home. Even after KP was discharged, there were occasions when the mother did not answer calls from the CFHN or answer the door when service professionals attended her home, even when she was clearly aware that the CFHN would be visiting, and she had agreed to the visit.

12.16 Ms Alexander's evidence was to the effect that the risk assessment, had it been undertaken, was likely to have had the outcome that DCJ would have continued to work with the family. That happened in any event. Although caseworkers did not attend the home again after 9 December 2021, KP's case remained open. The failure to conduct a risk assessment was, again, a missed opportunity, but not one that would likely have affected what occurred in relation to KP.

12.17 DCJ conducted its own review into its conduct in relation to KP's death and has learned significant lessons from its examination of this matter. Ms Alexander gave evidence that since KP's death, there have been changes implemented at Albury CSC. Holiday arrangements have been tightened and strengthened to avoid gaps in service provision over peak holiday period. More recently, a system of casework specialists has been

implemented whereby senior practitioners work closely with new caseworkers to provide close support and guidance.

3. How was information regarding risk shared between stakeholders, including through the Safe Start meetings? Was this process adequate?

12.18 The primary means by which information about risk associated with KP and his family was shared was through the SAFE START program that was operated through Albury Community Health at the time of KP's birth. SAFE START is a New South Wales Health early intervention program for the provision of coordinated and planned responses by health workers involved in the identification of families at risk of adverse outcomes during the perinatal period. SAFE START is focused on early identification of psychosocial risk and depressive symptoms and timely access to appropriate interventions for pregnant women and families with infants up to two years of age.

12.19 At the time that KP and his mother were referred to SAFE START, in October 2021, the program was guided by the *SAFE START Strategic Policy* (PD2010-016) and the *SAFE START Guidelines: Improving Mental Health Outcomes for Parents and Infants* (GL2010-004). Each Local Health District is responsible for the development of guidelines for the operation of SAFE START in its area. The relevant MLHD guideline was *SAFE START – Families NSW Supporting Families Early* (August 2019).

12.20 CFHN Deborah Sanger gave evidence that historically Albury Community Health formed part of the MLHD before it was transferred to AWH (a cross-border service) in about 2014. SAFE START had been part of MLHD before the transfer. Although after the transfer the program continued within Albury Community Health, the absence of a formal transfer of SAFE START and other NSW programs following the split of Albury Community Health from the MLHD meant that there was no documentation via a Memorandum of Understanding or other process as to how the SAFE START program was to run.

12.21 According to CFHN Sanger SAFE START had previously been a combined effort between Community Health services within MLHD with each service taking turns to chair meetings and take responsibility for the administration of the program. However, with the move across to AWH in 2014, responsibility for SAFE START program became unclear. To navigate the resulting gaps in service delivery after the transfer, CFHN Sanger took on the role of Chair of the SAFE START case management meetings, despite this not formally

being part of her role. It was clear from CFHN Sanger's oral evidence that the responsibility for chairing and providing administrative support for SAFE START required a considerable time commitment.

12.22 CFHN Sanger outlined shortcomings in the operation of SAFE START at Albury including, but not limited to:

- the absence of clear articulation of the roles and responsibilities for those involved in SAFE START;
- inconsistent recording of minutes of the SAFE START meetings, and minutes not being incorporated into available health records;
- minutes not being circulated;
- the absence of clear articulation of any actions arising from discussions at SAFE START meetings;
- the reference in policy documents to a 'comprehensive plan developed in consultation with the family, a copy of which is held by all relevant services' not translating into any 'plan' as such, but rather minutes reflecting an exchange of information;
- that for some time community mental health services had ceased to be involved in SAFE START meetings, despite the focus of the SAFE START program being on the mental health of pregnant women and new families;
- the absence of a Memorandum of Understanding or other document that sets out the different roles of the organisations involved in SAFE START, how they participate in the meetings in terms of who would attend, how often they would attend, and what information they would provide.

12.23 It was clear from the evidence that the operation of SAFE START in Albury had been driven by the commitment of CFHN Sanger, as opposed to any formal allocation of roles and responsibilities. CFHN Sanger indicated her intention to retire in April 2025.

12.24 The meetings of the SAFE START program provided a clear avenue for comprehensive support to be provided for KP's family. Unfortunately, although KP and his family were discussed at four different SAFE START meetings, there were limited records kept as to what was discussed. Clearly though there was some sharing of information from DCJ about historical risk and dialogue about what services might be offered.

12.25 In my view, more could have been made of the SAFE START process in terms of creating a comprehensive program to support KP and his mother. However, I am not of the view that any inadequacy in the SAFE START process was significant in terms of what occurred in relation to KP.

4. Was there an adequate response when [the mother] failed to keep appointments with health practitioners and caseworkers? Should caseworkers have attended the home?

12.26 The mother's missed appointments with health practitioners develop a significance in retrospect that they may not have had at the time. It is not entirely unexpected that parents of new babies might miss appointments. However, as I've already commented there is evidence of the mother's ambivalence towards the involvement of support services even before KP is discharged from hospital, and the missed appointments with health professionals after his discharge, suggests a process of disengagement. Despite this, both DCJ and health practitioners were proactive in following up with the mother after appointments were missed to reschedule or in contacting the maternal grandparents when the mother could not be contacted. Despite the missed appointments, when health professionals did see the mother, she was caring adequately for KP. He seemed well and was gaining weight.

12.27 The question of whether caseworkers should have attended the home after the missed appointments is really part of the broader issue about the failure to review the Safety Assessment after KP's discharge from hospital, and the failure to conduct a Risk Assessment. In KP's short life, DCJ caseworkers met with the mother on only two occasions, once at the hospital on 15 November 2021 and once at the granny flat on 9 December. Quite aside from the missed health care appointments, there appears to have been something of a failure to really engage with the mother in her care of KP. With the benefit of hindsight, it is confronting that the last visit occurred about six weeks prior to the discovery of KP's death.

5. Was there an adequate and timely response to the risk of significant harm report received on 17 January 2022?

12.28 This is the report that related to the missed appointment with Dr Christie. But CFHN Nardino also contacted DCJ that day to report to caseworker F the fact that the mother had missed an appointment. The last time any service provider had seen KP and his mother was on 4 January 2022, about two weeks prior.

12.29 DCJ practitioner F tried to call the mother unsuccessfully on 17, 18 and 19 January 2022. At the time the ROSH report was received on 17 January 2022, the usual caseworker, DCJ practitioner G and her manager were both on leave. The case had not been handed over formally between staff so there was no reason for DCJ practitioner F to appreciate the risk that missed medical appointments might pose to KP's safety.

12.30 Clearly in retrospect, it could be said that the appropriate response ought to have been to go out and try to see the mother. But that is in hindsight, knowing what happened a couple of days later. I accept the way in which Ms Alexander characterised the response to this risk of harm report as 'lacking urgency.'

6. What were the circumstances of [KP's] death? What factors may have caused or contributed to [KP's] death?

12.31 The account that the mother gave in her interviews to police - that she met a person for the first time three or four years prior, saw him again in the street, and agreed to leave her three-month-old child with him without knowing his phone number or his address – is inherently implausible. There is also inconsistency in the way she described those events to police as either occurring the day prior to her arrest or possibly up to three to four days prior. The person that she mentioned she identified simply as 'Only.' Nobody else who knew the mother knew of this person, and the police investigation was not able to locate this individual or anyone matching the description or name that could be linked to the mother. I am unable to accept that the events described by the mother occurred. Unfortunately, the result is that there is no evidence as to what occurred in the days leading up to KP's death.

12.32 In terms of the timeline of KP's death, the evening of 12 January 2022 is the last occasion on which there is any evidence that KP was alive. That was the occasion when the first sibling attended the mother's home and hears baby cooing noises. There is evidence of contact of an innocuous nature between the mother and the first sibling up to 14 January which might have significance because it seems inconsistent with KP's death having occurred prior to that date. However, 12 January is the latest point at which we can establish that KP was alive.

12.33 As to precisely what occurred, of course, drawing on the evidence of Dr Marks and Dr l'Ons, it is simply not possible to say. Several possibilities were canvassed in the evidence: the possibility of drowning, the possibility of suffocation, accidental or

otherwise, and the possible effects of inadequate nutrition. But ultimately the unsatisfactory state of the evidence is that none of the possibilities that were identified by Dr l'Ons or Dr Marks rises to a level of probability.

12.34 It is tragic and inadequate, but we simply don't know what happened to KP.

13 The need for recommendations

13.1 During submissions, counsel assisting suggested a draft recommendation arising from the evidence. The recommendation was in these terms:

To: The Chief Executive Officer, Albury Wodonga Health

Murrumbidgee Local Health District

That AWH and MLHD consult in order to formalise the administration and governance of the Safe Start Program for the Murrumbidgee Local Health District and the Albury Wodonga health catchment, which is networked with Victoria. The formalisation should give consideration to:

(a) a clear and documented allocation of roles and shared distribution of responsibility for the administration of the Safe Start program between each health service;
(b) which agencies will be responsible for the administration of the program;
(c) expectations for participation by the agencies in case management meetings;
(d) minute taking and distribution of minutes, and
(e) a process to identify and track agreed action.

13.1 During oral submissions, counsel appearing on behalf of AWH welcomed the making of the proposed recommendation, stating *'it is plainly necessary*.'

13.2 Written submissions were later received from MLHD. In short, these submissions advised that AWH and MLHD had planned to meet for some time to discuss their continued collaboration in the provision of health services and that a meeting had taken place on 23 January 2025. The court was advised that there was an acknowledgment by those present at the meeting that the governance of the SAFE START program required further work and a further meeting was scheduled to occur on 20 February 2025 to continue and enhance discussions about the logistics and governance of providing ongoing services for (amongst other things) SAFE START. With respect to the proposed recommendation, it was submitted that:

a) The MLHD already has appropriate 'SAFE Start' polices (and training for same) in place together with a framework for providing services to children and families.
b) The MLHD and AWH continue to embark upon collegiate efforts to consult in relation to the administration and governance of the SAFE Start Program (networked in Victoria).
c) The allocation of roles and shared distribution of responsibility is encapsulated in current policy.

13.3 While MLHD envisaged that collegiality and collaboration between the agencies would continue, it did not consider it 'necessary or desirable' that such an arrangement would need to be formalised by way of a recommendation made by the court pursuant to section 82 of the Coroners Act.

13.4 In my view, while it is encouraging that MLHD and AWH have been meeting to discuss their continued collaboration in the provision of health services, the evidence of CFHN Sanger made it clear that the existing SAFE START polices and training do not provide adequate guidance in the allocation of roles and shared distribution of responsibility nor in how SAFE START should be organised or operate in practice. The submissions made by MLHD do not address the aim of the proposed recommendation, namely, to formalise the arrangements for the administration and governance of SAFE Start program. The advantage of a recommendation is that it may give impetus to the changes to SAFE START suggested during the inquest. For the reasons given above, I intend to adopt the recommendation proposed by counsel assisting, albeit with some minor changes to expression.

14 Findings required by s81(1) Coroners Act 2009

14.1 As a result of considering the documentary evidence and the oral evidence given at the inquest, I am able to make the following findings in relation to the matters listed in s 81(1) of the Act:

The identity of the deceased

The person who died was KP.

Date of death

KP died between 12 January 2022 and 19 January 2022.

Place of death

The available evidence does not allow for any finding to be made as to KP's place of death.

Cause of death

The available evidence does not allow for any finding to be made as to the cause of KP's death.

Manner of death

The available evidence does not allow for any finding to be made as to the manner of KP's death.

15 Recommendations pursuant to s82 Coroners Act 2009

To: The Chief Executive Officer, Albury Wodonga Health

Murrumbidgee Local Health District

That AWH and MLHD consult with a view to formalising the administration and governance of the SAFE START Program for the Murrumbidgee Local Health District and the Albury Wodonga health catchment, which is networked with Victoria. This consultation should consider formalising:

(a) a clear and documented allocation of roles and shared distribution of responsibility for the administration of the SAFE START program between each health service;
(b) which agencies will be responsible for the administration of the program;
(c) expectations for participation by the agencies in case management meetings;
(d) minute taking and distribution of minutes, and
(e) a process to identify and track agreed action.

16 Close of Inquest

16.1 I thank counsel assisting, Mr Jake Harris, and his instructing solicitors, Ms Susan Ellicott and Ms Claudia Hill of the Crown Solicitors Office, for all the assistance they have provided in preparing and conducting this inquest. I also thank Detective Senior Constable Matthew Kelly for the hard work he has done in investigating the circumstances of KP's death over several years.

16.2 Once again on behalf of the Coroners Court, I offer my sincere and respectful condolences to KP's family.

16.3 I close this inquest.

Magistrate Kasey Pearce

Deputy State Coroner

Coroner's Court of New South Wales

Date 30 May 2025