CORONERS COURT

OF NEW SOUTH WALES

Inquest:	Inquest into the death of BG
Hearing dates:	19 August 2024 – 20 August 2024
Date of findings:	17 January 2025
Place of findings:	Coroners Court of New South Wales, Lidcombe
Findings of:	Magistrate Kasey Pearce, Deputy State Coroner
Catchwords:	CORONIAL LAW – death of 7-month-old baby – family known to Department of Communities and Justice – cause and manner of death
File number:	2020/00147231
Representation:	Dr P Dwyer SC, Counsel Assisting the Coroner, instructed by K McKinlay of the Department of Communities and Justice, Legal Ms R Graycar instructed D Chennell for the Department of Communities and Justice Ms K Burke, instructed by S Robinson of the Office of General Counsel, for the Commissioner of Police and NSW Police Force Mr B Fogarty, instructed by D Captain-Webb of Legal Aid NSW, representing the Senior Next of Kin
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. A copy of this order is on the Registry file
Findings:	BG died on 17 May 2020 in Aberdeen, New South Wales The cause of BG's death was concussive brain injury BG died as a result of head injuries intentionally inflicted upon him by a known person, in the context of domestic and family violence.

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1 Introduction

1.1 This is an inquest into the death of BG. BG was 7 months old when he died on 17 May 2020 following a series of assaults on him.

1.2 At the time of his death, BG, his mother, brother, and sister, had recently moved from their home in Muswellbrook, to a new home in Aberdeen. The partner of BG's mother, AM, also moved with the family. He had a significant history of violence and of drug use. BG, his mother, and his brother were subjected to violence at the hands of this man.

1.3 It was clear from the photographs that were provided to me, along with the family statement given at the close of the inquest, how much BG was loved by his family. BG is survived by, and missed by, his mother, his now nine-year-old brother and six-year-old sister, and by his grandparents, uncles, aunt, and cousins.

1.4 In making these findings, I acknowledge the profound impact that BG's death has had, and will continue to have, on both his immediate and extended family and 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. BG 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 BG's life

3.1 BG was born on 2 October 2019 at Muswellbrook Hospital. He was carried to term at 40 weeks and 5 days. The evidence suggests that his birth was without complications except for the fact that his mother lost a substantial amount of blood. His weight was 2.94 kilograms and his length 48 centimetres. His Apgar scores were normal. Both BG and his mother were discharged from hospital on 4 October.

3.2 BG was the second child born to the relationship between his parents. At the time BG died his older sister was about 2 years old. BG's mother also had an older son from an earlier relationship who was 4 years old at the time of BG's death.

3.3 The relationship between BG's parents was marred by drug use and domestic violence. On the day of BG's birth, his father was sentenced to a term of imprisonment of 12 months with a non-parole period of 6 months for an assault occasioning actual bodily harm on BG's mother. He was released from gaol on 1 April 2020 just one month prior to BG's death. An apprehended domestic violence order (**ADVO**) that was in place at that time prevented him from having any contact with BG's mother. He never saw or had any contact with BG before his death.

3.4 There appears to have been poor engagement with pre-natal and post-natal medical services by BG's mother. Although BG was given his newborn Hepatitis B vaccine, he did not receive his immunisations at 6 weeks, 4 months, or 6 months. An ultrasound booked to investigate a distended bladder seen antenatal in BG was cancelled. After BG went home from the hospital he lived at an address in Muswellbrook with his mother and his two older siblings. According to his mother, BG was a healthy baby boy. He was bottle fed

[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.

with baby formula and began taking solids by April 2020. He had no difficulty meeting his milestones like rolling over and he was rocking back and forth preparing to crawl at the time of his death. He slept and ate normally. In the week or so prior to his death, BG had begun to hold his own bottle.

4 AM

4.1 In or about November 2019 BG's mother began a relationship with AM. She had initially met him a few years before through BG's father. According to BG's mother, AM initially got on well with her children. He encouraged the children to call him 'Dad'.

4.2 AM was 34 years old at the time of BG's death. He had had a traumatic childhood which was later reflected in his propensity to use drugs and to harm others. His criminal record commenced at the age of 17 years with a charge of common assault, and continued to include many domestic violence offences, including contravening ADVOs, stalking/intimidating and assault. He had served terms of imprisonment in relation to some of these charges.

4.3 AM had a son born in 2005 to a previous partner. He had been very violent to this previous partner, to their son, and to a son of hers from a previous relationship. An ADVO was ultimately put in place to prevent AM from having any contact with either his previous partner or his child. There is evidence that BG, his mother, and at least one of his siblings were also the victims of violence at the hands of AM. On one occasion BG's mother saw AM hit her eldest child across the buttocks with the brush of a broom, which she thought was excessive. When she confronted him about it, he said to her *'I'll do whatever the fuck I want. If you want to keep carrying on I'll hit you*.' Ultimately most of the violence was directed towards BG's mother rather than the children.

4.4 In the months prior to BG's death, neighbours of BG's family when they lived in Muswellbrook had seen, heard, or been told of a number of instances when AM had been violent towards BG's mother or damaged walls and property in her home, often in the presence of her children. None of these incidents were reported to police or to DCJ.

5 Events leading up to BG's death

Wednesday 13 May 2020 – Friday 15 May 2020

5.1 On 13 May 2020, BG's mother began moving her and her children's belongings from their home in Muswellbrook into a house in Aberdeen owned by Compass Housing. BG's mother wanted to move away from the home she and her family had been living in in Muswellbrook, in part to get away from exposure to drugs in the area where she lived, and in part to avoid contact with BG's father, who had been released from custody a few weeks prior. The move occurred over several days. BG's mother was assisted in the move by a friend, SD. He noticed at the time of the move, that there were several damaged walls in the Muswellbrook property and that BG's mother had a black right eye.

5.2 According to SD, he said to BG's mother: *'I'm not stupid. You don't have to tell me why but look at your house, you've got a black eye, what the hell are you doing?'*

She replied: *'He's violent. I'm scared. I don't know how to get out.'*

5.3 Ultimately BG's mother told police that just prior to this occasion AM had hit her in the face after an altercation over a mobile phone. She did not report this incident to police. She explained her reasons for not reporting the assault as *'…one, he was on the run, and two, he's somebody that I, if I had have reported it to youse and he was still staying at my house, I don't know what would have happened…I just I didn't report it out of pure fear.'*

5.4 AM also moved with BG's mother and her children from Muswellbrook into the Aberdeen home, although he was not listed on the lease. The first night BG's mother and her children stayed over at the new address was Friday 15 May 2020.

Saturday 16 May 2020

5.5 On the morning of Saturday 16 May 2020 BG's mother was in the kitchen when she heard BG scream. She went into the lounge room and saw AM sitting on the lounge holding BG and biting him on his left arm. BG was crying and his mother asked AM what he was doing. She took BG away from him and he called her *'a fucking dog and a fucking slut'*, and then hit her across the left cheek. After this occurred BG's mother moved the children to the kitchen and gave them breakfast. BG's mother did not report the assault on BG to the police.

5.6 BG's mother later bathed BG and noticed bruises on both the back and front of his body: a bite mark on his left arm, a bruise on his left foot, bruising to his stomach, and a dark bruise at the top of his bottom. After BG's mother had dressed him, she confronted AM about the bruises on his body. According to BG's mother she said to AM *'What the fuck is all over my son?'* to which he replied, *'I don't fuckin' know'.*

5.7 On the Saturday night, BG's mother put together her daughter's toddler bed for her to sleep in. Significantly, given the state of the bed after BG was found to have passed away, when she put that bed together on Saturday night the slats were intact, and the mattress was flat.

5.8 On the Saturday evening, BG's mother left BG and his elder brother home with AM when she went to buy some hot chips from across the road with her daughter. She was gone for roughly 15 minutes. Later investigations confirmed that the order for the chips was placed at 5:25 pm and the chips were collected at 5:40 pm. When BG's mother returned BG was on his mat on the floor of the loungeroom and the elder boy was on the lounge watching TV. After dinner she changed BG and showered the other two children. BG slept with his mother that night.

Sunday 17 May 2020

5.9 On the morning of Sunday 17 May BG's mother was in the kitchen when she heard BG scream. She entered the loungeroom and said to AM *'What the fuck is wrong with him?*' to which he replied, *'I don't know'.* She took BG into the kitchen to get his bottle and saw what appeared to be a bite mark on his left cheek. Although she hadn't witnessed it, BG's mother assumed that BG had been screaming because AM had bitten his face. BG did not report this assault on BG to the police.

5.10 At about 9:30 am BG's mother called SD to ask whether he was able to help her clear rubbish from outside the Muswellbrook address.

5.11 At about 12:00 or 12:30 BG's mother put BG down for a sleep on the toddler bed in her daughter's room. She wrapped BG in a black and white blanket and put another light pink blanket under the edge of his bottle so that BG was assisted in being able to hold his bottle. She laid him on his back on a boomerang pillow, left the bedroom door ajar, and went downstairs. By this time the other children were in the backyard along with AM, who was burning small piles of garden rubbish.

5.12 Not long after this, SD arrived at the property. He and BG's mother had a coffee. According to SD, AM was initially outside burning sticks in the backyard. Later SD saw AM walk up the hallway of the house to where the bedrooms and bathroom are. BG's mother was in and out of the house hanging up washing. When BG's mother offered SD another coffee, she realised that she had run out of sugar. SD offered to get some more sugar and left about 10 minutes later to go to the supermarket. Police inquiries confirmed that SD bought sugar from the IGA at Aberdeen at 2:54 pm.

5.13 A short time after SD left, BG's mother went to check on BG. When she walked into the room in which BG was sleeping, he didn't move. She picked him up by the arm and noticed that he was floppy, that his lips were bluish, and that his colour was unusual. He had one eye shut and the other open. She said she was still inside near the front door when she put BG on the ground to have a proper look at him. She yelled to SD, who had just returned from the shops *'You've got to help me.'* He said, *'What's wrong?'* According to SD, AM came towards the front door and said *'What?*' He then looked at BG and said, *'Oh fuck'* and then walked out of the loungeroom.

5.14 SD noticed that BG was limp and wasn't moving. He saw bruising on BG's arms. He told BG's mother to get in the car and they immediately drove straight to Muswellbrook Hospital. The older children could not fit in SD's ute, so they stayed at the Aberdeen house. On the way to the hospital BG's mother called an old neighbour from the Muswellbrook address, AH, and asked him to go and pick her children up from Aberdeen, which he agreed to do.

5.15 After SD dropped BG and his mother at the emergency entrance to Muswellbrook Hospital he drove towards BG's maternal grandparent's house. He then received a phone call from AH, so he turned around and returned to the Aberdeen address. According to both AH and SD, when they arrived at that address, AM was still inside the house, although he left shortly afterwards on foot.

6 Events at Muswellbrook Hospital on 17 May 2020

6.1 BG and his mother arrived at Muswellbrook Hospital at about 3:05 pm. It quickly became clear that BG's heart had stopped beating. Attempts were made to revive BG using CPR, intravenous drug therapy, and a defibrillator. Staff from the Newborn Emergency Transport Service (**NETS**) were watching the team at Muswellbrook Hospital working on

BG over AVL and advising on treatment. Staff at Muswellbrook Hospital conducted a continuous cycle of resuscitation for about 30 minutes, but BG showed no signs of life during that time. He was pronounced deceased at 3.41pm. Nursing staff noticed bruising on BG's arms and body, as did the doctors who treated him. At no time did AM attend the hospital or contact BG's mother while she was there. It was clear to medical staff that BG's death was likely to be referred to the coroner, so police were contacted soon after BG's death.

6.2 On their arrival at Muswellbrook Hospital, Police immediately commenced an investigation into BG's death. They spoke to BG's mother at the hospital on 17 May and recorded their conversation with her. They examined BG's body and recorded seeing circular and semi-circular shaped bruises on both his arms, chin, and both cheek areas of his face, a bruise on his right leg just below the knee, an abrasion to the top left of his left foot, and a blister on his bottom right big toe.

6.3 In addition to the interview she gave at the hospital, on 18 May BG's mother participated in a formal electronic recorded interview with police. She denied ever assaulting BG herself and detailed assaults committed on him by AM. The account given by BG's mother of those assaults is consistent with the bruising found on BG's body.

6.4 Police conducted a crime scene examination at the Aberdeen address. Multiple photographs taken of the scene by Senior Constable Sven Gerber of the Newcastle Forensic Services Group were included in the brief of evidence. Photographs of the room where BG had been sleeping on Sunday 17 May show a white coloured timber toddler bed. Relevantly, photographs show that the slats under the toddler bed are broken, the mattress is on an angle, and one leg of the bed is up on the skirting board. BG's mother told police that the bed was not like that when she last saw it.

7 AM's arrest and charging

7.1 After he was last seen by AH and SD at the Aberdeen address, AM's whereabouts were unknown. AM was eventually located hiding in the back seat of a car that was stopped by police on the New England Highway at about 6:30 pm on 20 May 2020. He was arrested and taken to Muswellbrook Police Station but declined to answer any questions in relation to the circumstances of BG's death.

7.2 Ultimately AM was charged with six offences:

1. common assault (DV) (hitting BG's elder brother with a broom);
2. intentionally or recklessly destroy/damage property (DV) (damage to the Muswellbrook house);
3. assault occasioning actual bodily harm (DV) (assault on BG's mother causing a black right eye);
4. assault occasioning actual bodily harm (DV) (biting BG's left arm);
5. assault occasioning actual bodily harm (DV) (hitting BG's mother across the left cheek); and
6. assault occasioning actual bodily harm (DV) (biting BG's left cheek).

7.3 Ultimately AM pleaded guilty to sequences 2, 3 and 5 and was sentenced to an aggregate term of imprisonment of 2 years with a non-parole period of 1 year commencing 29 March 2021.

7.4 It appears that AM's offending in a domestic violence context continued after his release from custody. On 2 March 2024 he was charged with a further domestic assault and was placed on bail.

7.5 At the time this matter was first set for inquest there was a live issue as to whether AM was a still a suspect in the police investigation in relation to BG's death. However, in April 2024 AM was himself killed in a fight with another man who struck him in the head with a scooter causing head injuries that ultimately resulted in his death.

8 What issues were considered at the inquest?

8.1 The following issues were considered at the inquest:

1. Can the cause of BG's death be ascertained?
2. Whether any act or omission of a third party directly caused or contributed to BG's death, including whether the identity of that person who caused or contributed to that harm is known.
3. The adequacy of the response by NSW Department of Communities and Justice ('DCJ') to the Risk of Serious Harm ('ROSH') reports received relating to BG and his siblings.
4. Whether the DCJ was aware of domestic violence experienced by BG's mother and children, and/or ought to have been aware via interagency communication, including with NSW Police and/or Hunter New England Local Area Health District,

and if so, whether and how that was factored into the response taken to ensure the safety of BG and his siblings.

5. Whether, and if so how, the DCJ should have intervened prior to BG's death on 17 May 2020, and if so, what lessons can be learnt from BG's death.
6. Whether changes and/or improvements to DCJ systems, procedures, and resourcing (including how it uses, and the weight (if any) it places on, NSW Police Child Wellbeing Unit (CWU) reports that are assessed as not meeting ROSH) have taken place in the time since BG's death, either at a statewide or district level.
7. Whether NSW Police were aware of domestic violence experienced by BG's mother and children, and if so, what action was taken to ensure their safety. What lessons, if any, can be learnt from a review of the actions of NSW Police in this case?
8. Whether NSW Police (including its CWU) should have taken any and/or more steps to communicate to DCJ knowledge and concerns it had prior to 17 May 2020 about BG, BG's siblings and BG's mother about domestic violence experienced by BG's mother and children.
9. Any recommendations that flow from a review of the issues set out above.

8.2 The major issues in contention at the inquest were the cause of BG's death and the manner of his death, by which we mean the circumstances leading to his death.

9 What caused BG's death?

Post mortem examination

9.1 On 19 May 2020 Dr Hannah Elstub, staff specialist in Forensic Pathology at Forensic Medicine in Newcastle conducted an autopsy on BG's remains. A summary of Dr Elstub's findings is set out below.

- BG was normally developed but small for his age with lower body weight and length than predicted. His head circumference was normal and there was no evidence of malnutrition.
- There was no evidence of fractures.
- There were multiple bruises and abrasions involving the face, neck, scalp, all limbs and both sides of BG's body. Many of these had an appearance strongly suggestive of human bite marks, particularly the injuries to the left cheek, right shoulder, left upper arm, right thigh and both flanks.

- Examination of the brain, upper cervical column and spinal cord showed several non-specific findings, including focal thin-film subdural haemorrhage, focal intra-dural haemorrhage, focal epidural haemorrhage of the cervical spine, focal sub-arachnoid haemorrhage of the cervical cord and small areas of peri-and intra-neuronal haemorrhage, the significance of which was uncertain.
- The trachea and main bronchi contained gastric contents occluding the airways distally. The lung parenchyma was congested and oedematous with focal yellow material consistent with aspiration of gastric contents and inhalation of vomitus. There was no inflammation or viral inclusions in the lungs despite a nasopharyngeal swab being positive for adenovirus.

9.2 Ultimately Dr Elstub recorded the cause of BG's cause of death as 'unascertained.'

Evidence of Associate Professor Michael Buckland

9.3 Associate Professor Buckland analysed BG's brain and spinal cord. He found:

- acute intradural haemorrhage may be present as a postmortem artefact or as agonal changes and is a non-specific finding;
- there is focal positive staining of the anterior corpus callosum in a central perivascular location which may represent mild traumatic axonal injury although changes are focal and restricted to one region and therefore are of uncertain significance;
- there is also diffuse faint staining with a zig-zig architecture which is likely to represent agonal hypoxic/ischaemic change;
- there is a small epidural haemorrhage in the supper cervical spine which is likely artefactual in origin.
- there is a very small subarachnoid haemorrhage at level C2/C3, of uncertain significance in the context of vascular congestion; and
- there are very small areas of perineuronal and intraneuronal haemorrhage of the nerve roots at levels C3/C4 and C7 of uncertain significance.

The evidence of Consultant Neurosurgeon, Professor Michael Besser

9.4 Consultant Neurosurgeon, Professor Michael Besser, provided a report to the court in which he reviewed the known circumstances leading up to BG's death, the postmortem report of Dr Elstub, the neuropathology findings of Associate Professor Michael Buckland

and the postmortem scans of BG's brain. Professor Besser also gave oral evidence at the inquest. In summary, Professor Besser's evidence was:

- BG's brain was heavier than predicted for a child of his size (970g against a predicted weight of 817g);
- there was congestion in the blood vessels to the brain;
- there were superficial head injuries including multifocal frontoparietal scalp bruises, and subcutaneous bruising with a reflexion of the scalp;
- there was no skull fracture;
- there was evidence of a focal traumatic axonal injury, that is, there had been an injury to the neurones and pathways in that area of the brain which is consistent with trauma to the brain;
- there were small areas of haemorrhage in the upper cervical spinal cord and also the nerve roots at C3/4 and C7, findings that have been universally described as evidence of the so called 'shaken baby syndrome' in the diagnosis of infant abuse; and
- there was plenty of neuropathological evidence of non-accident traumatic injury to the brain and other parts of the nervous system.

9.5 Ultimately Professor Besser was in no doubt that most of the pathological findings in a seven-month-old, barely mobile infant, represented non-accidental traumatic injury to BG's brain and nervous system.

9.6 In his evidence, Professor Besser suggested three mechanisms of sudden death in children with traumatic brain injury: epilepsy, second impact syndrome and malignant brain swelling. He felt that BG's age made him more vulnerable to these conditions.

9.7 Professor Besser excluded Sudden Infant Death Syndrome (**SIDS**) as a likely finding in BG's case as this diagnosis is one that can't be entertained in circumstances where there are findings of other injuries.

9.8 Professor Besser agreed that the cause of BG's death was concussive brain injury resulting from head trauma inflicted by a known person.

10 DCJ interaction with BG's family

10.1 Three reports were made to DCJ in relation to BG's family prior to his birth. All these related to violence on the part of BG's father towards his mother. Two (from 10 December 2017 and 8 July 2019) were triaged as involving a risk of significant harm **(ROSH**), requiring a response of less than 72 hours and less than 10 days respectively. A further report (from 31 January 2018) was triaged as non-ROSH.

10.2 The only notification to DCJ that was made after BG's birth, was on 5 March 2020 when BG was about 5 months' old, and his family were still living at the Muswellbrook address. This call included reports that BG's mother had depression, that she was struggling to care for the children and was leaving them with known drug users. A male referred to by AM's first name was reported as living at the property as well as a man who drove a white ute. A reference was made to BG's elder brother having bruises and a suspicion that BG's mother may be using ice. There was also a reference to a paedophile living at the property as well as concerns about the possibility of BG's father being permitted to visit the property after his release from gaol. The report was characterised as ROSH requiring a response less than 10 days.

10.3 There is no evidence that BG's mother was ever contacted by DCJ in relation to any of the ROSH or non-ROSH reports. Staff at the Muswellbrook Community Service Centre (**CSC**) decided to close each of the ROSH reports at the triage stage following a weekly allocation meeting (**WAM**), due to 'no capacity to allocate'.

10.4 In 2013, 2015 and 2020 information about AM, and in particular, allegations of sexual abuse of two children unrelated to BG and his family were reported to DCJ. In 2013 the Newcastle Joint Child Protection Response Program completed an assessment and substantiated sexual harm in response to allegations of sexual abuse by AM. These resulted in AM being recorded in DCJ's information system, ChildStory, on 27 August 2013, as a 'Person Causing Harm' (**PCH**). A PCH flag on ChildStory operates as a safety alert for caseworkers when they are required to make decisions about the current or future safety of a child or young person. However, prior to BG's death, DCJ did not receive any information identifying AM as a person known to BG and his family. This information therefore could not be considered in any of the WAM discussions about the reports made in relation to BG and his family.

10.5 On 4 June 2021 BG's death was reviewed by DCJ's Serious Case Review Panel. Relevantly, the review found that:

1. The intended functions of triage and assessment were not well utilised by Muswellbrook CSC when reports were received about BG's family. Despite the CSC not having capacity to respond to the reports received, there were alternate mandated options available at triage, apart from allocation, that should have been utilised.
2. Practitioners who work in triage are required to analyse confronting and distressing information about multiple families simultaneously and prioritise who should receive a response. This work is complex and requires practitioners with skill and experience who are supported with strong supervision.
3. Not all decisions made by Muswellbrook CSC about the response to BG's family were recorded. Without these records, decisions cannot be understood or critiqued. Clear recording of decisions made about children and families is not just an administrative requirement. Keeping accurate records holds DCJ to account to ensure that decisions made about children at risk of significant harm are transparent.
4. BG's mother and his siblings experienced significant violence. These experiences and the dynamics of this violence was not well understood or captured in records of decisions made by Muswellbrook CSC about the family.

10.6 Ms Katherine Alexander, the Executive Director of the Office of the Senior Practitioner at DCJ, provided two statements and gave oral evidence at the inquest in relation to initiatives that have been implemented at DCJ since BG's death. I do not intend to repeat the detail of her evidence but will refer only to the most significant changes of immediate relevance to these proceedings.

Changes to the Triage Assessment Mandate **(TAM**)

10.7 The TAM provides practical guidance to CSC caseworkers and Managers Casework when responding to and prioritising ROSH reports received from the Helpline. The aim of the TAM is to ensure that children at the highest risk are prioritised for a face-to-face assessment and that shared knowledge is used to guide decisions about the allocation, referral, or closure of ROSH reports.

10.8 A new TAM was implemented across all CSCs in February 2022. The revised TAM requires that children who are the subject of a ROSH report with a recommended response time of

24 hours be prioritised for a face-to-face assessment. It should be noted, however, that none of the ROSH reports in relation to BG's family were subject to a recommended response time of less than 24 hours. In addition, the triage process as reflected in both the new TAM and the TAM in place at the time of BG's death, appear to focus on children who have received more than 10 prior ROSH and non-ROSH reports. This was not the case in relation to BG and his family.

10.9 There appears to be a greater focus in the new TAM on preparing matters for a WAM in such a way that the ChildStory Timeline together with field assessments, notes and attachments are used to ensure the context of the relevant family's child protection history (as opposed to the single report) can be considered during the WAM. However, although Ms Alexander went into significant detail about the operation of the new TAM in her evidence, a comparison of the TAM in operation at the time of BG's death and the new TAM does not readily reveal significant changes to practice or procedure in relation to responses to ROSH reports.

Recording reasons for decision making

10.10 In her first statement, Ms Alexander provided details of several DCJ policies, procedures, and guidelines in place to assist DCJ staff to record decisions made about children and families they work with including:

1. the NSW Practice Framework;
2. the DCJ practice advice topic 'Documenting your work with family';
3. the ChildStory recording tool, which provides clear advice to caseworkers and managers about where information should be recorded within ChildStory; and
4. numerous 'how to guides' contained within ChildStory which provide guidance to caseworkers about the system requirements and casework practice considerations for all aspects of recording and reporting decisions within each record, which must be digitally recorded in accordance with the mandate for 'Managing digital records for children and young people'.

Staffing

10.11 According to Ms Alexander 'while there are a number of factors that may influence why a ROSH report may be closed without a face-to-face assessment, workforce capacity (the need to balance available caseworkers and caseworker time against new ROSH reports) is

the primary factor.' Low staffing and resourcing continue to be a significant challenge faced by Muswellbrook CSC. As of February 2024, the CSC was operating with 9.3 casework staff despite being funded for 19 full time positions. Staffing has been low since the end of 2022 and the CSC has had difficulty attracting new caseworkers to fill the vacancies.

10.12 Ms Alexander advised that the New England area has always been one of DCJ's hardest to fill locations, both in terms of attracting staff to the location and ensuring that staff are appropriately qualified. Unfortunately, even by the time of the inquest, low levels of staffing continued to plague the New England offices of Moree, Muswellbrook, Glen Innes, and Inverell. A variety of options had either been implemented or were being considered to attract qualified staff to the New England area, including those relating to rates of pay, options for providing housing as an incentive, targeted recruitment to those areas, targeted partnerships with universities, student development programs, and flying staff in from Sydney areas. Ms Alexander found it difficult to think of any potential recommendations in relation to the issue of staffing that were not already being considered or implemented.

10.13 A new manager client services started at Muswellbrook CSC in January 2024 and is working with the leadership team to streamline processes, particularly via the following strategies:

- increasing casework support positions at the CSC (which are easier to recruit to) and using these positions to buddy with a caseworker, therefore increasing overall caseworker capacity;
- exploring options such as whole team allocation to enable increased allocation of new ROSH reports; and
- building relationships with community partners and capacity building with them to increase service capacity and encourage direct referrals to services when a statutory child protection response may not be necessary or available.

10.14 Low staffing impacts upon the ability of the CSC to conduct Interagency Case Discussions (**ICDs**). However, Muswellbrook CSC is exploring creative ways to do this so that ICDs can be used and relied upon as an alternate response to increase safety of children at triage.

Reviews of DCJ practice and procedure

10.15 Ms Alexander notes in her statement of March 2024 that DCJ's Child Protection Policy team is undertaking a detailed review of DCJ's prioritisation, triage and allocation policies and processes. Insights and findings from Internal Child Death Reviews **(ICDRs**) where allocation decisions were identified as a factor, including BG's death, as well as previous findings and recommendations from the Coroners Court, are being considered in this policy review, alongside detailed analysis of current practice, extensive stakeholder consultation and a review of best practice research to develop an improved prioritisation process. The review is expected to be completed sometime in 2024, with DCJ to report to the NSW Ombudsman by December 2024 on the findings, recommendations, and outcomes of this review. At the time of the inquest the results of this review were not yet available.

10.16 On 6 June 2024 the NSW Auditor General tabled its final report of the performance audit of the Oversight of the child protection system (**the Audit Report**). The Audit Report concludes that *'[t]he NSW child protection system is inefficient, ineffective, and unsustainable'* and further *'[d]espite 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'*. The Audit Report concludes that there is an urgent need to extensively reform the child protection system in NSW. In response to the Audit Report, DCJ provided a written response to the key recommendations in which all the recommendations were accepted or supported, although, according to Ms Alexander, the timeframe and resource implications of the recommendations means that they will need to be further considered by the NSW government.

10.17 On 5 July 2024 the NSW Ombudsman tabled its report *Protecting children at risk: an assessment of whether the Department of Communities and Justice is meeting its core responsibilities* (**the Investigation Report**). The Investigation Report concluded that *'the child protection system is not adequately protecting and supporting children and families and this situation is not improving'* and included 7 recommendations for DCJ aimed at improving the child protection system in NSW. DCJ is to provide the Ombudsman with a final outcomes report on its implementation of these recommendations by no later than December 2025.

11 Police interactions with BG's family after his birth

11.1 On 21 January 2020, the State Parole Authority issued a warrant for the arrest of AM in relation to the revocation of an intensive corrections order to which he had been sentenced on 3 September 2019 at Muswellbrook Local Court. He was also wanted on two conviction warrants and two arrest warrants that had been issued by the Local Court between March 2020 and May 2020 in relation to other charges.

11.2 In early 2020 Police were actively searching for AM. It was clear that information had been provided to the police to the effect that AM was living at BG's mother's Muswellbrook address. On 17 February 2020 police attended the Muswellbrook address. BG's mother told police she had not seen AM in months. She allowed police to search her house. Police did not locate AM. This was reflected in the information recorded by police on the Central Index System for AM, which against both the Muswellbrook address and the entry in relation to his possible connection with BG's mother, the word 'unconfirmed' is recorded.

11.3 Other than what is outlined above, there is no suggestion that the New South Wales Police Force (**NSWPF**) had any information that would lead them to suspect that BG and his family were subject to, or at risk of, domestic violence at the hands of AM.

12 Conclusions

12.1 The evidence given by Professor Besser as to the cause of BG's death being concussive brain injury was compelling. The cause of death, articulated in this way, is supported by the forensic evidence, by the injuries evidenced on BG's body, by the account given by BG's mother, and also by AM's history of violence, including violence committed in a domestic context. It is also supported by findings at the crime scene as to the damage done to the bed in which BG was sleeping on the day of his death.

12.2 One of the issues raised in the course of submissions at the close of the inquest was DCJ's response to recommendation 3 made by Deputy State Coroner Grahame in Her Honour's findings in relation to the death of Baby Q which was to this effect:

> *That consideration be given to amending ChildStory so that if an Assessment Officer in a Child wellbeing Unit makes an entry under the CWU tab for a family where this is an open file at a Community Service Centre (CSC), the CSC is automatically alerted to the*

entry having been made (for example, recording contact with the family and concerns assessed as non-ROSH).

12.3 Ultimately the evidence did not suggest that recommendation 3 in the findings into the death of Baby Q had any real relevance to the inquest into BG's death. This was because firstly, there was no open file at a CSC in relation to BG and his family, and secondly, the only entries made by a CWU Assessment Officer in ChildStory in relation to BG's family were from 2018, before BG's birth, and related to ADVO breaches by BG's father prior to him being sentenced to a term of imprisonment in 2019 for violence towards BG's mother.

12.4 The evidence given by Ms Alexander, who gave evidence on behalf of DCJ, was both candid and helpful. Ms Alexander conceded that DCJ could, and should, have done more in response to the ROSH report made on 5 March 2020, the only report made after BG's birth. It is clear both from the contents of the ICDR Report and the evidence given by Ms Alexander that DCJ has learned some valuable lessons from BG's death, although it is less clear that changes implemented by DCJ between the date of BG's death and the inquest were such as to adequately address the issues raised in the ICDR report. The very comprehensive reports of the NSW Auditor General of 6 June 2024 and the NSW Ombudsman of 5 July 2024 are critical of fundamental aspects of DCJ practice and procedure, many of which are reflected in the shortcomings of DCJ in relation to BG's case. Time will tell whether much needed changes to the NSW child protection system that might assist in preventing future deaths of the most vulnerable members of our community, will flow from these two significant reviews. Inadequate staffing was, and continues to be, a key barrier to DCJ providing a satisfactory service in the Muswellbrook area, although given what DCJ is already doing to try to recruit staff to the available positions, I was unable to conceive of any recommendation that is likely to go any way towards addressing this issue.

12.5 None of the evidence given in the inquest provides any basis for any criticism of the NSWPF in relation to BG's death. While police were aware that BG's father had perpetrated violence on BG's mother (and that he had been charged, convicted and gaoled for this), there is no evidence of any report having been made to the NSWPF prior to BG's death of domestic violence perpetrated by AM against BG, his mother, or any other member of the family. Police were actively searching for AM in early 2020 due to

warrants being issued for his arrest. They attended BG's family home in Muswellbrook seemingly in response to information suggesting that AM may be associated with BG's mother. However, she advised police that she had not seen AM for months.

12.6 Counsel appearing on behalf of BG's mother submitted that the following recommendation should be made in relation to the NSW Police Force:

That within 6 months of findings being given in relation to this matter that the NSW Police Force complete an audit or review the training of officers in the Muswellbrook Local Area Command in relation to the following areas:

- *Intra-agency communication with DCJ, health and other service providers in the area including understanding of safety action meetings and intra-agency case discussions;*
- *Awareness and referrals to the Child Wellbeing Unit;*
- *Understanding risk in respect to reports of domestic and family violence and responding to those reports; and*
- *Recognizing and responding to mothers living with a child or children experiencing and /or at risk of domestic and family violence perpetrated by a male cohabitant*

and that where any gaps are found, that steps be taken to remediate those by reviewing, changing and/or supplementing training for that Local Area Command or considering introducing a buddy system or mentoring system in the LAC for more junior officers to be overseen by domestic violence liaison officers, if one has been appointed.

12.7 While the potential usefulness of a review of training of all, or any, police officers in domestic violence related matters is not disputed, the training of police officers did not fall within the issues to be considered during the inquest, nor did the adequacy of police training in domestic violence matters arise during the evidence given in the inquest. For these reasons I decline to make the recommendation suggested.

12.8 At the time of BG's death, BG's mother was 27 years old and a single mother of three children under the age of 5 years. She had already experienced a violent relationship with BG's father and was subjected to further violence at the hands of AM. It is clear that she found herself in a relationship with a man she was terrified of, and from which she found it difficult to extricate herself and her children. Friends and neighbours knew of the

domestic violence occurring in the house in which BG lived and knew that young children lived there, and yet it appears that no one reported this violence to police or to DCJ.

12.9 The circumstances of BG's death are unfortunately all too familiar to first responders, to DCJ, and to those who work in this jurisdiction. Domestic and family violence is a scourge on our community. Both the short and long terms risk that exposure to such violence poses to children, particularly very small children, like BG, is well known, as they are entirely reliant on the adults in their immediate environment for all aspects of their care and protection. We are all complicit when our silence allows domestic and family violence to be perpetrated unchecked.

13 Findings required by s81(1)

13.1 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 BG

Date of death

BG died on 17 May 2020

Place of death

Aberdeen, New South Wales.

Cause of death

Concussive brain injury

Manner of death

BG died as a result of head injuries intentionally inflicted upon him by a known person, in the context of domestic and family violence.

14 Close of Inquest

14.1 I thank counsel assisting, Dr Peggy Dwyer SC, and her instructing solicitor, Kathleen McKinlay of the Department of Communities and Justice, for all the assistance they have provided in preparing and conducting this inquest. I also thank Detective Sergeant Nicole

Hardy for the hard work she has done in investigating the circumstances of BG's death over several years.

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

14.3 I close this inquest.

Magistrate Kasey Pearce

Deputy State Coroner

Coroner's Court of New South Wales

Date 17 January 2025