
CORONERS COURT

OF NEW SOUTH WALES

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| **Inquest:** | Inquest into the death of Jacob |
| **Hearing dates:** | 10-14, 17, 19-21, 24-26 July 2023 and 30 January 2024 |
| **Date of findings** | 8 August 2025 |
| **Place of findings:** | Coroners Court of NSW, Lidcombe |
| **Findings of:** | Deputy State Coroner, Magistrate Erin Kennedy |
| **Catchwords:** | CORONIAL LAW – Child Abuse, unexplained death of an infant, methylamphetamine, failure to protect child from harm, presentation to hospital with unexplained injury, frenulum injury, gingival mucosa, multiple fractures, multiple unexplained injuries, premature birth, subarachnoid haemorrhage, subconjunctival haemorrhage, Child Protection Unit, traumatic brain injury, suffocation, impact injury, failure to maintain care within DCJ, Joint Child Protection Response Program, JCPRP, case management of infant |
| **File number:** | 2018/310524 |

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| Representation: | Counsel Assisting the Coroner: Mr Chris McGorey instructed by Amber Doyle and Yvette Edgell, NSW Crown Solicitor's Office |
| | Jacob's mother and Jacob's father: Ms Chauntelle Ingenito instructed by Kamal Hamka, King and York Lawyers |
| | Mr AM: Mr Peter Naughtin instructed by Jess Diaz, Diaz Lawyers |
| | The Secretary, Department of Communities and Justice: Mr Michael Fordham SC with Mr Ian Fraser instructed by Maria Panos and Joshua Vardanega, Norton Rose Fulbright |
| | Manager A: Mr Matthew Minucci instructed by Erica Elliott, Kingston Reid |
| | Caseworker DA: Ms Jane Taylor instructed by Ella Rooney, Minter Ellison |
| | Caseworker CS: Ms Amelia Avery-Williams instructed by Bryony Adams, Herbert Smith Freehills |
| | Manager Client Services (Parramatta CSC): Dr Katherine Fallah instructed by Rachel Garrett, Moray and Agnew |
| | JCPRP Manager Client Services: Mr Matthew Hutchings instructed by Dr Ashley Tascalos, Clayton Utz |
| | Manager M: Ms Kim Burke instructed by Mark Crollos, HWL Ebsworth |
| | Commissioner of Police, NSW Police Force: Ms Jillian Caldwell instructed by Aurhett Barrie, Office of the General Counsel, NSWPF |
| | Detective Senior Constable Tiffany Duane: Mr David Jordan instructed by Graeme Watson, Walter Madden Jenkins |

Sydney Children's Hospital Network, Western Sydney Local Health District and Dr Kapilesh Balachandar: Mr Patrick Rooney instructed by Ann-Maree Pascoli, Makinson d'Apice

Wesley Mission: Mr Clyllyn Sperling instructed by Julie Robinson, Wesley Mission

Findings:

## Identity

The person who died was Jacob.

## Date of death

Jacob died on 10 October 2018.

## Place of death

The location of his death was Toongabbie, New South Wales.

## Cause of death

The cause of Jacob's death was an unnatural event involving the application of significant non accidental force in the form of infliction of injury to his head, specifically to his face and gum region, in the process of which, based on expert opinion, Jacob was either deprived of oxygen resulting in suffocation or such infliction of injury was sufficient to cause traumatic brain injury causing death.

## Manner of death

Jacob's death was not the result of accident or misadventure but was a result of the application of significant force by unknown person/s. However, the mechanism by which this force was applied cannot be established on the available evidence.

Recommendations: To the Secretary, Department of Communities and Justice

### Recommendation 1

The findings are to be provided to the Secretary, and the Minister for Families and Communities, for consideration and review to have the opportunity to carefully consider these findings, Jacob and what occurred in the child protection response.

### Recommendation 2

The Secretary consider updating relevant guidance and policies in line with its position with a direction that cases in which an infant has presented with injuries not reasonably accounted for by caregivers, DCJ should retain case management responsibility for the child.

### Recommendation 3

The Secretary consider these findings with respect to sufficiency of the procedures around Case Transfers and Sibling Case Coordination, noting Ms Brunner's evidence that a review of the Case Transfer Mandate has been completed and changes made and a review of the Sibling Case Coordination mandate was expected to be completed in 2024.

### Recommendation 4

The Secretary give consideration in respect to the training provided to casework teams from caseworker level to Manager Client Services level regarding the assessment of the seriousness of bruising in infants that is not reasonably accounted for by caregivers. This extends to examining how there can be greater inclusion of child protection clinicians in Group Supervision sessions and casework discussions, especially in the cases of infants. Consideration should also be given to possibly using Jacob's case as part of scenario-based training of caseworkers.

To the Commissioner of Police, NSW Police Force

Recommendation 5

The Commissioner of Police, NSW Police Force, allocate the police investigation into Jacob's death to the NSW Police Force's Unsolved Homicide Team, Homicide Squad, for review and further investigation.

To the Attorney General of New South Wales

Recommendation 6

That the findings are provided to the Attorney General for his consideration and if considered appropriate to do so, with the assistance of the NSW Law Reform Commission, review the sufficiency of criminal offences in New South Wales with respect to unlawful injury and death of infants and children. This would include consideration generally of whether there would be any benefit to the introduction of an offence in NSW in similar terms to that in section 5 *Domestic Violence, Crime and Victims Act 2004* (UK).

Non-publication orders: Non-publication orders made pursuant to s 74 of the *Coroners Act 2009* and/or the incidental powers of the Court apply in this matter and are available on the Court file.

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## INTRODUCTION AND FOCUS OF THE INQUEST

1. This is an inquest into the death of a baby boy, who is referred to for the purposes of the findings as Jacob, so as to protect and respect his family, particularly his brother. Jacob was born on 19 April 2018, he was born at 29 weeks gestation and immediately went into the neonatal intensive care unit. He died on 10 October 2018, just five and a half months later. He was small for his age, the equivalent size of a 3 month old, with an adjusted age given his premature birth. He was tiny and precious.

2. Jacob was born by emergency caesarean section, and weighed just 1.2 kg at birth, with the complications associated with premature birth resulting in a number of significant health conditions. He managed to survive and grow despite his difficult and challenging start to life and, after spending over 11 weeks in a neonatal unit, Jacob's health improved greatly and by July his weight had increased to 4.1kg. By 10 July 2018 he was sufficiently well enough to be discharged from hospital, and he went home with his parents.

3. After discharge from the Special Care Nursery at Blacktown Hospital, Jacob presented twice to the Emergency Department at the Children's Hospital at Westmead (CHW) with injuries. The first time was only three days after his discharge from neonatal care, when he presented with a brain bleed and a blackened eye, a suspected inflicted injury that could not be properly explained. He was examined by the Child Protection Unit at the CHW who identified concerns for his safety, the Department of Communities and Justice (DCJ) were called in and he was discharged home with his parents with supervisions and supports put in place. DCJ determined that he was safe with a plan.

4. Jacob presented to CHW again 12 days later. The same medical team saw him, this time with bruising to the underside of his foot, which was an injury that could not be considered self-inflicted on an infant his size. The medical team called DCJ, who again returned him home with his parents. DCJ determined again that he was safe with a plan. Further supports were put in place.

5. Jacob's care need and risk level were downgraded, supports were no longer available, and he was placed under the supervision of Wesley Mission via their Brighter Futures Program. DCJ closed Jacob's file.

6. On 10 October 2018, paramedics attended the family's home as the result of a call made by his father. Jacob and his parents were the only ones present at the time the paramedics arrived. They found his mother performing cardiopulmonary resuscitation (CPR) on Jacob who was by then grey in colour and cool to touch. The paramedics could not locate a pulse. They took him to the Emergency Department at the CHW however Jacob could not be revived.

7. Jacob's death was sudden and unexpected. An autopsy identified multiple suspicious injuries. His body was found to have bruises of different ages and multiple fractures to his ribs, toes, legs, feet and fingers; fractures that were in various states of healing, indicating different infliction dates. He had bite marks. He had a laceration of extraordinary proportions on his upper gum, through to his unerupted baby teeth. These injuries had not been the result of a single incident but, rather, multiple. No disease process or abnormality was identified that reasonably accounted for his death. No explanation was ever given that could account for his injuries or his death. Jacob had been the victim of serious and significant child abuse.

8. This inquest was an exploration of what was known of his short life, to identify the manner and cause of his death, and to investigate how a baby who is known by DCJ to have occasioned two separate sets of suspicious injuries dies this kind of death. The evidence before the inquest left no doubt that Jacob had endured significant pain and suffering throughout his short life.

9. The findings are divided into two parts. The first focuses on the cause of his death, the manner of death and the role any third party had to play in the infliction of injury and death. The second relates to exploring the involvement of government agencies in the care of Jacob. Jacob was known to be a child at risk, however, went from a child who DCJ were giving close consideration to removing from his parents, to a child who had his file closed, outsourced to a lower care private agency, within just a matter of weeks.

## PART 1: INVESTIGATIONS AND THE CORONIAL PROCESS

### Injuries identified after death

10. The injuries found on Jacob's body after his death are listed below. The inquest considered these injuries in context of his death, timing of the injuries, how those injuries were occasioned, and whether any injuries could be linked to the cause and manner of his death.

11. From the evidence, we know that these injuries likely occurred in approximately a five-week period prior to his death:

    a. ***Bilateral rib fractures (healing)***: Jacob had posterior, anterior and lateral rib fractures in various stages of healing. Several were in a state of advanced healing with no acute (recent) fractures found. The posterior rib fractures found are typically caused by forceful anterior-posterior compression to the chest (e.g., fingers positioned on the posterior ribs squeezing with force).

    b. ***Other fractures (healing):*** Jacob had other healing fractures, namely:

        i. a right radial fracture (near to his wrist);

        ii. fractures in two fingers and two toes; and

        iii. possible fractures in his shins near to his knee and his right upper knee.

    c. ***Laceration to the upper gum***: Jacob had a deep, large (16 mm) laceration of the superior labial frenulum extending laterally on the right along the junction of the labial and alveolar mucosa (described as an "*irregular wound under the upper lip*"). The laceration extended a long away horizontally across the gum. It was of such depth that a baby tooth within the gum was visible. This was not attributable to the emergency treatment administered on 10 October 2018.

    d. ***Laceration and abrasion to right and left nostrils***: Jacob had three lacerations to his right nostril (nasal septum area) and one abrasion to his left nostril (appearance of healing). These was not attributable to resuscitation efforts.

e. ***Bruising of the left ear***: Jacob had extensive bruising to his left ear which showed signs of early healing. It may have resulted from forceful pinching or twisting of his ear or direct forceful blunt impact trauma to that location.

f. ***Bite markings:*** Jacob had bruising and abrasions on his left arm and left hand that had the appearance of being human bite marks.

g. ***Other markings and abrasions:*** Jacob had other injuries including:

   i. two superficial abrasions on the right side of his upper lip with discolouration (bruising) and swelling of his upper lip;
   ii. an abrasion on his left eyebrow (linear in appearance);
   iii. subcutaneous bruising on his legs and right knee;
   iv. bruising and swelling on multiple fingers and toes; and
   v. abrasions near his nails and a significant injury to the left thumb nail, which was missing, and the top of his thumb cut.

12. Jacob's parents have not reasonably accounted for any of these injuries. Just one of these injuries should have caused serious concern when found on a baby of Jacob's age and size.

13. Dr Sairita Maistry, the pathologist who carried out Jacob's autopsy, was unable to ascertain Jacob's cause of death other than that it occurred "in the context of numerous, severe and recurring non-accidental injuries".

14. Detective Senior Constable Hannah Packer (OIC) led the NSW Police Force's homicide investigation into Jacob's death. The investigation was extensive, exhaustive and excellent. No one has been charged in relation to Jacob's death or the injuries he was found to have after death.

15. This is a coronial matter that has gone through many stages of the different Coronial processes, that is; initial physical investigation, detailed evidence gathering, police investigation, medical review and expert opinion gathering. The Coronial process can take some time, and did in this case. However, through this process there has been evidence adduced to answer some of the previously unanswered questions, or move closer to answers.

16. This is an inquest that a senior coroner has jurisdiction to hold. Jacob is a child for whom a report was made under Part 2 of Chapter 3 of the *Children and Young Persons (Care and Protection) Act 1998* (CYP Act), within the 3 years before his death, and because his death is or may be due to abuse or neglect and occurred in suspicious circumstances: s 24, *Coroners Act 2009* (the Act).

17. I have been greatly assisted through the submissions of Counsel Assisting, Mr McGorey, who prepared substantive written submissions, together with Ms Edgell and before her Ms Doyle. The background material below has been drawn in part directly from this excellent and comprehensive work, and I openly acknowledge the time, effort and work they each have contributed to this very important inquest and the contribution this has made to the findings.

## The various parties

18. To assist the following is an explanation of the many parties with sufficient interest, the various acronyms used and the part each played in Jacob's care. The following is a brief summary of the several NSW Government and other institutions which were involved with Jacob, namely:

    a. ***Westmead and Blacktown Hospitals:*** Jacob was admitted to Westmead Hospital's Neonatal Intensive Care Unit (NICU) after his birth. He was transferred to Blacktown Hospital's Special Care Nursery (SCN) on 13 May 2018 where he remained until his release home in his parents' care on 10 July 2018.

    b. ***Children's Hospital Westmead (CHW):*** Jacob's parents presented Jacob to the CHW on 12 July 2018 and he was admitted until 19 July 2018. Numerous specialists consulted about Jacob (12 to 19 July 2018). The CHW's Child Protection Unit (CPU) became engaged with Jacob shortly after his presentation on 12 July 2018. The CPU specialises in treatment of children with suspicious injuries or who are suspected to have suffered abuse.

    c. ***Department of Family and Community Services (DCJ):*** Family and Community Services (FACS) now known as the Department of Communities and Justice (*herein called DCJ)* received a report from the CHW CPU team on 13 July 2018 which was screened as a risk of significant harm (ROSH) report. This report

resulted in DCJ, opening individual child protection cases for Jacob and his brother (then aged 16 months).

d. ***Parramatta Joint Investigation Response Team (JIRT):*** Jacob's matter was referred to JIRT now known as the Joint Child Protection Response Program (**JCPRP**) (*herein called JCPRP*), on 13 July 2018. Parramatta JCPRP became involved owing to the possibility that the injuries Jacob presented with on 12 July 2018 resulted from deliberate harm or neglect. The JCPRP team consisted of three government agencies working together:

    i. a DCJ casework team;

    ii. NSW Police Force officers; and

    iii. a NSW Health representative.

    The JCPRP DCJ casework team had formal child protection casework responsibility for Jacob until about 9 August 2018.

e. ***Paramatta Community Service Centre (CSC):*** Parramatta CSC is part of DCJ. Its casework team, which was separate to that within the JCPRP, had formal casework responsibility for Jacob's brother's matter after his case was opened. On about 9 August 2018, casework responsibility for Jacob's case was transferred to Parramatta CSC.

f. ***Other parties:*** DCJ also contracted non-government organisations to provide services to Jacob's family. These included:

    i. Zest Support Services (**Zest**): provided two weeks of in home support for the family after the first injury to Jacob and spanning the second injury as part of the "safe with plan" determination; and

    ii. Wesley Mission Brighter Futures Program (**Brighter Futures**): Jacob was transferred to their care following CSC downgrading his risk level and subsequently closing his file, leaving Brighter Futures visiting weekly.

## Background

### *Jacob's family*

19. Jacob's parents' relationship began in about 2014 and his parents began leasing their home in around September 2016. Jacob's elder brother was born on 17 March 2017 and Jacob was born on 19 April 2018. Unusually, both his parents suffered cardiomyopathy during 2018. His mother was admitted to Westmead Hospital on 3 April 2018, just shortly before Jacob's birth, suffering dilated cardiomyopathy with severe left ventricular dysfunction and pre-eclampsia in the context of non-compliance with medications and fluid restriction. After Jacob's birth, she transferred to Westmead Hospital's cardiology ward where she remained admitted until 10 May 2018. During her admission she received an implantable cardioverter-defibrillator device.

20. The evidence supported that both Jacob's mother and father were unwell with serious heart health conditions. At the time of his birth, Jacob's mother was taken for immediate treatment and was required to remain separately in hospital being treated for a period of time. She was discharged some time before Jacob however.

21. The family lived in a small granny flat, that really only had one bedroom. Jacob's brother was rarely at the home, he was being cared for by his mother's sister and his maternal grandmother and at the relevant time was living between those homes. There was no bed for Jacob's brother at the family home. It seemed that in the one functioning bedroom, once Jacob went home, he slept either in the main bed with his mother, or possibly sometimes in a cot that was situated in a "spare" room that appeared to be mostly used for storage. Jacob's father slept in the main room on the couch.

### *Timeline of Jacob's life prior to his first injury*

22. Jacob remained in hospital until he was 11 weeks and 5 days old, from 19 April 2018 to 10 July 2018. Initially he was in a high needs unit at Westmead Hospital, the NICU, where he stayed until he was able to move to Blacktown Hospital SCN on 13 May 2018. He was not regularly visited or supported by his parents during this time. This was of concern to hospital staff.

23. Meanwhile, Jacob's mother was admitted in the cardiology ward at Westmead Hospital. Nurses on Jacob's mother's ward noted she had been observed missing from the ward multiple times overnight. On one occasion on her return, on 25 April 2018, she had an ataxic gait and smelt of alcohol. Jacob's father was present when staff attended on his mother. Her speech was described as slurred, and she did not appear "*fully with it*".

24. A Medical Officer assessed Jacob's mother on the ward in the early hours of 25 April 2018, in the presence of his father. His mother denied substance misuse when this was raised with her. The Medical Officer stated she had slurred speech when he attended but could answer the questions asked of her. A plan was formulated that included regular tracking and a urine drug screen. Attempts to obtain a urine sample were unsuccessful. Jacob's mother's condition deteriorated further, and she was treated for acute hypoglycaemia. The doctor formed the view that this is what had affected her behaviour.

25. At about 1:00am on 27 April 2018, Jacob's mother provided a urine sample that tested positive for the presence of amphetamines. Unusually, no report was made to DCJ about this result. DCJ only learnt about this after Jacob's death.

*Pre-Jacob's discharge from hospital*

26. Unknown to the hospital Jacob's parents were users of illicit substances and often went during late nights or early mornings to various licensed premises to engage in gambling activities. This evidence was explored extensively through witnesses, however it is relevant in the timeline to mention the following particular incidents.

27. Jacob's mother and father gave staff many reasons for their inability to visit Jacob. These explanations included that Jacob's mother was in hospital and unwell, they had another toddler, and at various times Jacob's mother had flu-like symptoms.

28. However, on 5 May 2018, Jacob's mother's bank account recorded two transactions at Westmead Tavern at 4:53 and 5:11pm. As of this date, Jacob was admitted to the Westmead Hospital NICU and his mother was admitted to the cardiology ward, the

evidence further supports observations made by hospital staff noting her absence from the ward on the same date.

29. Jacob's mother was discharged from hospital on 10 May 2018. On 13 May 2018, his mother's bank account records a transaction at the Woolpack Hotel at 2:42am. On that date Jacob was transferred to Blacktown Hospital SCN.

30. Leah Mendegorin, an associate of Jacob's parents, appeared before the inquest and gave detailed evidence about one occasion when she and Jacob's father "*snuck*" Jacob's mother out of Westmead Hospital late one night. They travelled to the family home and smoked "ice", after which Ms Mendegorin and Jacob's father returned his mother to the hospital.

31. The records of interaction with Jacob while he was alone in hospital were also reviewed. It was recorded by Blacktown Hospital that his mother did not visit Jacob on many occasions as she reported that she was unwell. There were often long gaps between her visits, and the visits would be very short in duration, often around 5 minutes.

32. During the investigation, police were able to locate activity on Jacob's mother's bank account, such as on 10 June 2018, when Wenty Leagues Club (Wentworthville) recorded poker machine ("pokie") payouts to his mother at 11:40 and 11:55pm and a further payout at 12:33am on 11 June 2018.

33. On 22 June 2018, Wenty Leagues Club recorded a pokie payout to Jacob's mother at 11:25pm. This evidence supports that his mother was recorded as not visiting Jacob at Blacktown Hospital SCN between 15 and 20 June 2018, however it appears that she was active in other ways in the community. His father was noted as visiting Jacob on 20 June 2018, with his last prior visit being on 17 June 2018.

34. A video of recorded evidence of 21 June 2018, made at the family home, captured another associate, Natasha Tabligan, Jacob's parents, and others smoking ice in the lounge area of the home.

35. During Jacob's admission to Westmead Hospital's NICU, from 19 April to 13 May 2018, and Blacktown Hospital's SCN, from 13 May to 10 July 2018, concerns were noted by nurses, social workers and doctors about Jacob's parents' infrequent visits to Jacob. His mother often reported sickness as the reason for non-attendance. The evidence supports a finding that Jacob had limited parental contact in the first three months of life while admitted to hospital.

36. The staff were appropriately concerned, however expressed that when the time came for discharge, Jacob's father had made some attempts, and they were aware that Jacob's mother had been in hospital and unwell. Without the benefit of hindsight, Blacktown Hospital allowed Jacob to leave when his mother and father engaged in the process of discharge.

*Examinations completed at Blacktown Hospital before release on 10 July 2018*

37. Prior to his release from Blacktown Hospital on 10 July 2018, Jacob underwent several medical investigations including ophthalmology examinations (14 and 28 June 2018), chest x-rays and a cranial ultrasound (4 July 2018). No head bleed was seen in the ultrasound. No bruising was recorded in the Blacktown Hospital's records, which was consistent with no bruising being observed or having existed.

38. If a nurse observed a bruise on an infant's face during admission, they would be expected to document that fact and escalate it to treating clinicians. Jacob's parents did not indicate that they saw a bruise at discharge or following. On 9 July 2018, to prepare for his release, Jacob underwent an unclothed full physical examination by a Registered Medical Officer, Dr Joanna Connolly. Dr Connolly documented checking Jacob's eyes, ears, mouth and palate and abdomen. No injuries or markings were observed to Jacob's face or body.

*Jacob's release from hospital on 10 July 2018*

39. On 10 July 2018, day Jacob was moved to the Stepdown Unit to prepare for discharge. His mother stayed overnight in the unit with Jacob, at Blacktown Hospital's invitation, as part of a transition process to ready her and Jacob for his release.

40. Jacob left Blacktown Hospital in his parents' care at about midday on 10 July 2018. In effect, Jacob's mother had spent a single day with Jacob since his birth, with support of Blacktown Hospital staff, prior to taking him home. There is no criticism of the hospital staff in that regard. They did a thorough job of caring for him and managed to discharge a healthy baby after an incredibly difficult start to life.

*Jacob presents to hospital on 12 July 2018 and first Injuries observed*

41. At about 10:00pm on 12 July 2018, Jacob's parents presented him to the CHW's Emergency Department. Jacob was found to have periorbital bruising of his left eye, described as not completely encircling the eye, with bruising on a small area on the right lateral aspect. The bruising was recorded as blue in colour. A large left subconjunctival haemorrhage, or redness in the eye, was also noted. The injuries were clearly observable.

42. It was the treating team's position that this was caused by direct impact to the face or direct pressure to the eye. The evidence supports the position that Jacob could not have caused this injury to himself. A yellow-brown bruise on his right flank without associated swelling (2cm x 3cm) was also observed.

43. Further injuries were recorded as follows:

    a. A red bruise on his medial left thigh (1cm x 0.5cm).

    b. A brown bruise with mild swelling on his lateral right thigh (0.8cm x 0.3cm).

    c. A small faint bruise on his anterior left knee (less than 0.5cm).

    d. A focal left subarachnoid haemorrhage (3 mm) with no skull fractures detected (revealed in a CT scan on 13 July 2018).

44. The opinion of the treating team was that Jacob's head injuries resulted from forceful trauma to the left side of Jacob's head or face. Jacob remained admitted to the CHW until 19 July 2018. Numerous specialities were consulted. No underlying medical cause was found for his head injuries.

45. When Jacob presented to the CHW with injuries, it was clear that they were recent, they were not able to be explained naturally and instead were likely injuries inflicted

upon him by some manner. He had only recently been discharged from Blacktown Hospital and had a full physical examination prior to discharge, making it highly unlikely that any such injury was inflicted prior to being placed in his parents' care.

46. His parents were not able provide a plausible explanation for the injuries.

*Movements between 10 and 12 July 2018*

47. The inquest had limited evidence as to what occurred in the days after Jacob left Blacktown Hospital and was admitted to the CHW. Some accounts were given by Jacob's parents as to the day leading up to his first admission into the CHW, together with some information from family. The following timeline was put together by Counsel Assisting from the available evidence:

    a. ***Tuesday 10 July 2018:*** Jacob left Blacktown Hospital in his parents' care at about 12:00pm and was taken home. In the late afternoon they went to his maternal grandparents' home for a family gathering. No one present at the gathering reported seeing bruising to Jacob's face that day. Although young children were present and attempted to interact with Jacob, no one reported observing any injury being occasioned or accident in his handling. Jacob was taken home by his parents afterwards and Jacob's brother was left with family members. Neither reported seeing bruising on Jacob after their return home.

    b. ***Wednesday 11 July 2018:*** the following day, Jacob was again taken by his parents to a family gathering. This time at the home of his maternal aunt and uncle (Mr AM), in the late afternoon/early evening. Neither parent reported seeing a bruise around Jacob's left eye before their arrival there. At that gathering Jacob's maternal aunt noticed bruising around Jacob's left eye and asked his parents about it. His mother stated she had not noticed bruising before then. No one present at the gathering reported observing any injury being occasioned to Jacob at his maternal aunt's home before she noticed the bruising. After the gathering Jacob's parents returned home with Jacob.

    c. ***Thursday 12 July 2018:*** that morning his mother noticed Jacob's left eye bruising had worsened and that Jacob now had redness in the white of his eye (subconjunctival haemorrhage). He was not taken to a doctor. His

parents left Jacob with his maternal grandparents at the grandparents' home that afternoon. Although Jacob's mother told the maternal grandparents she had to take Jacob's father to collect his pay at Menai, telephone records show they instead went to the Fairfield and Smithfield areas and there is no independent corroboration that his father was owed or collected wages. His parents returned to collect Jacob after his grandparents called them about their concerns over Jacob's eye.

d. ***Presentation:*** at about 9:00pm on Thursday 12 July 2018, Jacob's parents presented Jacob to a general practitioner (GP) at the Pacific Medical Centre at Blacktown. The doctor asked them to take Jacob to the CHW, which they did by about 10:00pm.

48. In summary, there was no acceptable or likely explanation from Jacob's parents, nor was there any other evidence to explain the injuries. Neither parent reported seeing any blow to Jacob, accidental or otherwise, nor did any other adult at the family gathering. His mother believed the leg bruise resulted from an immunisation injection. She wondered if Jacob's subconjunctival haemorrhage resulted from bowel straining rather than a blow or impact. Although his mother said there were numerous children at the maternal grandparents' gathering, who were excited to see Jacob and trying to hug him, and by inference suggested that a child may have been responsible, she did not report seeing anything that caused her concern. Jacob's father said that Jacob's brother had leaned over and kissed Jacob on 11 July 2018. He wondered if Jacob's brother accidentally knocked Jacob's head doing so, although he did not report seeing actual contact on this occasion.

49. During interviews with DCJ caseworkers on 16 July 2018, Jacob's mother suggested Jacob may have suffered his injuries while still at Blacktown Hospital, including by him being struck to the face by a stethoscope, although she did not see this happen.

50. There is no evidence to suggest any known incident caused the injury. Suggestions that it occurred at Blacktown Hospital are conjecture and there is no evidence to support such a significant injury was caused at that time.

51. I accept that it was more likely than not that Jacob's head injury was a blunt force impact that occurred sometime after he left Blacktown Hospital and likely before the gathering of family. His parents have given no feasible explanation as to how it occurred.

*Involvement of DCJ after the first injury*

52. At about 2:45pm on 13 July 2018, Dr Karrnan Pathmanandavel made a report to DCJ's, Helpline about Jacob. The Helpline operator assigned that report a ROSH classification (13 July 2018 ROSH report). Parramatta JCPRP and the Parramatta CSC became involved. Between 13 and 19 July 2018, regular, daily, telephone conferences occurred involving the CPU team and the JCPRP team about Jacob's progress, investigations and engagement with his parents.

53. The first involvement Jacob had with DCJ, was with the high risk area of DCJ (JCPRP). Given the seriousness of the injury and the fact there wasn't any obvious explanation for it; he was a small vulnerable baby just released from neonatal care; the response was appropriately allocated to JCPRP. This would allow a multidisciplinary approach to his care. A file was also separately opened for Jacob's brother, as was protocol.

54. During Jacob's admission to the CHW, the CPU staff noted various concerns about the lack of visitation of Jacob in hospital. A note was made by the CPU team on 17 July 2018 that his father was present at times but "*the Mother had not been seen on the ward and this was considered unusual*".

55. On 18 July 2018, Jacob's parents entered into a 'Safety Plan' with the JCPRP casework team (18 July Safety Plan) and, as a result, the JCPRP casework team determined not to begin care proceedings or assume care responsibility for Jacob upon his discharge. The 18 July Safety Plan stipulated that his parents would ensure the following:

    a. Extended family would assist them to care for Jacob at home after discharge.

    b. Jacob would not be handled by any children.

    c. Jacob would be taken to hospital immediately if any new injuries were noticed.

    d. Jacob's mother would see her GP for an emotional wellbeing check.

e. Jacob's parents would cooperate with JCPRP, DCJ and Zest.

f. Jacob would be supervised by at least 2 people where possible (at the very least his mother or father being one of the persons providing supervision).

56. Jacob was discharged from the CHW into his parents' care at about 6:20pm on 19 July 2018. He was examined beforehand and not found to have any new or additional injury. A skeletal survey on 17 July 2018 showed no bone fractures. Jacob returned home with his parents. Workers with Zest were engaged by DCJ (through the Parramatta CSC) to attend the family home twice daily (morning/late afternoon) to assist in caring for Jacob.

57. The next day, on 20 July 2018, Jacob's mother communicated with her friend Ms Mendegorin via Facebook Message, asking Ms Mendegorin to "*babysit later at 2am?*", which Ms Mendegorin declined to do on that occasion. Two days later however, on 22 July 2018, his mother's bank records show a transaction at the Kings Park Tavern.

58. Between 19 and 24 July 2018, Jacob was returned to his parents' care. Jacob's brother may have had visits with his parents, but he was at that time living with his maternal aunt or the maternal grandparents. His contact with Jacob was limited. There was no evidence that anyone from DCJ was aware of where Jacob's brother was living, whether he was living at home or not, or how Jacob's brother was.

### *Jacob's new bruising on 24 July 2018*

*CPU outpatient review*

59. Part of the agreement was that Jacob would present to the CHW for outpatient review. At about 10:00am on 24 July 2018, Jacob and his mother attended an outpatient clinic review and Dr Pathmanandavel examined Jacob. Sarah Carman (CPU Occupational Therapist) and Caroline Knight (CPU Senior Social Worker) were also present.

60. Dr Pathmanandavel located two new bruises on Jacob's right sole, being a linear dark red coloured bruise (2 x 1cm) on the inner foot and a smaller dark red coloured bruise (0.5 x 0.5cm) near to his toe. Photographs were taken of these markings. Dr Susan

Marks, the CPU Staff Specialist, was notified of the bruises and attended and examined Jacob herself.

61. Jacob's mother spoke with the CPU team and said that she didn't know that the bruising was there or how it was caused. She suggested Jacob's foot may have been caught in a clothing zipper of a one piece suit although she didn't see that occur. Dr Marks observed that Jacob was wearing a one piece outfit, and the zipper did not extend down the leg or near to the foot area.

62. It is worth noting at this point that Dr Marks is one of the most experienced specialists in the child protection team at Westmead Hospital. She regularly appears in inquests and other hearings as an expert witness on the topic of child abuse and her expert view is often requested on issues relating to suspicious injuries.

63. After discussion, the CPU team were concerned. They discounted the possibility of the zipper explanation and considered that if Jacob had his foot caught in the zipper he would have cried out in distress, alerting his mother, and nothing like this was reported to the team. The CPU team also noticed what appeared to be bruises or scabbing on Jacob's mother's hands. Jacob's mother was questioned about these, and she gave the explanation that they were caused by the insertion of cannulas when she was previously admitted to hospital, which was over 2 months earlier.

64. Ms Carman saw the marks on Jacob's mother's arms. She noted that although this was the first time she had met his mother that the marks were "*quite unusual marks that I hadn't seen on other people*". Dr Pathmanandavel said in evidence that if they were canula injuries he would have expected to see cannula scabs in the previous interaction, but did not recall that. Ms Knight recalled seeing Jacob's mother wearing gloves when she first met her at the CHW on 12-13 July 2018. In the recorded police interview on 14 July 2018, Jacob's mother can be seen with bandages on her hands and around her fingers. The inference being drawn was that they were scabs resulting from the habit of picking from drug use.

65. In the view of Drs Marks and Pathmanandavel, Jacob's mother account did not reasonably account for the markings. The CPU team were concerned that the

markings were potential flags of drug use by Jacob's mother. They were also of the view that, in their opinion, these further injuries could not have been self-inflicted by Jacob. He was too small to cause injury of this nature and, in particular, they were troubled by the location on his body. Dr Marks raised the issue with DCJ. She gave DCJ time to come and attend the CHW, however they failed to do so after she informed them and she was therefore left with no option but to discharge Jacob.

66. The process of contacting DCJ by Dr Marks was the subject of evidence. It was an extraordinarily complex process of doctors calling a help line and waiting on line, sometimes for hours, to get through to DCJ. Although it is accepted that there are a large number of mandatory reports to DCJ, it was surprising to hear that so much of the time of a hospital child protection team could be taken up, on hold, waiting to make a report. Dr Marks was not happy with the response she received and made a separate call to DCJ about Jacob.

67. What was very clear from the evidence of the team at the CPU was that they were now on very high alert. The likelihood of these two injuries occurring naturally or by accident was remote in their view. The team now considered that Jacob was at considerable risk. Simple bruising to a foot may be considered minor alone, but to these experts it carried potentially quite sinister implications. Given that Jacob could not self- inflict the injury to the bottom of his foot, the various methods of incurring injury suggested some sort of intentional inflicted force, given this is not an area easy to accidently injure. Nonetheless and despite these concerns he was sent home, given DCJ did not immediately act and attend the hospital.

*DCJ caseworker home visit on 24 July 2018*

68. At about 4:00pm on 24 July 2018, DCJ caseworkers, including DA, visited Jacob's parents at their home in response to the report received from the CPU. The caseworkers saw the bruising on Jacob's foot and took photographs. His mother told caseworkers that, other than Zest workers and the maternal grandmother, no adults had visited or handled Jacob since his discharge from CHW on 19 July 2018.

*New Safety Plan*

69. The solution proposed by DCJ to the new injury was to have his parents agree to a further Safety Plan with DCJ caseworkers on the afternoon of 24 July 2018 (**24 July Safety Plan**). This plan provided:

    a. The maternal grandmother or another relative would reside in the family home that night. There were no reports or checks recorded that this occurred on any night.

    b. Zest would continue to attend the home as instructed by DCJ.

    c. Jacob's parents would continue to comply with directions of DCJ and Zest.

    d. Jacob's mother would attend on a GP to have her hands reviewed. There is no evidence that his mother had her hands medically examined. There was no follow up on this.

*August 2018*

70. Following 24 July 2018, Jacob was expected to attend a number of reviews. He attended very few.

*Missed CPU review on 1 August 2018*

71. Jacob was not brought to the CPU for follow up review on 1 August 2018. His mother called the CHW and stated she could not make the appointment as she had car difficulties.

*Jacob looked after by Ms Mendegorin*

72. Jacob's mother asked Ms Mendegorin to babysit Jacob in the late hours of 2 August 2018 and again on 4 August 2018. Ms Mendegorin confirmed she attended on 4 August 2018, but not on 2 August 2018, and looked after Jacob alone for a couple of hours. While at the family home, she smoked ice given to her by Jacob's parents. His mother's bank card records evidence that it was used at a licensed premises in the early hours of the latter date.

*Paediatric outpatient review on 8 August 2018*

73. Jacob was presented by his parents for an outpatient paediatric review on 8 August 2018. The paediatrician, Dr David Hartshorn, considered his parents to present as

appropriately concerned about Jacob's wellbeing. Dr Hartshorn "*observed no signs of bruising on Jacob's body"* but observed "*very superficial scratches on Jacob's nose"* which Dr Hartshorn considered were (likely) "*self-inflicted*". Jacob appeared to Dr Hartshorn to be making good progress.

*DCJ casework formally transfers to the Parramatta CSC on or about 9 August 2018*

74. On or about 9 August 2018, DCJ's casework for Jacob formally transferred from the Parramatta JCPRP to the Parramatta CSC. The latter already had responsibility for Jacob's brother's case.

*Missed CPU review on 14 August 2018*

75. On 14 August 2018, Jacob was not presented for his scheduled CPU Outpatient review. A new appointment was scheduled for 27 August 2018. The CPU team told the Parramatta CSC about the missed appointment.

*DCJ caseworker home visit on 16 August 2018*

76. On 16 August 2018, DCJ caseworker CS (Parramatta CSC) made a home visit. The caseworker saw Jacob without clothes to check his body for marks. Nothing material was seen.

*GP attendance on 26 August 2018*

77. On 26 August 2018, Dr Josefina Fieischner, a GP at the Pacific Medical Centre in Blacktown, examined Jacob. Dr Fieischner considered this consultation to be "*very routine*" and administered Jacob vaccinations (Infanrix Hexa in the left thigh; Rotarix orally and Prevenar in the right thigh).

*Missed CPU review on 27 August 2018*

78. Jacob was scheduled to be reviewed by the CPU on 27 August 2018 (having missed the 14 August 2018 review). At 2:16 and 2:38am that day, Jacob's mother received payments from the Wenty Leagues Club. These records suggest his mother (if not both parents) were away from the family home without Jacob. Later that morning his mother contacted Jacob's assigned DCJ caseworker and asked to reschedule the CPU review, stating:

"*[CS] are u able to rebook my appt with CPU?? I'm booked for now at 10:30am I just realised but Jacob had his 4-month vaccination yesterday and had a fever last night, so no sleep again and only Just recovered now, The weather isn't ideal either however if you can u can come over to give him a quick [check] up? [Please] reply asap*".

79. Although many appointments were missed by his mother, no action was taken by DCJ.

*CPU home visit on 31 August 2018 (last known medical review before Jacob's death)*

80. A new CPU review was scheduled for 31 August 2018, after the missed review on 27 August 2018. Jacob's mother was reminded by the assigned DCJ caseworker on 30 August 2018 to ensure she kept that appointment otherwise the CPU "*may get a bit worried*". On 31 August 2018, the morning of the scheduled review, Jacob's mother told the CPU team by phone she could not go to the scheduled review owing to transport difficulties.

81. Ms Carman, Dr Pathmanandavel and Ms Knight opted to conduct a home to undertake a review. In fact, in evidence, when asked if they conducted home visits as a usual practice, they said that they did not. When asked how many times they could recall doing so with a doctor present, they replied; once, for Jacob. They attended out of concern for Jacob.

82. Jacob's mother was notified of the home visit in advance and did not oppose attendance. The CPU team had not sighted Jacob in about 5 weeks (since 24 July 2018). His mother and Jacob were the only people home when the CPU team attended. Jacob was examined without clothing by Dr Pathmanandavel. Nothing of concern was seen. Ms Carman observed Jacob's mother had band-aids on her hands during this visit.

83. Tragically, this was the last time Jacob was seen by medical professionals, and it is from this time his injuries discovered at autopsy were likely inflicted. Although Drs Marks and Pathmanandavel could not exclude the possibility of Jacob having fractures which weren't revealed in the examination on 31 August 2018, I accept it is more probable that Jacob suffered most, if not all, of his fractures after this

examination. Jacob exhibited no signs of discomfort or pain during that examination. This view was strengthened by the nature of the examiner. Dr Pathmanandavel was working in the area of child abuse, and he was there because of specific concern for Jacob. He was looking for any signs of abuse, and found none. This position is also supported by the expert evidence.

*September to early October 2018*

*Brighter Futures engagement*

84. In early September 2018, Brighter Futures accepted a referral from DCJ (Parramatta CSC) for Jacob and his family. A Brighter Futures caseworker, Tracey Gray, was assigned to the family. Initially Brighter Futures rejected the first application for the family because of the high risk nature attaching to Jacob. After a further application was made, where DCJ downgraded the risk level, Brighter Futures were able to accept Jacob and his family as per their criteria.

85. What became apparent after police investigation is that Jacob's parents were heavily involved in ice use and gambling. The witness evidence is explored further below. During this time of supervision, there was evidence of messages between Jacob's parents and Jose Amurao, a drug associate, on 30 September 2018. It appears from those messages that Mr Amurao attended on Jacob's father, and he has given evidence that he supplied ice to Jacob's parents.

86. There are transactions from Jacob's mother's bank card records at licensed premises in early hours on 1, 15, 21, 23 and 29 September 2018. These are complimented with other messages, such as at 2.43am on 30 September 2018 from Mr AM texting about his wife waking up at 4.00am. It appears Jacob's mother's phone was located in Mays Hill, a location away from the family home.

87. The purpose of this evidence was to interrogate whether the ice use and general supervision by Jacob's parents had ceased once Brighter Futures were involved, but it appears from the evidence that it continued.

88. Even though there was involvement from Brighter Futures, Jacob continued to miss reviews and appointments. Jacob was not seen by a medical professional between 1 September and 9 October 2018, despite reviews and home visits being scheduled:

a. *Rehabilitation outpatient review scheduled on 5 September 2018*: Jacob was not brought to the clinic. Clinicians attempted calling his parents and also asked for a social worker to contact the CPU to discuss.

b. *DCJ caseworker home visit on 21 September 2018:* On 21 September 2018, CS carried out their last home visit. This was done together with Brighter Futures caseworker Ms Gray. The visit was scheduled in advance however Jacob's mother was the only one present on CS and Ms Gray's arrival. Jacob, Jacob's brother and their father were not sighted. Jacob's mother reported that Jacob and Jacob's brother were at swimming lessons with her sister (Jacob's maternal aunt in her evidence did not support Jacob's mother's claim about this). Earlier that morning, at about 2:16am, transactions were recorded on Jacob's mother's bank card at the Lalor Park Hotel (this was not disclosed by Jacob's mother to the caseworkers).

c. *DCJ closes Jacob and Jacob's brother's cases on 25 September 2018*: On 25 September 2018, CS closed DCJ's cases for Jacob and Jacob's brother.

d. Scheduled brain injury/rehabilitation review on 26 September 2018 (at which time the CPU also planned to review Jacob): Jacob was not brought to this appointment.

e. *Brighter Futures caseworker home visit on 28 September 2018*: Ms Gray was scheduled to conduct a home visit on this date. Jacob's mother messaged Ms Gray and cancelled the appointment, stating she had to take Jacob's brother to swimming lessons. That same day the assigned DCJ caseworker (CS) exchanged text messages with Jacob's mother about the missed medical review, reminding her that it was "*really important you attend these appointments*".

f. *Brighter Futures caseworker scheduled home visit on 5 October 2018*: Ms Gray was scheduled to conduct a home visit on this date. This was rescheduled at Jacob's mother's request who stated she was tired after a

sleepless night as Jacob had been sick (a new appointment scheduled for 9 October 2018).

## What happened to Jacob between 7 and 10 October 2018?

89. Mr AM cared for Jacob on 7 and 8 October 2018 between about 11:00pm and 12:50am, while his parents attended licensed premises leaving Jacob at home with Jacob's maternal aunt's husband. Mr AM again looked after Jacob during the day, at his premises, while Jacob's maternal aunt was at work.

90. Ms Gray from Brighter Futures made a home visit at about midday on 9 October 2018. Jacob and his mother were present. Jacob's brother and his father were not home. The visit lasted about 60 minutes. During the visit, his mother held Jacob in Ms Gray's presence for a time. Ms Gray's evidence is that Jacob was dressed in a long sleeve jumpsuit. Jacob appeared "*upset*", was crying intermittently and seemed to be in discomfort.

91. Jacob's mother looked calm and said Jacob had been "*feverish, having wind and that she took him to the doctor the day before*". However, there is no evidence and no records that could be located of Jacob being presented to a doctor the day before as reported. His mother also said Jacob had nasal congestion without a fever when she took him to the doctor the previous day, and she indicated that Jacob slept in the "*same room as her and that at times they co-sleep however she had a device to stop him being rolled on"*. Jacob's mother gave him a dummy when he continued to be "*unsettled*" and stated: "*He is not due for a feed yet*". Jacob remained in his mother's arms the entire visit and he was never held by Ms Gray.

92. Ms Gray could not see Jacob's arms, legs or trunk as he was clothed in a long sleeve jumpsuit.

93. Jacob's maternal grandmother also visited on 9 October 2018 when, in the early evening, she delivered dinner to his parents at their home. Review of CCTV footage shows his grandmother's vehicle leaving at about 7:00pm. When questioned by police after Jacob's death, his grandmother did not report seeing injuries on Jacob during this visit.

*Parents' account given to paramedics*

94. Jacob's parents' initial account to the paramedics was that they put him to sleep, both independently said that he woke and fed the following day at 9:20am. The next either heard from him was when he was found lifeless. This can be contrasted with the account given to police, where a slightly different version was provided.

*Mother's text message account*

95. This can be contrasted with a text message sent by his mother at 11:52am on 10 October 2018 where she said Jacob had woken "*at 9am and he was awake and he was fine…by 9:30am for a feed I walked in to find him unresponsive and pale*".

*Parents' account given to police*

96. Both parents participated in a recorded record of interview with police on 10 October 2018. Police were not aware of many factors that later came to light, such as Mr AM's attendance at the home the night Jacob died and other nights, ice use by them, Jacob's healing fractures and upper gum injury, or bed sheets being put on the line in the early hours of the morning that he was deceased. The evidence of the accounts given by Jacob's parents about the events on 9 and 10 October 2018 included that Jacob had a runny nose and cough for 2 days and a fever the day before, and that he had difficulties feeding during the day on 9 October 2018.

97. Ms Gray from Brighter Futures visited the home about midday on 9 October 2018. The maternal grandmother visited the home about 6:30 or 7:00pm. Jacob slept in the same bed as his mother in his parents' bedroom in a horseshoe pillow. Jacob's father slept on the lounge overnight. Jacob's mother stated he slept "*very well"* overnight as he had kept himself awake during the daytime. He went to sleep at 10:00pm and his mother gave him a feed at about 11:00pm. Jacob's father stated he woke at around 8:00am on 10 October 2018. He drove to Blacktown, bought cigarettes, and returned home before 10:00am. His mother stated she woke at about 9:00am. Jacob was unsettled or restless. She placed a dummy in his mouth. She removed him from the horse-shoe pillow and laid him flat on his back. He was wearing a singlet, nappy and a "*onesie*" suit. She then left the bedroom and went to the kitchen. Before leaving the room, she left a pillow on the side of the bed away from him and made sure there weren't blankets, bibs or pillows around him. The heater was on in the room but on

low and he didn't require a blanket owing to the temperature. Jacob was not yet able to roll by himself.

98. Jacob's mother was outside the bedroom when his father returned. At or shortly after 10:00am, his parents heard a noise that they thought was made by Jacob. In his mother's recorded interview on 10 October 2018, she stated, "*then we heard Jacob's, not scream, but he just made a, Uh, noise…*" In his father's interview on 10 October 2018, he stated, "*I heard him yell and I go, there he's awake. So [Jacob's mother's] with the bottle ready. I am about to go in the room and then [Jacob's mother's] started screaming*". His mother had prepared Jacob a bottle of formula and went into the bedroom to feed him. Jacob was still lying on his back on the bed in the same position she had left him and his mother did not report seeing anything over Jacob's face. Jacob looked pale and not to be breathing. She called out his father for help and to call triple zero which he did. His mother shifted Jacob onto his back on the floor and began administering CPR until the paramedics arrived.

99. She indicated that her first reaction when she found Jacob unresponsive was to blow into his nose to ensure any obstruction was cleared. A white coloured fluid or mucus came out his mouth and nose when she did this. Later, during CPR, more fluid came out of his nose (not mouth). His father assisted in CPR by wiping the fluid coming out of Jacob's nose. Police asked his parents about their movements on the night of 9 to 10 October 2018. Neither disclosed being away from home between 11:00pm and 1:00am, nor that Mr AM had looked after Jacob. His mother said that after feeding Jacob at about 11:00pm she had a shower and went to bed.

## Exploration of other evidence in the inquest

### *Jacob's parents' movements based on CCTV and witness accounts*

100. Exploring Jacob's parents' lifestyle assisted in trying to piece together how care was provided to Jacob during his life, and trying to determine how injuries might have been inflicted over a period of time. There were a number of witnesses who gave detailed evidence of involvement with Jacob and his parents, and various experiences of drug use with them.

*Ice use, gambling and money making opportunities taking Jacob's parents' attention*

101. The inquest explored other areas of relevance to Jacob's death which included how he was parented and supervised. The evidence disclosed that his parents were heavily engaged in the use of methylamphetamine, or "ice", in the home around the time that Jacob was taken home. They also engaged in gambling and theft which appeared to remove them from providing care from him at times. However, the evidence supported that arrangements would be made for his care, and no evidence was given to raise any suggestion that he was left alone during his parents' absences.

102. Jacob's father committed drug related offences before Jacob's birth, including the possession of methylamphetamine (February 2017) and driving under the influence of a prohibited drug (methylamphetamine) (November 2017). These offences were committed after his participation of the Drug Court MERIT program in 2016. Neither of his parents were employed in 2018. It appeared that the source of income that funded their lifestyle was partly through dishonesty offending. This included involvement in forging receipts to deceive shops to pay them money ostensibly as a reimbursement. The evidence supported this after extensive police investigation into Jacob's death.

103. Analysis of his parents' activities pieced together from the evidence, during September and early October 2018, indicates his parents continued contact with drug associates, some of whom visited the home, and attended licensed premises late at night. During this time Mr AM looked after Jacob on occasion in the late hours/early morning.

*Ms Mendegorin*

104. An associate, Ms Mendegorin, attended the inquest and was a witness able to give a considerable amount of evidence about her personal knowledge of ice use at Jacob's home, and the inquest was greatly helped through her frankness and truthfulness as a witness. She was familiar with Jacob's parents and had spent some time with them engaged in the use of ice and was privy to their lifestyle in 2016 to 2018.

105. Sometime in late 2016, Ms Mendegorin accompanied Jacob's parents on an occasion when they falsely claimed refunds as part of a theft scheme that was used by his parents to make money. She was aware that they had a practice in that regard. She

was asked to participate on one occasion, but declined. She believed, from information that they had given her, that Jacob's parents sometimes earned between $1,000 to $1,800 from this offending weekly. In her estimation they generally spent about $200 a day on ice.

106. Jacob's brother was left in Ms Mendegorin's care at various times in 2017 and in 2018 including when Jacob was admitted to hospital. Ms Mendegorin had an understanding that she would be given ice from his parents in return for time spent with their children. Ms Mendegorin looked after Jacob's brother on one occasion at the residence in early 2018 when his parents went out. Ms Mendegorin was clear to indicate that they would not engage in illicit substance use with children in the room, but the child or children would be in a separate room.

107. Ms Mendegorin saw Jacob's mother scratching her hands and arms at times, which appeared to her to be a symptom of her ice use. Ms Mendegorin was able to give this evidence given her own illicit drug use and experience. She also saw Jacob's mother sometimes sniff baby wipes after smoking ice. The meaning of this behaviour was not explained in the inquest, but was raised on a number of occasions, the most that could be made from it was that it was a behaviour attributed to the effects of ice use. Much of this evidence was her opinion of course, however what I accepted was that Ms Mendegorin had engaged in regular ice use with Jacob's parents, and that at times she had cared for each of the children in exchange for the provision of ice.

*Ms Tabligan*

108. Ms Tabligan was another associate who also gave evidence of ice habits and use. Ms Tabligan met Jacob's mother in about 2016. She and his mother used to use ice together twice a week. Ms Tabligan saw his mother using ice in the later stages of her pregnancy with Jacob's brother. After Jacob's birth, his parents visited Ms Tabligan's home a few times with Jacob and used drugs.

109. A video recording was located on Jacob's parents' mobile phone. The recording was made on 21 June 2018 and captured Ms Tabligan and others smoking ice in Jacob's home. Ms Tabligan was unaware that recording had been made but recalled Jacob's mother telling her that she and Jacob's father had set up a camera to record people

they left Jacob's brother or Jacob in the care of. She suspected this recording was made on that camera, again this was not fully answered in inquest. Nonetheless the evidence was powerful, and displayed people, including Jacob's parents, partaking in illicit drug use. It corroborated the evidence given by Ms Tabligan and was further evidence that ice use by his parents at that time was regular and that others attended at their home to engage in the use of illicit substances.

*Jacob's Maternal Aunt's Husband*

110. Mr AM was Jacob's uncle. According to Mr AM, he had known Jacob's mother to use ice only from around the time that she met Jacob's father, and he knew both parents to be drug users. Jacob's brother's birth, and then Jacob's birth, had not stopped that use. His wife (Jacob's maternal aunt) was not aware of their drug use. It was his understanding that Jacob's parents sourced their money through revenue from playing pokies and was aware of some fraud.

111. Mr AM had formed a view that Jacob's parents were addicted to gambling, usually in the form of pokies. His evidence was that they regularly played pokies, and they had discussed with Mr AM losing variously between $500 to $800 on occasion. Mr AM attended the family home about five times to look after Jacob late at night while his parents were out. In return he was given ice for doing so. It was distressing evidence for Jacob's maternal aunt at the hearing. She was not aware that her husband, together with her sister and her sister's husband were engaging in such activity. Mr AM was secretly leaving her house and attending upon her sister for the purpose of socialising and using ice. It is important to emphasise that Jacob's maternal aunt had absolutely no understanding or knowledge of this.

112. CCTV and text messages reveal that between 7:00 and 8:00pm on 9 October 2018, Jacob's father exchanged SMS messages with Mr Amurao in which his father asked where Mr Amurao was and the latter stated, "*I can come by*". Mr Amurao confirmed with police that the messages concerned drugs. At about 8:55pm, his father left home alone. At about 10:08pm, his father returned home. At about 10:55pm, his parents both left the home in their car (Silver Forrester). By this time Mr AM was at Jacob's home to look after Jacob.

113. At about 12:44am on 10 October 2018, Mr AM and Jacob's mother exchanged messages in which Mr AM was querying when Jacob's parents were expected to be home. At about 12:54am, Jacob's parents returned to the family home. At about 2:18am, Mr AM left the family home in his vehicle.

*Mr AM's evidence about caring for Jacob on 9 to 10 October 2018*

114. Jacob's maternal aunt's husband provided two statements to police and gave oral evidence (without objection). In his first statement, Mr AM did not disclose that he was present at the family home between 9 and 10 October 2018 while Jacob's parents were out. In his second statement, Mr AM gave the correct account that was, between August and October 2018, he looked after Jacob about 5 times in total at Jacob's home, at his parents' request. They typically asked him to do this late at night so they could go to licensed venues to play the pokies. He did this without his wife's knowledge. During these attendances he saw Jacob's parents smoke ice and he himself smoked ice given to him by Jacob's parents in exchange for caring for Jacob.

115. On 9 to 10 October 2018, Mr AM began texting Jacob's parents as Jacob woke up. Jacob did not seem overly distressed, and Mr AM held him in the lounge area of the family home and fed him a bottle. When Jacob's parents returned, he observed that they appeared to be *"a bit upset*". Mr AM handed Jacob to his mother on their return. He remained there for a time smoking ice with Jacob's father and then left.

116. In his evidence at hearing, Mr AM said that when he went to Jacob's home on the evening of 9 October 2018, Jacob was dressed and lying on the bed with pillows around him.

117. Mr AM used ice before he held and fed Jacob during that visit. Jacob took the bottle well but seemed to only have a "*couple of sips*". Mr AM assumed Jacob wasn't hungry. He held Jacob continuously until his parents arrived home. Jacob was not crying. This is the first occasion he had ever held Jacob when looking after him. He did not see any blood on Jacob or on the bed when he picked Jacob up. He denied causing Jacob's gum laceration, he did not see Jacob with that injury, nor was he aware of any event that happened that might have accounted for that injury. Mr AM was the last person to see Jacob before his death, other than his parents.

118. He gave evidence that he had never held Jacob before this night while caring for him. He noted some reluctance because Jacob was so small. Although it did not come out in the evidence clearly, inferences can be drawn as to the fact that he held Jacob the entire time. It is known now that at that time Jacob was recovering from previous injuries including healing fractures and other injuries that were previously inflicted.

*CCTV Evidence: Early hours of 10 October 2018*

119. One factor that was not mentioned by the parents to police or any interviewer, was the fact that Jacob's father was hanging bedlinen out on the morning Jacob died. At about 5:47am, CCTV cameras at a neighbouring residence capture Jacob's father in the rear yard hanging white bedlinen, seemingly sheets, on the clothesline. No mention was made of this in the subsequent reports to police.

120. CCTV also assisted in verifying movements of cars from the home that evening, and corroborated the movement of Mr AM, Jacob's grandmother and the fact that no other person appeared to attend the home that night other than Jacob's parents.

*Father's movements between about 7 and 9am on 10 October 2018*

121. At about 7:00am, Jacob's father left the home in his car. Footage shows that he travelled near to Westpoint Shopping Centre in Blacktown. CCTV footage shows he returned home sometime between about 8:50 and 9:00am.

*Triple zero call and paramedics' attendance on 10 October 2018*

122. Jacob's father made a triple zero call from the family home at about 10:10am on 10 October 2018. Paramedics Jack Pears, Brad Graham and Trainee Paramedic Charles arrived at the family home at about 10:20am. They were met at an entrance gate by Jacob's father. On entering Jacob's parents' bedroom, they saw Jacob lying flat on his back. His mother was performing CPR on him. Jacob was wearing a jump suit, singlet, and nappy. He appeared "*grey in colour and cool to touch"* and a discernible pulse could not be located.

123. Jacob was placed in the ambulance. Emergency treatment continued with an oropharyngeal airway inserted. Jacob had a non-shockable rhythm (asystole cardiac arrest). Ambulance Inspector Brian Parsell, an accredited intensive care paramedic,

arrived at about 10:26am. Jacob was already in an ambulance. Jacob was poorly perfused and dusky grey in colour. He saw lividity on Jacob's upper torso. In his view Jacob had been deceased for a couple of hours by that time. Police arrived shortly after paramedics. Sergeant Adam Cook travelled with Jacob's parents in the ambulance to the hospital. He took a brief account from Jacob's parents, noting his father last saw Jacob alive and sleeping about 9:20am. He next saw Jacob "*not breathing, pale*" at about 9:50am. When Jacob was last seen he appeared settled, with a dummy placed in his mouth, and was left to sleep for about 30 minutes before he was found deceased. At 10:37am, Jacob arrived at the CHW Emergency Department. At hospital, paramedics reported being told that his mother had last sighted Jacob, well, at about 9:20am. At 11:00am, following further efforts to revive Jacob, a Paediatric Emergency Physician (Dr Jason Hort) pronounced Jacob deceased.

124. While at the hospital, Sergeant Cook spoke further to Jacob's parents outside. Sergeant Cook noted his mother stating that Jacob had been fed the night before about 11:00pm before she put him to sleep. She woke about 9:20am that morning and put a dummy in Jacob's mouth. Jacob appeared asleep but restless.

*Scene examination*

125. An examination of the family home was carried out by police including Senior Constables Gavin Vlaar and Brian Herk. Photographs were taken which included the bed in Jacob's parents' bedroom. A horseshoe pillow can be seen on the bed. A marking or stain was found on a "NSW Health Share" brand bed sheet on the bed on which Jacob slept that tested presumptively for blood, which was analysed and found to have Jacob's DNA. The sheets that his father hung on the clothesline that morning weren't on the line when the crime scene photos were taken. There was no known opportunity for Jacob's parents to have removed the sheets from the line *after* they left with paramedics at about 10:30am. There was no excessive blood present at the scene in his bed or elsewhere.

*Events after Jacob's death*

*Medical assessment of Jacob's brother*

126. Jacob's brother was examined on 11 October 2018. This included a whole body scan. No injuries were detected however Jacob's brother was primarily in the care of Jacob's maternal aunt before Jacob's death.

*DCJ assume Jacob's brother's care on 19-20 October 2018*

127. On 19 or 20 October 2018, the Secretary, DCJ, exercised his statutory power to assume Jacob's brother's care from his parents and thereafter began care proceedings. Jacob's brother remains placed with Jacob's maternal aunt to this day.

*Commencement of urinalysis on 24 October 2018*

128. On about 24 October 2018, DCJ began testing Jacob's parents for illicit substances. Both parents tested positive for methamphetamine and amphetamine use.

*Jacob's burial on 10 November 2018*

129. On 31 October 2018, the OIC was notified by the Coronial Support Unit that it had received no communication from Jacob's parents about Jacob's body. Jacob was still at the mortuary at this time. The Unit queried if Jacob was to be treated as a destitute burial or cremation. The OIC then spoke to Jacob's parents expressing concern at their lack of contact with the Coronial Support Unit. Jacob's mother advised the OIC she "*didn't want to have to deal with it"* and her sisters were the ones arranging his funeral. This was not the understanding of the extended family who believed he was not ready for release. The Children's Court later made final orders granting parental responsibility for Jacob's brother to the Minister.

*Subsequent charging in March 2020 for dishonesty offending*

130. Jacob's parents were arrested and separately charged on 11 March 2020 with committing dishonesty offences. This concerned dishonestly obtaining benefit from shops through fraudulent claims for refunds. Jacob's father had methylamphetamine in his possession at the time of his arrest. Jacob's parents later pleaded to these offences, and both participated in the Drug Court's MERIT program between March and June 2020 (completed on 17 June 2020). These were serious charges that the parents were ultimately dealt with in the Local Court.

## PHYSICAL INJURIES AND EXPERT OPINIONS

### Autopsy

131. At autopsy, no disease, process or abnormality was identified that accounted for Jacob's death. Jacob's healing fractures did not themselves account for his death. A neuropathological examination revealed an old subarachnoid haemorrhage in the left superior lateral frontal area, which is attributable to that detected shortly after Jacob's presentation to the CHW on 12 July 2018. No obvious acute trauma to the brain was detected. Signs of viral infection were seen in Jacob's lungs during autopsy. These were not severe and not of such magnitude to have materially contributed to death.

### Expert Evidence

132. Dr Skellern is a forensic paediatrician, who has a fellowship of the Royal Australasian College of Physicians within the division of paediatrics and a Fellowship with the Royal College of Pathologists Australasia within the faculty of clinical forensic medicine. She practiced at the Queensland Children's Hospital in forensic medicine and child protection, being in the field for 23 years as a specialist.

133. Professor Duflou is a forensic pathologist. He has specialist qualification s in forensic pathology from the Royal College of Pathologists of Australasia and from the University of Cape Town and is a Fellow of the Faculty of Forensic Medicine of the Royal College of Physicians in London. He has been a specialist forensic pathologist since 1988. He was the clinical director at the Department for Forensic Medicine in NSW.

134. Dr Prelog is a paediatric radiologist at the CHW, and has been for 20 years. Her speciality is neuroimaging and imaging of children at risk and she is also a Fellow of the College of Radiologists of Australia.

135. Dr Maistry is a forensic pathologist in NSW and she has Fellowships from the College of Forensic Pathologists of South Africa and well as a Master's in Medicine from the University of Cape Town and the Royal College of Australasia. She has been a forensic pathologist for 15 years, and performed the autopsy on Jacob.

136. These witnesses gave evidence jointly, after preparing reports. The witnesses also had the opportunity to conclave prior to giving evidence.

*Views expressed on first injury subarachnoid haemorrhage*

137. Dr Skellern was able to say that the subarachnoid haemorrhage was likely to have resulted from an impact mechanism of some sort. She did not automatically assume however that the bruises apparent were caused by the same application of force, and Professor Duflou agreed. They also agreed the bruise was likely to be apparent minutes or hours after impact, rather than days in this case. They agreed that bruising was likely within a day of impact. They agreed that it would be blunt trauma, along with Dr Maistry.

138. Dr Prelog was able to comment on the dating of the fractures. She indicated that the fractures were not fresh or acute, that they did not occur within 10 days of death, because they all demonstrate a degree of healing. She ultimately believed they were all incurred between 2 and 6 weeks prior. She canvassed this view on the basis that a number of factors, including age, health and immobilisation all played a part in healing.

139. Dr Skellern was of the view that the injuries would have created significant pain to Jacob. She noted that was because there were a lot of them, and because a baby requires handling to be fed and changed and that would all cause pain. She noted that the injuries may have triggered other injury infliction, through the pain and crying response, potentially escalating carer behaviour that could potentially further reinjure a child.

*Extensive upper gum injury - severe gingival wound*

140. Dr Skellern described the extensive gum injury as a very significant injury. She described it as an extensive split in the mucosa along the alveolar gum margin, and she would expect it to cause bleeding and pain. She noted it was the type of injury that would have benefited from surgical treatment and suturing, to speed it up.

141. Professor Duflou said it was the worst injury that he had seen in terms of an injury to a frenulum. He noted that if Jacob had no heartbeat there might have been some

limited loss of blood from the area, and if death occurred upon, or very shortly after infliction, it wouldn't be bleeding as such, it would be more oozing blood.

142. Dr Maistry said this in response "I agree with what Professor Duflou said, exactly, it's one of the most horrific injuries I've also seen. It was large, it was deep, it was one of the most horrific things I've seen…"

143. Dr Skellern had not seen an injury of that magnitude before, when asked about the gum injury.

144. The experts agreed that Jacob would have suffered considerable pain.

145. Dr Maistry raised the potential cause as being smothering or mechanical occlusion, she clarified that this might be blunt trauma, shearing injuries. There was a possibility that it could be penetrative, but she preferred the other mechanisms. The other two experts thought it more likely that there was a penetrative injury.

146. The witnesses discussed the possible type of force that could cause this significant injury, although Professor Duflou also indicated that he hadn't seen this injury to this magnitude previously.

147. Dr Maistry noted that there was blood stained fluid in his mouth. She said if it had been a significant amount she would normally have quantified it.

148. In relation to the timing of the infliction of the injury, Dr Maistry was of the view that it was inflicted perimortem, or in other words just before death. She was able to identify slight bruising, she couldn't see any healing or scarring, which would suggest more recovery time after infliction. She wasn't able to do a histology of injury however. Dr Duflou said he could identify no evidence of healing, he would have expected to see some very early stages of the appearance of healing after a number of hours, and he couldn't see that. He ultimately concluded it was a perimortem injury around the time of death, at the outside he suggested possibility a few hours prior to death. The injury was thought be sometimes between 5:00am and 10:00am on 10 October 2018.

149. Dr Maistry also noted a 2mm laceration to the upper lip on the right, and "*there was an area of superficial abrasion and discolouration bruising and associated swelling of the upper lip on the right*". That was in a similar area to the laceration. There was a 1mm abrasion to the lower lip on the right. There were further injuries to his face including bruising to his face and jawline, and to the left eyebrow.

150. Dr Cameron is a specialist paediatric dentist, since 1991. He was the head of the Department at Westmead Hospital and the head of the University of Sydney as a specialist in that discipline. He is currently a clinical Associate Professor in the discipline at the University of Newcastle with a concurrent appointment at the University of Sydney and Charles Strut University. He has worked in the field for 33 years and now is in private practice, but also consults for the Central Coast Local Health District.

151. Dr Middleton has practiced in forensic odontology since the 1980's. He has worked extensively on mass disasters across the world, such as the Boxing Day Tsunami, Bali Bombings and multi-death scenarios here in NSW. He works at the Department of Forensic Medicine seconded from Westmead Hospital as a part time staff specialist. and he is a specialist forensic odontologist.

152. Dr Cameron had seen this type of injury before. In fact, the severity of Jacob's injury sits in line with those injuries he would see in general practice. He would usually see this injury in 18 month olds to 8 or 9 year olds. It is usually seen in mobile children, as toddlers are learning to walk and fall down frequently. He could only recall seeing this type of injury in an infant once before where the injury occurred in circumstances where the mother was holding her baby and the child's mother tripped at the time causing injury. He said for an infant to have that type of laceration at Jacob's age was an extremely rare occurrence.

153. He described usual infliction of the type of injury with a case of a lateral force, the injury, on Jacob is also consistent with a small tear at the bottom of his nose. It is more likely to have been some type of force over the upper lip, moving laterally in the horizontal plane. He likens the incurring of this injury to a child diving onto the grass and experiencing a shearing force on the upper lip, the force being applied either

laterally or inferiorly nor superiorly. He referenced the type of fall that might be seen in the process of the scoring of a try. He was of the view it could be consistent with forceful suffocation, but not exclusively necessarily occurring that way.

154. Dr Middleton was of the view that it was a tool like injury. That is the infliction of force with an object such as a spoon, but he also agreed with Dr Cameron's view as to a possible cause of the injury.

155. In relation to the swelling, Dr Cameron said that the swelling observed was minor and not to the level that would be suspected if the injury had occurred other than around the time of death.

156. He said this:

> "*Swelling occurs very quickly and you'd know probably from your own experience if you have children they fall over, you know, collateral oedema, fluid extends into the surrounding tissues in response to inflammation and damage, and so that's quite a rapid thing. So within half an hour you end up with a big fat lip from those types of injuries, so when I observed the photographs that were supplied, there was really no major – I think if you observe the lip without knowing what the injuries were intraorally then you could actually miss those particular – what was happening in the mouth*."

157. He is able to say that, given the lack of swelling, death occurred within around 30 minutes of that injury. Dr Middleton agreed with this view. Dr Middleton broadened that to 30-40 minutes.

158. Dr Middleton said:

> "*Once the heart stops there's no blood pressure, so there's no impetus to push blood around the body or through any injuries and leaks, so you're not going to get a lot of external bleeding once the heart stops pumping and, I am generalising, and I think the fact that, you know, maybe there isn't a lot of blood there would indicate that maybe the heart stopped early*."

159. Professor Michael Besser AM is a neurosurgeon, clinical Professor in the discipline of surgery and lecturer in surgical anatomy at the University of Sydney with over 40 years experience, who expressed his view as to cause of death. He noted that the gum laceration was a most striking finding. He also noted that the anterior lividity on Jacob's face and upper trunk raised the possibility of smothering or mechanical occlusion of the external airways. He notes that Jacob must have been in a face down position for a significant period of time after his death to explain the anterior lividity.

160. He also noted that from the autopsy that the brain was markedly swollen, although there was no evidence of brainstem herniation and the degree of brain swelling was not such as to cause death from raised intracranial pressure (ICP) itself. He also noted that the post mortem CT scan results showed generalised cerebral oedema as the cause of the raised ICP in Jacob. He noted that he was of the opinion that Jacob had a traumatic brain injury affecting the left frontal lobe of his brain and suggested that this sat with the first injury identified in July 2018. He was of the view that at the very least some degree of concussion would have been associated with that injury.

161. In relation to the injuries presented to the emergency department on 12 July 2018 he confirmed that these injuries had a traumatic basis. The type of trauma cannot be identified now, but commonly represents a direct blow to the head in an infant of this age.

162. Professor Besser was of the view that the injury to the gum in his view could only have been caused by significant blunt force trauma, possibly by an object with a sharp edge which was forced onto Jacob's gum. The nostril laceration and abrasions represent blunt force trauma. He is not sure whether these are consistent with suffocation injury, but says this cannot be excluded due to the presence of anterior lividity of Jacob's face found at autopsy. He is also of the view it was an inflicted perimortem injury, occurring within about 30 minutes or at the most within 2 hours of death. In his view the presence of blood from the major gum injury indicates that the injury occurred more likely within 30 minutes of death, rather than a longer period.

163. He notes that the gingival mucosa has a large, abundant sensory nerve supply and this would have been a very painful injury to experience. He referenced the hurt suffered

when a mere toothbrush head hits that part of the gum, something most people have experienced and will recognise that area as being on that is sensitive to pain.

164. Professor Besser explained mechanisms of sudden death in children with traumatic brain injury. Firstly, he raised second impact syndrome, where a second or subsequent traumatic brain injury occurs at a variable interval of time, be it minutes, hours, days or weeks after the first event. The second blow can be minor "*but imparts accelerative and rotational forces to an already injured brain that has not recovered from the initial insult. This may result in sudden collapse with dilating pupils, respiratory failure and cardiac arrest.*"

165. Secondly, he opined there is a possibility that Jacob had a grand mal seizure as a result of traumatic brain injury.

166. Thirdly, he noted malignant brain swelling may have occurred due to concussive traumatic brain injuries, which can occur as a result of hyperaemia or vascular engorgement with a rapid increase in ICP. Although there was no evidence of brain herniation in Jacob, his cerebral oedema may have involved loss of autoregulation of blood supply to the brain with resultant inadequate cerebral perfusion contributing to his death.

167. He also gave the opinion that it was unclear if the severe gingival wound was also associated with a traumatic brain injury. He found that there were two other occasions when it is likely that Jacob would have suffered at least a concussive brain injury, namely the subarachnoid haemorrhage and the left periorbital bruising with subconjunctival haemorrhage. These episodes combined with the severe gingival mucosa injury could have caused one of the above explanations for sudden explained death.

168. In evidence he said that it was possible that if there was a direct impact blow causing the upper gum laceration would be sufficient to cause a concussive brain injury for an infant. He noted:

> "*Children's brains are very sensitive, they're tightly held inside the skull compared to an adult, an adult has a degree of atrophy and more space, but in an infant*

*that's not the case, it's very compact, tight and I use the word "sensitive" to trauma, particularly under the age of 12 months. It's been well documented that trauma in infants under 12 months, brain trauma, has a much worse prognosis than trauma after the age of 12 or 18 months from which children make an excellent recovery, but under the age of 12 months they have a very bad outcome*."

169. Professor Besser also discussed the brain swelling that he noted in the autopsy report. He said that there was significant brain swelling because the actual sutures of the skull were separated. Significant swelling is consistent with a sudden hyperaemic event, but there is also brain swelling when there is hypoxia. When there is cardiorespiratory arrest you would expect some degree of brain swelling. He considered the amount of swelling was greater than would be expected with solely cardiorespiratory arrest, but more likely consistent with swelling that occurred before the cessation of life.

170. Ultimately, he could not provide a definitive cause of death but offered some proposed mechanisms of sudden death following apparent minor traumatic brain injury. He noted that in view of lividity findings a suffocation injury cannot be excluded and remains high on the list of possible causation in his view.

*Lividity*

171. Dr Maistry explained lividity is the post-mortem gravitational pooling of blood, and it can sometimes become fixed, and from that you can gain an indication of the position of the body. Dr Duflou says from the pattern of lividity he is of the opinion that this is consistent with Jacob being in a face down position after death for a period of time. He opined this from the lividity that was apparent in the earlier photos compared to the autopsy photos. Professor Besser also indicated that the lividity was clearly indicating Jacob had been face down, and this evidence supported one medical hypothesis that he had potentially been suffocated.

*Body Temperature*

172. In relation to Jacob's body temperature at the hospital, he had a reading of 31.8 degrees Celsius. Professor Duflou's opinion was that, at that temperature, for a baby

he would expected the baby to have been deceased for at least 2 hours, or up to 6 hours prior to the arrival of paramedics.

*Findings based on evaluation of the expert evidence*

*Dating bruises and bleeds*

173. Expert evidence was given in relation to bruising and what could be determined to the age of the bruising, as a result of the appearance and colour of the bruises. The evidence was that bruising results from blood vessels being damaged owing to blunt force impact or pressure. Bruising typically becomes visible within minutes or hours of the traumatic event.

174. The overall evidence supported that bruises are hard to date from appearance. The age of a bruise or a subarachnoid haemorrhage cannot reliably be dated from appearance alone. Based only on its appearance, Jacob's bruising may have been caused up to 7 days before his presentation at the CHW. The subarachnoid haemorrhage, however, was likely suffered in the "*days*" (less than a week) beforehand as explained in evidence, and I accept that is the likely outer time frame for the infliction of the injuries relative to his presentation at the CHW. The evidence from the experts indicated that regard can be had to other circumstances in determining the likely timeframe in which an injury was caused.

175. Importantly among these is the primary carers' accounts about when a child was first seen to have injuries. In this case the bruises were noticed at a family function only days after he left hospital care.

176. On the basis of the evidence, the injury that first presented Jacob to hospital was occasioned after he left Blacktown Hospital. His aunt saw the bruise after the first family function, which was the day after he arrived home. I am satisfied on balance that he was thoroughly checked prior to being placed in his parents' care and he had no evidence of any injury prior to that time. The suggestion by Jacob's mother that it was a stethoscope injury was speculative and not based on any evidence. I am satisfied that it occurred when he was in his parents' care and control.

*Lividity*

177. In Professor Duflou and Dr Maistry's opinion, Jacob had fixed lividity posteriorly (back) and anteriorly (front). The anterior lividity was patchy and appeared in the areas of the face (nose, mouth) and the chest wall. Lividity can become "*fixed*" in areas if the body remains in a set position for a time. If a body is face down for a time lividity may become fixed on the front of the body (anteriorly). The time required for lividity to become fixed could range between 30 to 120 minutes but there is no definitive timeframe for this, nor can the period the body is in an anterior position be safely inferred solely from the presence of fixed lividity.

178. This evidence was persuasive, and supported by other observations made by experienced paramedics. It also cast doubt on Jacob's parents' explanation of events, because it appears contrary to their accounts, he was face down for a reasonable amount of time after his death.

179. Professor Duflou opined:

> "*An inference which can thus be made is that [Jacob] was dead and lying in a facedown position for a period of time, likely at least thirty minutes and possibly extending to some hours prior to attendance of emergency personnel at 10:19 hours. This is obviously contradicted by the mother's description that the infant was alive at around 09:30 hours, and was heard to make a yelp type sound at around 10:05 hours*".

*Timing of Jacob's death*

180. Jacob's parents' account would suggest that Jacob died very close to the time of the 000 call. They either heard a noise, which would suggest he was alive moments before he was found deceased, or, went in not long after he was seen alive and he was deceased. However, this account does not sit with the evidence, nor the expert opinions. The following is relevant to determining the approximate timing of Jacob's death, and suggest that Jacob was deceased for some time prior to the attendance of paramedics:

a. ***Anterior lividity***: this shows Jacob was face down for a period sufficient for the lividity to become fixed before paramedics arrived at around 10:20am. (Dr Marks also considered the presence of the anterior lividity to be a concern in

that it is possible Jacob may have been face down at the time he died or sometime thereafter).

b. ***Paramedic Brian Parsell's observations of Jacob and opinion***: it appeared Jacob had been deceased for a couple of hours by the time of his arrival at 10:30am based on Jacob's appearance and lividity.

c. ***Body temperature:*** Jacob's body temperature was measured to be 31.8 degrees Celsius shortly after his arrival at the CHW. In Prof Duflou's view, this temperature (accepting the limitations around that factor) and other evidence pointed to Jacob potentially be deceased for about 2 hours before his arrival at the CHW.

181. I am satisfied on the evidence that Jacob had died some significant time before 000 was called and the paramedics attended, likely hours before.

*Cause of Jacob's upper gum injury*

182. Drs Maistry, Marks, Skellern, Cameron, Middleton and Professor Duflou gave evidence about the possible cause of the upper gum injury. To be clear the laceration was not to the tissue connecting the upper lip to the gum (frenulum). The laceration penetrated the gum to such a depth that a baby tooth was visible. It is rare for infants to present with an injury of this kind let alone of that magnitude.

183. Dr Marks is the senior staff specialist at CHW working in child protection and the Emergency Department. She has worked in that role for 30 years. Dr Marks viewed the photograph of the laceration to Jacob's gum. She noted that usually when a frenulum, which is the small piece of tissue underneath the upper lip, a fine piece of tissue that connect the lip to the gum in the midline is injured, such an injury is described as a cut to that piece of tissue. She went on to say the following:

> "*This injury that we're looking at here is very different to those injuries that we talk about a lot. This is a significant injury to half the upper side of his-half of his upper gum and it does involve the frenulum at the middle but it extends a long way across his mouth. And as I've tried to explain, there's a cut there above the gum, but it also – there's an injury right up into and underneath that area and exposing the tooth underneath*."

184. She was asked whether she had seen many injures of that magnitude and she said this: "I've seen at least one other injury like this, but it was also as it happens in relation to a coroner's matter."

185. She indicated that in her view it would need a really significant amount of force to cause the injury.

186. The two primary scenarios identified by the experts are:

a. *Penetrative blunt force impact to the upper gum* (Scenario 1): This scenario involves a blunt force blow to the upper gum. The blow likely impacted under Jacob's upper lip rather than over the external lip area. This is because the upper lip was not injured to the degree that would be expected had the latter occurred. Whatever impacted with the upper gum likely had a hard well-defined surface (e.g., spoon).

b. *Shearing forces* (Scenario 2): This scenario involves forced applied down and over Jacob's mouth, with the force moving either side to side (horizontally) or downwards (vertically). The laceration results not from a penetrating impact but from forces causing the upper gum to tear. As for Scenario 2, possible mechanisms include the application of a hand over Jacob's lip/mouth area, or Jacob's face being pressed face down onto a bed or surface, with corresponding force applied horizontally or vertically. The laceration would not have resulted merely from Jacob lying face down on his stomach with his face resting on surface (e.g. bedding). This would not have produced the force required to cause the tearing.

187. Neither Dr Marks, Dr Skellern, Prof Duflou or Dr Maistry had ever seen an infant with an injury of this magnitude before. Dr Maistry described its depth and size as "*one of the most horrific injuries*" of this kind she had seen.

188. Jacob's right nostril laceration appeared "*fresh*". The nostril laceration was near to the upper gum laceration. The former may have been caused by the same forces that caused the gum laceration. Of the experts who gave evidence, Dr Cameron (paediatric dentist) had direct experience treating this type of injury in children. He had seen many, many cases of this type of injury. This has typically arisen in accidental injury

scenarios when a child has fallen forwards, with their lip/mouth area impacting the ground, resulting in shearing forces. The overwhelming majority of these cases concern children aged 18 months and over who are independently mobile, rather than an infant who cannot walk. In Dr Cameron's view;

> *"… Blunt trauma to the upper lips results, characteristically in separation (laceration) of the gingiva at the junction of these two soft tissues, termed the mucogingival margin. Depending on the amount and the direction of force applied, separation may take place within the body of the lips, involving a tear in the musculature and extending superiorly towards the nose or the tear may involve a "degloving" of the mucosa from the bone exposing the hard tissues below. In this case, the former appears to have occurred. I am of the opinion that a force has been applied, to the lips (from the outside of the mouth) resulting in a tearing of the gingiva. The small lacerations to the right margin of the columella at the top of the philtrum of upper lip [base of right nostril] would be consistent with this. …I differ slightly in the overall conclusion of Dr Marks that "the appearance and location of the injury to Jacob's gum could be explained by a tearing injury due to forceful traction/pulling on his upper lip." In explanation, in my experience, these injuries occur in relation to a lateral sheer movement of the upper lip, or a pulling down (rather than a pulling up) of the upper lip. I am unable to determine the exact mechanism by which the injury has occurred. A scenario that has been proposed that "the injuries were highly suspicious for forceful suffocation" and I concur with that opinion*."

189. The experts had various views on how this injury was caused, however the evidence of Dr Cameron was compelling. He was well versed in treating this very injury. He was confident in the manner in which he considered it inflicted, and he found that the other facial injuries of Jacob also fitted his scenario. He went as far as to say this was not the worst example of this injury, which Dr Besser picked up on, pointing out that in this case Jacob was a child with an adjusted age of just 3 months, and in the circumstances of an infant this size and age, it was indeed an horrific injury. Dr Cameron was making the point that the nature of the injury was one he was very familiar with in general terms, however agreed that it was not at all usual in a baby of Jacob's age.

190. I was persuaded that his explanation of cause of this injury (scenario 2) was more likely the method of infliction. All agreed that Jacob would have felt significant pain when the injury was inflicted and I am satisfied on balance that he suffered this injury prior to his death. There may have been some blood loss from the wound however the amount cannot be quantified. The closer in time to death the less bleeding there would have been, owing to cessation of blood pressure.

*Timing of the infliction of the upper gum injury*

191. As regards when the upper gum injury was inflicted relative to death:

a. Prof Duflou and Dr Maistry could not exclude the possibility the injury was caused after death but considered it more likely to have occurred perimortem (no more than a few hours before death). That was based on the absence of signs of healing of the injury at autopsy but with indications of slight bruising around the laceration.

b. Dr Marks could not estimate when the upper gum injury was caused, relative to time of death, other than to say it appeared on the photographs to be "*very fresh*" that and may have occurred in the hours before death (unlikely to have been days old).

c. Drs Cameron and Middleton (Forensic Odontologist) considered the injury was sustained perimortem. There was no evidence of healing of the wound margins that would be seen if it had occurred days before the event. The swelling Jacob had to his upper lip was "*minor and not to the level that would be expected if the injury had occurred other than around the time of death*". In his oral evidence, Dr Cameron elaborated on his abovementioned opinion, stating that the injury "*could result from either scenario mentioned in our reports and they are not contradictory. There is insufficient evidence to determine whether either has more merit than the other. Both scenarios are consistent with non-accidental injury*." (Prof Duflou did not exclude the possibility that significant upward movement of the upper lip might cause the laceration but did not consider its overall appearance as consistent with sideways movement). Dr Cameron provided further context:

"Q*: Can you explain to her Honour the significance of the absence of major swelling as to the timing aspect.*

*A: So with any - with any particular injury, particularly in an area that's highly vascular, which is the face. Q: Yes. A: Swelling occurs very quickly and you'd know probably from your own experience if you have children, they fall over, you know, collateral oedema, fluid extends into the surrounding tissues in response to inflammation and damage, and so that's quite a rapid thing. So within half an hour you end up with a big, fat lip from those sorts of injuries, so when I observed the photographs that were supplied, there was really no major - I think if you observe the lips without knowing what the injuries were intraorally then you could actually miss those particular - what was happening in the mouth, so from that - from that observable photograph. I would anticipate that any length of time following that you'd actually expect to see much more swelling to the lip.*

*Q: So do I understand your opinion to be that you'd expect substantial swelling or major swelling within about a half an hour of the infliction of the injury.*

*A: Typically.*

*Q: That the absence of that level of swelling in what you've observed suggests to you that death occurred relatively - within that 30 minutes of that injury which explains why there isn't major swelling.*

*A: Yes*."

192. In his original report, Dr Cameron opined that:

"*…It is conceivable that the injury might have been sustained in the hour(s) before death, however, I believe that swelling to the upper lip and bruising to the lip would have been seen due to the significant damage to the soft tissues and the vascularity of the upper lip. Furthermore, in such a scenario, I*

*would also expect to observe a haematoma or ecchymosis lateral to the labial frenum*."

193. In their oral evidence, Drs Cameron and Middleton gave the following evidence on this issue:

*"Q: --lateral to the labial frenum. When you say there in the "hour" or "hours," do I take it what you're saying is, is that the absence of those injuries points to this being within an earlier time than an hour?*

*CAMERON: That would be consistent.*

*Q: You've already given evidence that you would expect to see a major swelling of the lip within 30 minutes.*

*CAMERON: Yes, and certainly with that - when you have a tear in that sort of – in that tissue, then there tends to be extravasation of blood into the surrounding tissues and that's why you end up with a bruise and typically that's - the swelling is not only oedema, a fluid leaking from that area, but also blood as well.*

*Q: So what you're describing there is part of the swelling of the lip.*

*CAMERON: That's right.*

*Q: Would you expect to see a coloration of the lip consistent with a bruise.*

*CAMERON: You may not see a coloration extra-orally but certainly inter-orally.*

*Q: And to your understanding that wasn't observed.*

*CAMERON: That wasn't observed.*

*Q: Would you agree it is also possible that laceration was suffered at or about the time of death, perimortem but prior to death but within minutes or closer?*

*CAMERON: It would be consistent with that.*

*Q: Can I just ask, bruising, so would you see the bruising around the laceration in the mouth, is that-*

*CAMERON: No.*

*Q: --what would you expect to see.*

*CAMERON: You do. If I might draw you to figure A2 on page 10. So you can see the accumulation of blood adjacent to the frenum so there's obviously been damage to blood vessels around that area and blood has leaked into the tissues, so you would see it around - you may or may not see it around those areas, but that's the most common presentation of that.*

*Q: So, Dr Cameron, just is this a fair summation of your views, that based on what you've seen in the photographs, it's more likely than not that the laceration was inflicted within 30 minutes up until essentially the time of death itself but prior to death.*

*CAMERON: My feeling is that it's occurred prior to death.*

*Q: Yes.*

*CAMERON: The exact timing, I don't think anyone can determine. The scenario that you propose is extremely reasonable to - and I think the nature of the injuries and the fact that, as Dr Middleton described it, there's no - there's no healing process that has begun. Now, in children, particularly for these sort of injuries, within a very short period of time and I can't quantify that, but within hours there's – you don't (as said) form a scab in the mouth, there's granulation tissue, which is - there's a fibre network and that's - that healing process has begun, you know, very rapidly, so none of those signs were actually present so I think what - it's reasonable to conclude that conjecture.*

*Q: If you are weighing up likelihood whether this injury was more likely to be inflicted outside the 30-minute window of death or more likely within that window, are you able to offer a view given the lack of major swelling that you've observed.*

*CAMERON: I would agree that it was more likely to occur within that 30-minutewindow.*

*Q: Dr Middleton, do you have any difference in view?*

*MIDDLETON: My only comment from a post-mortem point of view is the time of death is a very difficult field to interpret, but the indications in terms*

*of how the body reactions to an injury indicate that that injury probably occurred very close to time of death, whether it's 30 minutes, 35 minutes, 40 minutes, I don't think anybody can say with great confidence".*

194. The experts all preferred the view that this was a perimortem infliction, likely very closely connected with the time of death. I am satisfied that the infliction of the upper gum injury was more likely than not very close to his death, enough that the inevitable level of bruising and healing had not commenced. That injury was most likely within 30 -40 minutes of his death.

*SUDI*

195. Infants can die suddenly and unexpectedly absent suspicious circumstances or known health issues, vulnerabilities and without an evident cause being found in autopsy. This typically occurs during sleep and is known as Sudden Unexpected Death in Infancy (SUDI). This captures what historically has been referred to previously as "cot death" or Sudden Infant Death Syndrome (SIDS).

196. What occurs in an infant's body leading to SUDI death is not definitively known. A SUDI classification is arrived at by exclusion of identifiable or potential causes for death. SUDI classification is excluded if there is evidence of suspicious injuries or circumstances. Although the mechanism is not definitively known, factors have been identified as associated with an increased incidences of SUDI death. This includes an infant sleeping in an unsafe sleep environment.

197. Dr Skellern and Prof Duflou observed that there was evidence of an unsafe sleeping environment in Jacob's case (e.g., co-sleeping with placement of Jacob inside a u-shaped pillow). That factor raises for consideration whether Jacob potentially experienced inadvertent airway obstruction from an unsafe sleep environment.

198. There may be no obvious signs that enable differential between deliberate airway obstruction and that arising unintentionally. Prof Duflou observed that petechial haemorrhages can sometimes been seen on the organs within the chest cavity and the thymus gland in SUDI cases (e.g., infant found deceased in bed in a face down

position). These were not observed in Jacob's case however the absence of such haemorrhages does itself exclude a SUDI death.

199. Other factors associated with a higher risk of SUDI death include infants' prematurity of birth, social disadvantage, parental health issues and co-sleeping. In Dr Skellern's view, the viral infection that onset before Jacob's death may have contributed to nasal blocking, which could have impacted his airway and potentially increased his vulnerability to a SUDI type event. This is so even though the signs of that illness were not severe. The expert evidence supported that the viral infection was not a cause of death.

200. However, Jacob's death would be excluded from a finding of SUDI as a result of the physical abuse evident. The SUDI finding does not sit with Jacob's parents' account of Jacob making a noise and therefore being awake at the time of his sudden demise. His mother makes a point of saying that she cleared the pillow and other items away from him and placed him on his back. There is no suggestion by any expert that this could or would be a finding in this case.

*Potential mechanisms/causes of death*

201. Two possible causes of death arose in the experts' evidence being:

a. ***Airway obstruction/suffocation***: Jacob's airway became obstructed which ultimately resulted in the cessation of his breathing and death. This might involve intentional obstruction (e.g., hand over mouth, face pushed down onto a firm surface) or unintentional obstruction (e.g., clothing or some other surface unintentionally covering Jacob's airway). The key indicators pointing to this possibility are:

   i. the upper gum injury (if caused by the shearing force scenario); and

   ii. the anterior lividity (which is consistent with Jacob being face down at some point).

b. ***Sudden unexplained death owing to traumatic brain injury***: this possibility was canvassed in the evidence of Dr Michael Besser (neurosurgeon). Simply put there can be mechanisms for death that may not be clear at autopsy except for cerebral oedema (brain swelling itself not enough to cause death). These

mechanisms fall under the umbrella of "*sudden unexplained deaths*" arising from traumatic brain injury, namely:

i. Second impact syndrome;
ii. Grand mal seizure; and
iii. Malignant brain swelling.

This is distinct from the scenario arising in SUDI cases. The precise mechanisms that cause death are not definitively known. Jacob had already suffered a traumatic brain injury resulting in the subarachnoid haemorrhage found during a scan on 13 July 2018. If Jacob's upper gum injury was caused by blunt force impact, that itself or in combination with injury caused during past trauma, may have occasioned further brain injury and served as the catalyst for Jacob's death. Evidence of brain injury, if occasioned on 10 October 2018, would not necessarily have been evident from in scans completed after death and in the neuropathological examination.

202. The majority of the expert evidence and objective evidence is that Jacob's death occurred in very close proximity to the extensive gum injury inflicted on him. Expert evidence ruled out death by natural causes. The mechanism of his death on balance would be either suffocation or smothering, or alternatively sudden unexplained death by methods described by Dr Besser.

## Overall Findings as to manner and cause of death

### *Findings regarding infliction of injuries*

203. In relation to Jacob's injuries and death:

a. Jacob's healing fractures were definitively caused some time after 19 July 2018. Medical investigations conducted between 13 and 19 July 2018 showed Jacob had no bone fractures when he was discharged from hospital on 19 July 2018.

b. The fractures were already healing before his death and were not attributable to emergency treatment administered on 10 October 2018.

c. On the expert evidence, the fractures were likely inflicted between 2 to 6 weeks before his death, at a time when his parents were responsible for Jacob's care.

d. The bruising on Jacob's body was of differing ages. Many bruises showed early signs of healing.

e. Jacob's upper gum laceration was extensive and was inflicted before Jacob's perimortem.

f. Jacob could not roll or stand owing to his age. There is no possibility he caused any of these injuries to himself.

g. Jacob's injuries resulted from multiple traumatic events.

h. Jacob underwent an endocrinology review on 17 July 2018. His osteopenia was found to be mild and improving. His bone strength would have continued to improve in the subsequent months leading up to his death. The fact he didn't suffer acute rib fractures from CPR compressions on 10 October 2018 is an indication of his bones' strength. This condition did not cause or contribute to his injury or death.

i. In relation to Jacob's gum injury, the expert opinion proposed two possible scenarios for the infliction of that injury. Scenario 2 is preferred given the extensive experience Dr Cameron has had with this type of injury, although it is noted to be a most unusual injury on a baby Jacob's size.

j. The exact timing of infliction of the gum injury cannot be precisely determined other than that it occurred after Mr AM left the family home and sometime in the hour or hours before Jacob's death.

k. Given the recency of the injury, relative to death, it is likely the injury and Jacob's are connected. It is also possible it was inflicted at the, or very proximate to the time Jacob died.

l. It is possible the hanging of sheets shortly before 6:00am on the day of Jacob's death is connected to the upper gum injury, or Jacob's death.

*Findings regarding timing of death*

204. The senior experienced paramedic Inspector Parsell formed the view that Jacob was long since deceased by the time they arrived. He had extensive training and experience. Further, although body temperature is subject to wide fluctuations after death dependent on a number of factors, Professor Duflou was able to form an opinion that this was a feature that supported death hours prior to the 000 call.

205. The accounts of both Jacob's parents does not sit with the objective findings, particularly any explanation of the lividity found when ambulance arrived. Their account was that he was always lying on his back.

206. The initial account by his parents suggested that there was a noise, then when he was attended, he was found deceased. Thie initial account given to paramedics conveyed the same time, being 9:20am. Both parents moved away from the timing and in some accounts there was a noise made by Jacob but in other accounts there was no noise identified.

207. Jacob's parents were not truthful about their movements in the early hours of the morning and the presence of Mr AM that night which is unusual given Jacob's sudden and shocking death.

208. In relation to Jacob's time of death it can be found on the evidence that he was already deceased some one to two hours prior to the attendance of the ambulance. Dr Maistry and Professor Duflou considered the presence of anterior lividity, and he was face down long enough for the lividity to become fixed. The temperature that he presented at hospital with also supported this finding, together with observations of a very experienced paramedic.

*Findings as to parents' account*

209. There has been no explanation for Jacob's injuries that were identified when he was alive. There was misinformation given to DCJ about ice use, there were excuses given to Blacktown Hospital as to why Jacob's parents were not visiting, although it appears they were at similar times able to attend licensed premises to play pokies or meet friends for ice consumption. His parents equally made excuses as to why they could

not visit or stay with Jacob at Westmead Hospital. His parents mislead their own family about Jacob's body being unavailable for collection from the mortuary. His parents appear to have been dishonest about Jacob being at swimming lessons and unavailable to be seen. His parents avoided or cancelled scheduled appointments with doctors and care workers; even the day prior to his death it was suggested that Jacob had been to the doctor when he had not. Evidence of their explanation of the events surrounding his death does not sit with the objective evidence available.

210. Jacob was left with drug associates of his parents on numerous occasions between his initial release from hospital on 10 July 2018 and his death on 10 October 2018.

211. Jacob's parents' explanation of the events of his death are not corroborated by the objective evidence and must be for the most part rejected.

*Findings regarding manner and cause of death*

212. I rule out the possibility of accidental airway obstruction. Jacob could not put himself face down on his stomach by himself. It is not consistent with any of evidence, nor his parents' various accounts. There was no evidence was Jacob placed in any position that compromised his breathing during sleep. The possibility he accidentally came to be in that position, or that some other airway obstruction accidentally arose, has never been suggested nor would this account for the upper gum injury.

213. The events of the night can be best summarised on balance in accordance with the evidence, as follows:

a. As at 9 October Jacob had a large number of healing fractures and other injuries.

b. Mr AM came over to care for him while his parents went out. His uncle smoked ice, and Jacob was restless and so his uncle held him for the first time, in fact, and spent the time with him holding him. His parents returned home, they were not in a good mood, they had been called back by his uncle who was telling them that Jacob was awake, the inference being that they needed to return home. He then stayed with Jacob's father and smoked ice, while Jacob and his mother went into the other room. Mr AM left, and at that time Jacob had not suffered any injury to his gum.

c. It can be accepted on the combined expert evidence that Jacob died soon after a significant amount of force was applied to him, enough to cause a shearing injury on his upper gum of significant size. This would have resulted in a massive trauma causing his death either through suffocation and asphyxiation or resulting in sudden death as result of traumatic brain injury inflicted as a result.

d. Jacob spent some time deceased prior to a call being made to 000, and the arrival of paramedics. He spent some time face down while deceased and was then turned over on his back for a period of time prior to arrival of paramedics. The time he spent deceased prior to their arrival was a number of hours.

e. At some point in the morning sheets were cleaned and put out on the line, and removed prior to the arrival of the paramedics.

f. Jacob's father left the home and then returned. The 000 call was then made, however by that time Jacob had been deceased for some time.

## PART 2: INSTITUTIONAL RESPONSES

214. The second part to the inquest relates to the institutional response to the care of Jacob. Jacob was harmed by others, and those who harmed him are responsible ultimately for his death. Our community considers that the protection and care of our children is something we value very highly, and as such departments and systems are in place to try and provide an additional layer of protection to our children. The systems are of particular importance because they provide checks and balances, so if something is missed through human decision making or error, the system should have further processes that might act as a safety measure to pick these up or offer review. No one person can be expected to hold this level of responsibility alone. The Coronial role extends to making recommendations if there are opportunities for improvement identified, and if those recommendations are necessary. Jacob's case is one where a number of significant opportunities were missed. This happened at all levels of his care, and it was important to explore these errors to analyse whether any improvements could be recommended.

215. Those who choose to undertake these caring and difficult roles should not be targeted or singled out in relation to this case, and the intention of this inquest was not to do so, but rather to broadly look at system improvements. At times witnesses gave uncomfortable and difficult evidence, but in doing so they assisted the process through being forthright and honest, even though it did not always paint themselves in the best light. However, their roles and demanding and they are as a general rule, time poor given the great community need for the involvement of DCJ staff for the protection of children. It is only through the assistance of the witnesses that problematic issues with the system could be properly identified.

### Westmead Hospital's response to positive drug screen from Jacob's mother

216. Westmead Hospital had an opportunity that was missed to start raising the flags in relation to Jacob's care.

217. At about 1:00am on 27 April 2018, a urine sample was obtained from Jacob's Mother. The urine screening detected amphetamines. The screening did not provide a concentration other than that it was above the cut off value (300ug/L). Westmead

Hospital staff did not report Jacob's mother's 27 April 2018 positive urine sample to DCJ. When the JCPRP casework team later requested information from Westmead Hospital about Jacob's mother's admission at the hospital, the information supplied did not mention the 27 April 2018 positive screening result. DCJ only learnt of this result after Jacob's death.

218. Westmead Hospital's records disclose no evidence which demonstrated that clinicians reviewed this result and what the treating team made of this it, save that Dr Kapilesh Balachandar reviewed the result on or after 30 April 2018. Dr Balachandar checked the results out of curiosity and brought those to the attention of a senior member of the treating team. He has no recollection now who the senior member was. He believes the result was probably interpreted as a *"false positive"* and was not attributed to possible illicit drug use.

219. Westmead Hospital clinicians may have thought the result was a false positive. Regardless, it was reasonably possible it reflected drug use, and it should have been reported to DCJ given the recent birth of Jacob combined with the observations made of his mother returning to hospital in the early hours of 25 April 2018 and her condition at that time. It was interesting the nurses' observations of his mother; the fact that she was going missing at times and they were concerned that she may have been substance affected; coupled with the results, did not lead to a report being made to DCJ regardless of the ultimate doctors' interpretation.

220. The value of this report may have prompted DCJ intervention in late April 2018 or led to greater investigation of Jacob's parents' drug use when the 13 July 2018 ROSH report was received. Westmead Hospital and Dr Balachandar accept that a report should have been made to DCJ. As regards Dr Balachandar, he was a junior doctor and was not directly responsible for Jacob's mother's care at the relevant time, and no responsibility is attributed to him. It can only be said that Westmead Hospital accept this failure and a report to DCJ erroneously did not occur, however I accept that its practice is to make such reports, and minds have subsequently been turned to this error. No recommendations are necessary in this circumstance.

## The Secretary's child protection casework response

### *DCJ structure and practices*

221. Child protection remains of important community interest, and as such systems have developed to assist vulnerable children in our community where possible. The totality of the evidence supports that, sadly, this work is vast and there are many children that are reported as children in need of support. Those working in this field are extremely busy and dedicated, and the closing of one file merely means the opening of another. Given the excessive need for the services, processes become even more important to provide checks and balances, and to use methods that aid in decision making.

222. The DCJ structure is one that played a part in much of the evidence. The following is an explanation helpfully provided by Counsel Assisting setting out the various roles and acronyms.

223. JCPRP was the first responder to the report of harm to Jacob. The JCPRP is a statewide tri-agency program which aims to provide a coordinated safety, criminal justice and health response to children and young people reported to have experienced sexual abuse, serious physical abuse or serious neglect.

224. The JCPRP DCJ casework team had responsibility for child protection casework which included considerations about safety planning and whether to exercise statutory powers under the CYP Act. DCJ opened a case for Jacob which was initially assigned to the Parramatta JCPRP. A separate case opened for Jacob's brother was assigned to the Parramatta CSC. Each team largely operated independently of the other. DCJ had a procedure (Sibling Case Coordination mandate) directed to the coordination of sibling cases assigned to different teams.

225. The JCPRP DCJ casework team typically holds casework responsibility for a short period. They provide the emergency and instant care. A case will usually be transferred to a CSC for ongoing casework after 30 to 60 days. Each casework team operates on a hierarchical supervision structure. DCJ caseworkers have an assigned Manager Caseworker (MCW) who reports to an assigned Manager Client Services (MCS). At the apex of this structure is the Secretary.

226. At Parramatta JCPRP, Manager A was the responsible MCW (JCPRP MCW). He supervised about 5 to 6 caseworkers. He reported to the JCPRP MCS. The JCPRP MCS was responsible for six casework teams spread across four JCPRPs (Bankstown, Penrith, Parramatta and Liverpool).

227. The CSC is the step down responder in this case. JCPRP will eventually hand over a case to the CSC for longer term management. At the Parramatta CSC, CS was the assigned caseworker reporting to Manager M (Parramatta CSC MCW). Manager M reported to the MCS (Parramatta CSC). DCJ had procedures for the conduct of risk assessments which included:

a. Completion of an initial safety assessment directed to a child's immediate safety in the home. This assessment produces one of three outcomes: '*safe'*, '*safe with a plan'* or '*unsafe*'. This is to be reviewed if new information comes to light that bears on the assessment of risk or otherwise within 72 hours of its creation.

b. Separate to the safety assessment is the requirement to complete a risk assessment. The latter must be completed within 30 days of an initial safety assessment.

228. As of 19 July 2018, potential DCJ casework options included:

a. Asking Jacob's parents to agree to a Safety Plan with requirements around supervision and supports with Jacob remaining in his parents' care.

b. Asking his parents to enter a temporary care arrangement providing for Jacob to be temporarily placed into the day-to-day care of other relatives or authorised carers upon his discharge from hospital.

c. Exercising statutory powers that provided for Jacob's assumption into the care of the Secretary under s 44 of the CYP Act and applying for the making of a care order under s 61 of the CYP Act. Such an order might have resulted in the allocation of parental responsibility to the Minister on an interim or final basis. The assumption of care and commencement of care proceedings required approval of the responsible MCS.

*Timeline of key events*

229. On 13 July 2018 Dr Pathmanandavel (CPU) made the 13 July 2018 ROSH report to the Secretary. This was the process that alerted DCJ to the harm Jacob had experienced. In addition to Jacob's injuries, the report noted concerns about his parents' limited visits to Jacob while he was admitted for neonatal care at Blacktown Hospital.

230. This ROSH report was then referred to the Parramatta JCPRP for a response. DCJ cases were opened for Jacob, assigned to the JCPRP, and for his brother, assigned to the Parramatta CSC casework teams respectively. Jacob's brother, being the sibling, automatically had a case opened, albeit not needing JCPRP's attention at that time, its focus was Jacob.

231. The JCPRP immediately took control, and requested the CHW to ensure the JCPRP was notified if his parents attempted to remove Jacob from hospital. A *Local Planning and Response* (**LPR**) was generated for the JCPRP. The LPR is typically part of the information considered during an initial JCPRP briefing when the referral is discussed amongst all JCPRP agency members. Jacob's LPR included information about his father drawn from police records, stating:

    a. "*EVENTS: 38 – AVO/Breach AVO (multi), DV (multi), Assault (multi), Malicious damage, Offence against the person, Drug detection*".

    b. "*CHARGES: 13 - Drive vehicle illicit drug in blood, Possess Proh drug (multi), Destroy property - DV, Assault - DV (multi), Contravene AVO, Stalk/Intimidate, Breach bail*".

    c. "*WARNING: Self confessed ICE/Heroin user*".

232. The LPR's reference to "*drive vehicle illicit drug in blood*" and "*possess proh drug (multi)*" concerned Jacob's father's drug related offences committed in February and November 2017, however the LPR did not specify the date of the charges or the offences. The casework team did not request his father's criminal record from police, or records of police dealings with his father. The Secretary has a statutory power to request information be provided without warrant or subpoena under Chapter 16A of the CYP Act. This is an important legislative tool allowing quick access to relevant material.

233. Between 13 and 19 July 2018 daily telephone conferences took place between the CPU and the JCPRP teams, during which the CPU team provided updates on medical investigations and their dealings with Jacob's parents. The advice given by the CPU team, at least by 19 July 2018, was:

a. Jacob's age meant he did not cause his injuries to himself;

b. medical investigations had not found a medical explanation for his injuries;

c. Jacob's parents had not reasonably accounted for how his injuries were caused; and

d. there were concerns raised by the team about Jacob's mother's attachment to Jacob, which took into account her lack of visitation of Jacob in hospital and other matters.

234. On 14 July 2018 JCPRP police investigators, Detective Senior Constable Tiffany Duane and Senior Sergeant Paul Grech interviewed his parents about Jacob's injuries. Police investigation is an important part of JCPRP.

235. On 16 July 2018 JCPRP Caseworker 1 and JCPRP Caseworker 2 interviewed his parents about Jacob's injuries and their circumstances.

236. Jacob's parents denied, causing Jacob's injuries. His mother suggested Jacob might have been hurt accidentally during family gatherings such as at the maternal grandparents' home on 10 July 2018, or even possibly before his release from Blacktown Hospital, although neither parent reported seeing any infliction of harm or accident.

237. During interview his father admitted that he had used ice about 3 to 4 years earlier, and that he had completed the MERIT program. However, he said that he had not used drugs in the preceding years. Jacob's mother acknowledged awareness of past drug use by her partner but not during their relationship. She denied that either she or her partner had current drug and alcohol issues. These reports were contradicted by Jacob's father's drug related offences which were committed after his completion of the MERIT program in 2016, which pointed to him relapsing in 2017. The interviewing caseworker, JCPRP Caseworker 1, was not aware of his convictions or this

inconsistency. Somewhat surprisingly no subsequent checks were made by the casework team to verify the accuracy of the drug use.

238. During a CPU/JCPRP conference later that day, the denials and suggestion that Jacob suffered injuries at Blacktown Hospital were raised with the CPU. The CPU team could not exclude definitively the possibility that Jacob's injuries may have been caused before his release from Blacktown Hospital on 10 July 2018, this was based on observation of injury alone. The team could not conclusively date the injuries.

239. On 17 July 2018 the CPU team was notified of concerns by nursing staff about the lack of visitation of Jacob on the ward and the engagement of his parents with him. The CPU reported those further concerns about the visitation to the JCPRP casework team. JCPRP DCJ caseworker DA contacted his parents after being notified of the CHW's concerns at the lack of attendance and support for Jacob by family. His mother explained that she had not been visiting as she was sick with the flu and was concerned she would make Jacob and other children sick. These followed a similar line of the reasons she had also given during Jacob's Blacktown Hospital admission as to why they were not attending.

240. Although all parents would respond differently and have differing capacity to remain with a child in hospital who has been found to have serious and unexplained injuries, it was a significant fact that the CPU was identifying this as an issue in relation to support and attachment for Jacob.

241. On 18 July 2018 the JCPRP DCJ team held the first of three Group Supervision meetings about Jacob's case. Participants included Manager A (JCPRP MCW), various caseworkers and a casework specialist. The JCPRP MCS was not present. The Parramatta CSC casework team were not invited despite having case responsibility for Jacob's brother. The CPU team were not invited to attend. During the Group Supervision some voiced support for the removal of Jacob and commencement of casework. The session concluded with a plan to adopt a safety planning approach. After the meeting Manager A informed his direct manager, the JCPRP MCS, about its outcome and the intended casework response.

242. Caseworker DA completed a Safety Assessment Decision Report that assessed Jacob as "*safe with plan*", which is included in the 18 July 2018 Safety Assessment Decision Report. Another way to view this outcome is that the JCPRP DCJ casework team viewed that Jacob was not safe in his home without a Safety Plan in place.

243. On 19 July 2018 Jacob was discharged from the CHW into his parents' care at about 6:20pm. His parents agreed to the Safety Plan developed by the JCPRP DCJ casework team. The plan involved the attendance of Zest workers to the home, twice daily, for one week (only).

244. Zest would have a fairly limited role, to observe in the home.

245. The JCPRP DCJ casework team did not have delegation to approve the engagement of Zest. Approval for that was sought from, and given by, the MCS (Parramatta CSC MCS). This was done via CS (Parramatta CSC caseworker) and Manager M (Parramatta CSC MCW). This is somewhat confusing, but the evidence made clear that while JCPRP DCJ came up with a plan that involved third party paid participation, it was up to the CSC MSC to approve this expenditure. This was a curiosity in the process, given they were not even part of the meeting, did not have a case open for Jacob and the plan was dependent upon such approval.

246. The JCPRP's investigating police concluded, after what can be said was a very superficial investigation, that there was insufficient evidence to bring charges for the injuries Jacob presented with on 12 July 2018. No further inquiries were undertaken by police until September 2018, upon the second injury. At this point no one within the JCPRP had spoken to the extended maternal family about his parents' circumstances, Jacob's brother's care arrangements, whether Jacob could have been injured at one of the family gatherings or before his release from Blacktown Hospital (to their knowledge) and what support they could provide to support him and his parents. Even more surprising is that medical staff and social workers at Blacktown Hospital had not been spoken to regarding what they knew about Jacob, his parents' involvement with him and the possibility Jacob was injured there before his release. No records had been sought through Chapter 16A CYP Act request at that time.

247. During a JCPRP and CPU conference, when the decision to discharge had already been made, but prior to Jacob's discharge, Dr Marks recommended that his mother undergo a mental health assessment and, separately, an expert assessment be undertaken to explore her attachment with Jacob. These were matters to assist in the care of Jacob, and the bonding of he and his mother. Dr Marks proposed the Tresillian service, which is a NSW Government funded service providing residential inpatient assessments of issues such as attachment by a multidisciplinary team. Tresillian is well known and well recognised as being capable of doing such things as assessing the interactions and attachment between a parent and an infant, as well as providing critical support for both. There is also an option of continuing engagement in the community after the initial admission period. His mother did not undergo a mental health assessment or attend Tresillian service assessment, nor does it seem that this requirement was followed through as part of the plan from the DCJ perspective at that time following the first incident.

*Jacob goes home*

248. From 20 July to 3 August 2018 Zest workers attended Jacob's home daily. This was, for the most part, twice daily, in the mornings and afternoon/early evenings. Zest workers completed daily reports which were submitted to the casework teams for review.

249. On 24 July 2018, while under the supervision of Zest, Jacob was presented by his mother for a pre-arranged review by the CPU team. This was just 12 days after the first presentation at CHW, and just 15 days after he was released from neonatal care. He was under the supervision of JCPRP, assessed "safe with plan".

250. Two new bruises were found on Jacob's right foot, and photos of the bruising were taken. The CPU team were very concerned at Jacob's new bruises. They were confident that Jacob could not have caused them. This was the second occasion in 12 days that Jacob had presented with injuries which could not reasonably be accounted for. This bruising had been caused despite Zest's engagement. The CPU team also observed suspicious markings on his mother's hands which it considered was a possible indicator of drug use, and was a concerning warning sign in relation to the ongoing safety of Jacob.

251. Dr Marks contacted the JCPRP by phone and spoke to Manager A about Jacob having new bruising and his mother's presentation (hands). In a contemporaneous note of that contact, DA noted:

> *"…Dr Marks said that Jacob and his mother have presented for a follow up appointment this morning and whilst being examined by [Dr Pathmanandavel] a bruise on the sole of Jacob's right foot that is about 2cm by 1cm has been sighted. Dr Marks said that it is unlikely that Jacob would have sustained this bruise from doing something to himself and the explanation that the mother has provided is that [the bruise was possibly] caused by the zipper. Dr Marks said that she does not think this explanation is consistent with Jacob's injury as the zip goes up to the nappy. Dr Marks said that a photo has been taken of the bruise and will be sent to [JCPRP]. Dr Marks said that the bruise was purple in colour. Dr Marks said that the mother had not noticed the bruise prior to CPU staff sighting it and doctors also noted that the mother was pulling her sleeves down and when [Dr Pathmanandavel] asked what happened to her hands as bruising and scabs were sighted and the mother said it was caused by having numerous cannulas in. Dr Marks said it is unlikely that the bruising and scabs were caused by a canula. Dr Marks said that the social worker [Ms Knight] had noted that while Jacob was in hospital last week the mother was wearing gloves. [Ms Knight] said that the father had come with Jacob and the mother to hospital but didn't come to the appointment."*

252. There was some dispute in the evidence as to whether Dr Marks was offering to keep Jacob in hospital until a case manager came to the hospital, which is explored further below. Nonetheless it is accepted that Dr Marks made the call directly to the first responder team with the case open for Jacob.

253. No one from JCPRP offered to attend the hospital, nor did they attend. Instead, JCPRP DCJ caseworkers attended the family home that afternoon and saw the bruising and further photos of the bruising were taken. A new Safety Plan was agreed to by his parents including:

a. Jacob's maternal grandmother or another relative to stay overnight;

b. Zest to continue attendance in the home;

c. parents to continue to comply with JCPRP, DCJ and Zest; and

d. Jacob's mother to attend a GP to have her hands reviewed.

254. Zest workers were directed to check Jacob each shift for suspicious markings.

255. There was relatively little change to the plan, and in any event, it was not enforced or reviewed to ensure that it was being complied with.

256. Manager A notified the JCPRP MCS that same day of the new bruising and the immediate plan.

257. The following day, on 25 July 2018 the second of the Group Supervision meetings took place. Manager A asked to discuss Jacob's case, and the possibility of beginning care proceedings, with Manager M (Parramatta CSC). Photos of Jacob's bruising were forwarded to the Parramatta CSC casework team that same day. The JCPRP DCJ casework team held its second Group Supervision session for Jacob's matter which the JCPRP MCS attended. The Parramatta CSC team and the CPU were again not invited to attend. Views for and against Jacob's removal were expressed in the session. The session concluded with Manager A and the JCPRP MCS agreeing to the continuation of safety planning.

258. However, the 18 July 2018 Safety Assessment Decision Report was not reviewed, nor was a risk assessment instrument completed, at this time. This was a failure in process and ought to have occurred.

259. On 26 July 2018 Jacob's parents met with Manager A and DCJ caseworkers including CS (Parramatta CSC). Manager A informed Jacob's parents that he was sitting with the highest level of risk as regards Jacob's injuries. In essence this meant that Jacob was now sitting at an extremely high level of risk, and that risk was sitting with DCJ to manage.

260. After this meeting, Manager A emailed the Parramatta CSC team asking for an extension of the Zest engagement with the family. Manager A also asked to discuss

Jacob's case with Manager M as it was "*a tricky one".* Manager M responded that she had been updated about the situation by CS and that Zest workers would be requested to check Jacob "*head to toe*". A Zest record noted that "*[Manager A]*" from DCJ requested they "*check the baby all over for bruises*" and "*[Manager A]…has serious concerns around this*". Manager A emailed; "*Can you give me a quick buzz re this matter? We are continuing to become increasingly concerned for the family and if we do need to go to court I'd like to make that decision jointly*". Manager A has no recollection of receiving a response from Manager M about his invitation to discuss the case. It was likely that CS was present as the assigned caseworker for Jacob's brother and because it was anticipated Jacob's case was expected to be transferred to the Parramatta CSC in the near future. Manager A believes he did speak with Manager M about the request and Jacob's case as he considered ongoing Zest involvement as important.

261. This process illustrates the issues relating to CSC being in control of the funding approval for Zest, while the plan development remained the responsibility of JCPRP.

262. Manager A's request to extend Zest was forwarded to the MCS (Parramatta CSC) copying Manager M. The MCS (Parramatta CSC) was asked to approve the continuation of Zest for a further week as "*another mark*" had been found on Jacob. This language did creep into the notes and correspondence and was challenged in evidence. Jacob had two unexplained bruises in an unusual location, and the terminology of "mark" or "bruise" (singular) seemed to diminish the strength of the medical finding.

263. The MCS (Parramatta CSC) approved that extension for just one week but asked to discuss the matter with CS and Manager M the following week, stating "*I'm worried about Zest purely monitoring for future injuries. Not sure what is going on for this family but it is concerning that there are 2 suspicious injuries so close together.*"

264. In approving an additional one week extension of Zest, The MCS (Parramatta CSC) advised Manager A by email,

> "*I will approve this for one more week, however, we're going to need to work out another plan, it's going to be a very expensive exercise for Zest to be only*

*monitoring. We usually would use Zest for an in-home support. Can we use this week to look at what additional services we might be able to put in place? There are current vacancies with the Telopea, as one possibility*".

265. In response Manager A proposed a meeting be held between the two DCJ teams which involved the MCSs (JCPRP and the Parramatta CSC) to discuss "*next steps*".

266. On 27 July 2018 DA completed a referral to the Tresillian Service consistent with the recommendation made by Dr Marks on 19 July 2018. There was no evidence given to explain why that hadn't been done immediately after the first incident and corresponding recommendation by Dr Marks. Caseworker DA also completed a risk assessment decision report for Jacob on 27 July 2018. The generated outcome was "*moderate risk*". Caseworker DA properly applied an override resulting in the risk outcome being listed as "*very high*". The override was applied given Jacob's injuries being suspicious. The assessment recorded, amongst other matters,

> *"Jacob's parents have not been able to provide an explanation for his injuries and when interviewed by [JCPRP DCJ] and Police they said that in the two days that he was home from hospital they were around numerous family members…*".

267. In an email to the MCS (Parramatta CSC) from Manager M on 26 July 2018, concerning Zest's quote for increasing its daily hours of attendance, Manager M stated:

> "*The quote is $4000 for the level of supervision being suggested by [JCPRP] in relation to this matter. Jacob was observed with another mark on his foot. [JCPRP] had a meeting on 25 July 2018 and still determined there is not enough information to proceed through court and so I've asked for a further supervision in relation to Jacob.*"

268. Manager A, in his evidence, denied he ever expressly said or intentionally suggested to Manager M that JCPRP considered there was insufficient information to justify making a care application.

269. The risk instrument used was noted to have recorded:

"*The family scored risk level based on the highest score on either the neglect or abuse instrument: Very High__adults and children who were all interacting with Jacob. [Redacted] said that Jacob's injuries are acute and could have occurred anytime within the past week which included his time in the special care nursery at Blacktown Hospital…….[JCPRP DCJ] do hold concerns in relation to the parents attachment with Jacob as he spent the first two months of his life in the special care nursery and during this time his parents visited sporadically and the hospital had concerns regarding the irregular attendance. At the time of writing this assessment there was insufficient information to say with certainty that the parents do not provide sufficient emotional support and affection towards Jacob, however the family have been referred to Tresillian as research has indicated that bonding and attachment can often be interrupted with premature babies, particularly in light of the pregnancy with Jacob being unplanned and the mother having significant health conditions."…….[The Father] has reported having a history of ice use two years ago however went on the MERIT program and no longer uses. [The Father] said that he had to stop using due to his heart condition and he 'flat lined' on two occasions. [The Father] has denied any current drug or alcohol use."*

270. The July 2018 Risk Assessment Decision made no mention of Jacob's presentation with new bruises on 24 July 2018, the suspicious markings seen on his mother's hands and the concerns raised by the CPU team about both matters.

271. On 31 July 2018 Manager A met with the MCS (Parramatta CSC). The JCPRP MCS did not attend the meeting as he was unavailable. It was decided at the meeting there would be no further extensions of Zest. During the meeting the option of referring the family to the Telopea Family Support Service was canvassed by the MCS (Parramatta CSC). This is an intensive family preservation service. In discussion it is understood this service would not provide daily home visits nor an assessment of the type provided by Tresillian. The possibility of Jacob being assumed into care and care proceedings being commenced, owing to the cessation of the Zest engagement, was not discussed in the meeting.

272. The JCPRP MCS had caseworker recruitment interviews already scheduled on 31 July 2018 when the meeting date was set and was unable to attend for that reason.

273. Another failure by Jacob's parents occurred in early August 2018 when Jacob was not presented by his parents for a scheduled CPU review. His mother reported she could not attend owing to issues with their car. A new appointment was scheduled for 14 August 2018. The CPU team notified Manager A of the missed review that same day.

274. Zest involvement ceased on 3 August 2018. By this date the JCPRP DCJ team had received documentary information about Jacob's mother's admissions to Westmead Hospital. The information provided noted observations made of his mother after her return to the hospital on 25 April 2018, but did not mention the outcome of the urine screening on 27 April 2018. Information was also received about the limited parent visitation of Jacob before his release on 10 July 2018. This was therefore information again raising concerns about attachment issues, which corroborated Dr Marks' concerns.

275. On 6 August 2018 Manager A emailed the MCS (Parramatta CSC) and Manager M asking for Jacob's matter to be presented at the Parramatta CSC's Weekly Allocation Meeting being held on 7 August 2018. Manager A stated: "*Now that Zest are finished and a referral to another service is underway [JCPRP] have completed our assessment. A number of concerns still remain and as such I highly recommend consideration for allocation."* Manager M responded that this was unnecessary as Jacob's matter had been assigned to a caseworker (CS).

276. This part of the evidence deserves some close attention. Jacob was about to be moved to the step-down service. JCPRP were still raising concerns, suggesting a referral to another service was underway, but not complete.

277. By 7 August 2018 Jacob's case was in the process of being transferred from JCPRP DCJ to Parramatta CSC. JCPRP DCJ held its third and final Group Supervision meeting for Jacob. The JCPRP MCS and several other MCWs participated to discuss the complexities and casework decisions made to date. Neither the Parramatta CSC

casework team nor the CPU team were invited to participate. Zest were gone, no longer providing supervision to Jacob as at 3 August 2018.

278. Extraordinarily, on that same day Manager M emailed CS (Parramatta CSC), with the heading "BF Referral [Jacob]", stating "*Can you complete a [Brighter Futures] referral for [Jacob], the outcome of the assessment would have been moderate but was bumped up to very high because of the non-accidental injury - - - BF have capacity this week*". On 7 August 2018, before Jacob was even transferred to CSC, plans were being made to refer him out.

279. Wesley Mission, a non-government organisation, provided the family preservation service known as Brighter Futures. Brighter Futures caseworkers engage families to enhance the quality of parenting in the home. The program does not involve daily home visits, nor an assessment of the kind provided by the Tresillian Service.

280. Manager A emailed Manager M and CS on 7-8 August 2018 confirming the transfer of Jacob's case to Parramatta CSC and stated: "*We would like to book a handover*".

281. Manager M queried why a handover was needed. Manager A replied: "*We don't have to do a handover if you don't want to [Manager M], that's okay, I can send the case over if that's easier*." In subsequent emails between Manager M and CS, Manager M requested the latter to speak with the assigned JCPRP DCJ caseworker (DA). Ultimately, a handover did not take place between DCJ caseworkers CS and DA. Again an opportunity, this time a critical one, missed.

282. Jacob's parents presented Jacob to a scheduled outpatient paediatric review with Dr David Hartshorn on 8 August 2018. Dr Hartshorn did not observe signs of bruising but sighted minor scratches to Jacob's face which he considered to have resulted from unintentional scratching by Jacob. He was satisfied that Jacob's parents presented as appropriately concerned and Jacob appeared to be making good progress. The outcome of this review was reported to the JCPRP and the CPU team.

283. By 9 August 2018 the DCJ casework transfer had been completed.

284. Parramatta CSC now formally held casework responsibility for both Jacob and Jacob's brother. Little was known about Jacob's brother still at this time.

285. On 14 August 2018, his parents did not present Jacob for the scheduled CPU review. The explanation for this was that it was forgotten. The CPU team contacted the JCPRP and learned, for the first time, that Jacob's casework has been transferred to the Parramatta CSC. This information had not been shared with the CPU.

286. DCJ caseworker CS spoke with Ms Knight from the CPU the next day and noted being told about:

a. the missed appointment;

b. the CPU's concerns about the markings seen on Jacob's mother's hands on 24 July 2018 of which the CPU "*thought there may be drug* use" and referenced his father's history of "*ice use*"; and

c. that DCJ had "*to confirm the Father's drug history in DCJ's records*". Ultimately no checks were made of DCJ's records or through other sources to investigate his father's drug history.

287. On 16 August 2018 CS carried out the first of two home visits performed while Jacob's matter was assigned to Parramatta CSC. This was the only visit in which CS met Jacob. Caseworker CS advised Jacob's parents that DCJ was referring them to Brighter Futures. Between this home visit and 21 September 2018, CS's contact with Jacob's parents was by phone only.

288. By this date Parramatta CSC had determined not to progress the Tresillian Service referral any further and not to submit a referral to the Telopea Family Support Service. The only referral proceeded with was that subsequently made to Brighter Futures. Parramatta CSC did not consult the JCPRP, or the CPU, about not proceeding with the Tresillian referral.

289. On 17 August 2018 Manager M emailed a referral to Brighter Futures to carry out ongoing casework with the family (independently of DCJ).

290. On 21 August 2018 emails were exchanged about the Brighter Futures referral to the effect:

a. Brighter Futures advised Manager M it could not accept the referral as DCJ had assessed Jacob to be "*safe with a plan*", a likely in reference to the 18 July 2018 Safety Assessment Decision Report.

b. Manager M replied, "*We would still like to refer this family and can review the safety assessment. The dangers which existed are no longer present. Please do not disregard this referral and I will get the caseworker to review the safety assessment*. Manager M then directed CS to review the safety assessment, stating that Brighter Futures would not accept the referral "*because it's safe with plan*".

c. Caseworker CS reviewed the safety assessment, resulting in a Safety Assessment Decision Report being generated (21 August 2018 Safety Assessment Decision Report). That report was forwarded to Manager M, who in turn forwarded it to Brighter Futures stating, "*There are two safety assessments attached the most recent reflects safe*".

291. Although the 21 August 2018 Safety Assessment Decision Report did not specify a conclusion of "safe" or "safe with plan", the Parramatta CSC casework team intended it to convey to Brighter Futures that Jacob was 'safe' in his parents' care without a plan. The referral was subsequently accepted by the Brighter Futures program. The above actions were done by Parramatta CSC with a view to Parramatta CSC ceasing casework that is, closing Jacob and Jacob's brother's cases, once Brighter Futures was engaged. This was less than 2 weeks after casework responsibility for Jacob was formally transferred to Parramatta CSC and after just one home visit by the CSC's assigned caseworker.

292. Another missed appointment was indicated on 31 August 2018 as Jacob's mother again advised she could not attend a scheduled CPU review for that day. In response Dr Pathmanandavel, Ms Knight and Ms Carman travelled to Jacob's home, with his mother's consent, to examine Jacob. This was owing to their concerns for Jacob. Home visits were not usual CPU practice. Nothing remarkable was seen during an

unclothed examination of Jacob. This is the last medical review of Jacob before his death.

293. On 5 September 2018 Jacob was not taken to a scheduled CHW rehabilitation outpatient review.

294. On 7 September 2018 CS spoke with Brighter Futures caseworker Ms Gray about the referral to Brighter Futures. Caseworker CS noted telling Brighter Futures that Jacob's injuries could not be explained, nor could whether they occurred in his parents' care or in hospital be "*pinned down*", no further injuries had been noted and there were no ongoing safety concerns.

295. During discussions Ms Gray queried if DCJ had obtained information about Jacob's father from police. Caseworker CS advised that checks would be made about this but ultimately no checks were made.

296. On 19 September 2018 the JCPRP police investigators formally determined that no further action was to be taken in the JCPRP police investigation into the injuries Jacob presented with on 12 July 2018. This followed DSC Duane's unsuccessful attempts at phone contact with the maternal grandmother on 5 and 17 September 2018.

297. Caseworker CS conducted the second and last home visit on 21 September 2018 and Ms Gray also attended. The visit was arranged in advance to introduce Ms Gray to Jacob's parents. Neither Jacob, Jacob's brother nor his father were present at the visit. Jacob wasn't seen.

298. On 25 September 2018 DCJ formally closed its cases for Jacob and Jacob's brother. His mother notified Ms Gray that a home visit scheduled for that day could not go ahead.

299. On 26 September 2018 Jacob missed a scheduled CHW brain injury outpatient review. The CPU team notified the Parramatta CSC about this missed appointment. The CPU team learned that DCJ had now closed its case for Jacob.

300. On 28 September 2018 Jacob's mother notified Ms Gray a scheduled home visit that day could not go ahead as she had to take Jacob's brother to swimming lessons. None

of the investigations were able to corroborate that Jacob's brother went to swimming lessons. Caseworker CS sent a text message to his mother about the missed review on 26 September 2018 and emphasised the importance of keeping these appointments.

301. On 5 October 2018 Jacob's mother again notified Ms Gray that a scheduled home visit that day could not go ahead, as they had had a sleepless night and Jacob was sick.

302. Finally on 9 October 2018, Ms Gray from Brighter Futures attended the home. Only Jacob and his mother were present. Ms Gray saw Jacob, but didn't hold him. Jacob's body and limbs were not visible as he was wearing a one piece suit. He was distressed and upset and unsettled on this day. That was to be the last interaction services had with Jacob. There is no doubt that on that day he was suffering many of the injuries that were later found to have been inflicted. There is little doubt that he would have been in pain at the time, and was suffering as a consequence of multiple bruises, fractures and other injuries while his mother held him and explained that he had a cold and had suffered a restless night.

*Issues in the casework response*

*Parents' background and presentation*

303. Neither parent presented with a known history of causing harm to a child. Jacob's parents seemed to engage at a minimal enough level to satisfy the caseworkers. Neither parent presented to caseworkers or other professionals as being possibly affected by drugs, other than when Jacob's mother returned to Westmead Hospital on 25 April 2018 and when observations were made of suspicious markings on her hands. Although it should be noted that drug use should have been of concern given there was no investigation of Jacob's father's claim that he was now no longer using illicit substances.

304. DCJ was never informed of his mother's 27 April 2018 positive urine screening result. It seems from the evidence that his parents were superficially persuasive and presented to many caseworkers as genuine in their concern for Jacob and in their willingness to engage. On all accounts the house was neat and tidy, and his parents interacted pleasantly with staff. His parents' significant health issues may have

contributed to caseworkers discounting the possibility of drug use and giving the parents the benefit of the doubt over missed visits or appointments.

305. It should also be acknowledged that none of the family members other than Mr AM, including importantly Jacob's maternal aunt, had any concept that there was this level of drug use going on by Jacob's parents. It was not something his aunt had even contemplated could have been a factor in their lives. The fact that knowledge of the use of drugs failed to reach close family members spoke to the ability of both parents to disguise the ice use, and further supports why those interacting with them did not form such a view.

## Discussion of various witnesses' evidence before the Inquest

*Dr Susan Marks - CPU*

306. Dr Marks is the senior staff specialist at the CHW working in child protection and the Emergency Department. She has worked in that role for 30 years. Dr Marks viewed the photograph of the laceration to Jacob's gum. She noted that usually when there is a frenulum injury, which involves the small piece of tissue underneath the upper lip that connects the lip to the gum in the midline, such an injury is described as a cut to that piece of tissue. She explained, as outlined previously the horrific size and extend of this injury.

307. Dr Marks was also able to comment on a number of the other injuries that Jacob suffered. She discussed the fractures that were in various stages of healing. Dr Marks discounted any suggestions of osteopenia or other bone fragility disorder. She said that given his early birth he did have some signs at birth that hadn't completely resolved, but even then it wasn't detected at a level that would have been expected to cause fractures. By the time he died, she noted that the osteopenia had essentially resolved, and was no longer visible in x-rays. She noted you would not see the distribution of Jacob's fractures in his hands and feet, even in a baby with bone fragility, as part of normal handling.

308. She said this:

> *"Yes and I was talking about the hand, so he had injuries to his left third middle finger, his left ring finger. So-sorry to the metacarpals. He had a fracture in*

*his toe. He had a fracture, he had two fractures in his feet. They are not fractures that you would get, even if you had one fragility, as part of normal handing."*

309. She commented specifically on the fracture to his right femur, a "classic" metaphyseal lesion or fracture, which is a fracture in the growing part of the bone. They do not normally appear in children as part of their normal activity and play. She indicated that they are usually due to a shearing injury to the bone and therefore have high correlation with inflicted injury. It could occur with someone pulling on the child.

310. Dr Marks was asked about the bruising to Jacob's left ear, the pinna, or earlobe. She noted that the bruising was extensive. She discounted any dressing scenario such as pulling a shirt over the baby, she indicated this type of injury would be a forceful pinching or twisting the ear. She would expect application of force to have been applied the head.

311. Dr Marks' assessment of Jacob's results was that he did not suffer from any bleeding disorder.

312. Dr Marks treated Jacob when he had the subarachnoid haemorrhage detected through CT scan on 13 July 2018. She indicated that it was a 3-millimetre bleed around the frontal lobe. She noted that the bleed was quite large for a very small baby.

313. She also indicated in relation to blood loss and the gum area that she would expect a reasonable amount of blood if he had been alive at the time of that injury, but if the injury occurred around the time of his death there would not necessarily have been a lot of bleeding.

314. Dr Marks was of the view that Jacob's dummy would not have easily settled him in front of the Brighter Futures' staff if he had that type of injury present on 9 October 2018. Her view was that it would not have been comfortable for him. She was of the view that sucking on a dummy with that injury would be painful. This evidence supported that it was unlikely that Jacob would have had this significant injury at the

time that Brighter Futures attended. There were differing views of what a baby would do with an injury of this nature. Dr Cameron said he had seen very different reactions from children, and in his view, Jacob could have possibly taken a bottle. However, given the nature of the size of this injury, the size of Jacob, the fact that Dr Marks had the advantage of treating Jacob, I would prefer her evidence that certainly at the time of infliction he would be unlikely to be able to tolerate a dummy or food.

315. Dr Marks gave evidence about the first injury and indicated that she cannot date bruises. She indicated that during her conversations with JCPRP she did not believe anyone really believed that the injury could have been inflicted by the staff at Blacktown Hospital. She had become very concerned about Jacob's mother's attachment to Jacob. The CPU team were less concerned about his father, who appeared to be handling Jacob and providing care in an appropriate manner. His mother had stated that she was intentionally not holding him and said that she didn't want him to become "too needy". The CPU team observed his mother prop feeding Jacob. She was not holding him, and she needed to be helped to attend to him to settle or sooth him. His father fell asleep at his bedside, and had to be woken to attend to Jacob, and so there were concerns about the care that might be given to Jacob.

316. Dr Marks was approaching this from the perspective that Jacob, as a premature baby, would have been too unwell to be held in the first five critical days after his birth.

317. In the second presentation to the CHW, Dr Marks was of the view after seeing the new bruising that someone had been hurting Jacob and someone was continuing to do so. She spoke with his mother, who attributed the bruises to the zipper. But the zipper didn't go down to the foot. There was some criticism made of Dr Marks about not being more firm about Jacob's mother, her mental health issues and her hands. However, Dr Marks correctly remarked in evidence that it was Jacob that was her patient, his mother was not. She nonetheless was concerned about her physical health and her mental health. For that reason, she had two conversations with JCPRP, one about the new bruises and the second call to discuss his mother. She had noted that his mother had multiple scab lesions to both her hands, and bruises. Jacob's mother said that was from a canula, which was not accepted by Dr Marks. She was

also seen to be wearing gloves in the hospital which was another unusual factor given the markings on her hands that were now visible.

318. Dr Marks gave evidence that she called and told the JCPRP DCJ team that she was really worried about Jacob, and that the Safety Plan was not working. Because the call through the usual line can take an hour, she called Parramatta JCPRP directly. She said it can take an hour to get on to the Helpline to make the report and another hour for the information to pass to the JCPRP team. She wanted an immediate discussion.

319. Caseworker DA in her evidence supported that Dr Marks expressed serious concerns about the decision to leave Jacob in his parents' care and asked to speak with Manager A. She also indicated that Dr Marks seemed somewhat abrupt, possibly angry. Dr Marks didn't recall this, but did say she was very concerned, and accepted that may have been the tone of her discussion.

320. Dr Marks also reminded us in her evidence that on the first presentation Jacob had a number of bruises, the bleed in his head and the injury to his eye. The fact he had these two new bruises suggested to her that someone who was continuing to provide care for Jacob was continuing to harm him. "*So in other words he wasn't safe. Even though there was a Safety Plan*", was her evidence.

*Ms Caroline Knight – Social Worker - CPU*

321. Ms Knight was the social worker from Westmead Hospital who worked with the CPU and the family. She was part of the important team who cared for Jacob. She contacted Blacktown Hospital and spoke to Remi Matias, a social worker. She was advised that Blacktown Hospital was concerned at the limited visitation, little face to face contact and short visits when they happened to Jacob while he was with them. Ms Matias also said that she was told by Jacob's mother that she had difficulty with "kangaroo hugs", or skin to skin contact considered important for bonding and attachment.

322. Jacob's mother also disclosed that she hadn't noticed the bruising on his legs before hospital. Ms Knight was told by her that Jacob didn't like to be held. He liked to be left alone. On 17 July 2018, Ms Knight made a note that Jacob's mother had not been

seen on the ward. His father was there one night at 6:00pm and then left before 10:00pm. Her concern was that usually someone would be with a baby during the day and someone would stay overnight, and this was not happening.

323. Ms Knight confirmed that when the second injuries, being the bruises, were found on Jacob, herself, Ms Carman and Dr Pathmanandavel didn't want his mother to leave the hospital until they had spoken with JCPRP. This was consistent with the evidence of Dr Marks. They also spoke to Dr Marks. Ms Knight was aware that Dr Marks wanted JCPRP to come to the CHW. She gave very clear evidence of attempts made, trying to prolong Jacob's mother's stay in the CPU to allow DCJ to attend. She recalled the conversation clearly. She recalled listening to Dr Marks express that she was really concerned about the bruising, particularly on an immobile baby who can't yet walk or roll, sustaining further bruising injury.

324. Ms Knight recalled Jacob's mother's hands and the marks on them. She was told by Jacob's mother that they were from a canula that she had in relation to her medical condition.

325. Following Jacob's discharge, CPU arranged for follow up appointments in order to continue to check on Jacob. There were two appointments that were not attended. CPU practitioners called JCPRP and sent emails in relation to those missed appointments.

326. On 1 August Ms Knight made a note of a phone call to Manager A:

> "*Phone call of PC to [Manager A], advised Jacob did not attend appointment. [Manager A] stated a lot of eyes on Jacob. [Caseworker DA] cited him today. Zest 6 hours in the morning and 7 hours in the evening. Very comfortable with the amount of eyes on him [Manager A] stated. No idea given re-bruising on foot. Grandma visits frequently. Child staying at grandmother's some nights. Appointment with paediatrician is 8.8.18. Given amount of eyes on Jacob at present, didn't feel need to make appointment earlier*."

327. Ms Knight herself had never undertaken a home visit for a child with physical injury prior to Jacob.

*DA – Caseworker - JCPRP*

328. Caseworker DA worked in the JCPRP DCJ team. JCPRP receive specific reports that meet a certain threshold for physical abuse, sexual abuse or severe neglect. This team work alongside Police and NSW Health. She had a caseload of 8-12 cases at any one time. She was involved in the casework of Jacob under the supervision of Manager A. She was doing as she was asked in relation to the management of Jacob, and for the largest part was guided by other more senior and experienced staff.

329. This was her first time working with physical abuse and she was new to DCJ. She had a conversation with Ms Hackett who expressed strong views during the Group Supervision meetings that Jacob should be removed from his parents. Caseworker DA says because she was new, she felt a little out of her depth. She did speak with his maternal grandmother, but no other family members. It was clear from her evidence that she would anticipate now, with more experience, that a wider family group would preferably be contacted. She confirmed that in relation to the grandmother staying overnight she was asked to do that on just one occasion, but it wasn't anticipated to be more.

330. Caseworker DA recalled that Dr Marks had contacted JCPRP about her concerns being that Jacob's mother was propping the bottle up, that his mother did not seem comfortable handling him, that there were attachment issues, that there were further worries because she had experienced a traumatic pregnancy and that she considered a mental health assessment was needed for his mother. She also recommended a referral to Tresillian.

331. Dr Marks also expressed concerns about the markings on Jacob's mother's hands and noted the CPU team were concerned of drug use as a possibility. Dr Marks expressed her serious concerns about the decision to leave Jacob in his parents' care. When DA told Dr Marks that they were going to be safety planning Jacob at home, she recalled Dr Marks being quite shocked and that she asked to speak to Manager A straight away. She recalled that Dr Marks was not apparently happy with that decision.

332. Caseworker DA noted that when Dr Marks called the second time, she recalled from her tone and manner that she seemed angry about the decision to discharge Jacob.

She recalled that Jacob was at the CHW at the time. Her recollection was that Dr Marks wanted something more done, and Jacob brought into care. Caseworker DA then spoke to Ms Hackett, and Ms Hackett was again a strong advocate for removing Jacob. Caseworker DA formed the view that Dr Marks thought this was another inflicted injury. She didn't recall Manager A asking Dr Marks to make a Helpline report. Dr Marks' evidence was that she could spend up to an hour on that Helpline.

333. This was further extraordinary evidence, the suggestion that Dr Marks was being asked to make a further report, through the general DCJ Helpline, when she was speaking with his team.

334. Caseworker DA then went on that day of discharge with CS to the family home, however, at first the gate was locked and they could not enter. She then returned at about 4:00pm with another caseworker. She had limited recollection of the second visit, but agreed that she saw the new injuries. The new Safety Plan that was signed suggested the grandmother or another relative was to reside in the home that night. The grandmother wasn't residing there at that time and it is not known if she did in fact stay even that one night. Zest was to continue to attend for that week. Jacob's mother was also to attend the GP to have her hands reviewed.

335. Caseworker DA was asked whether there is room for changes or improvements, and she said this:

> *"I think a lot of things have changed now, compared to then. I think, we do Care Pathways now, that's mandatory process where, before you remove any child you come together with particular people where you talk about everything. It's a really in-depth conversation, people can have dissenting views, and it's to – I guess really figure if this child needs to come into care , and I don't believe that was a process that was done then, and it's a really good process now, because it gives everyone the opportunity to share their views. You can have an independent person in there, so you've got people who aren't biased aren't you know, don't know the family and that's a really good process, and I wish that existed then."*

336. This demonstrated a real improvement in the sharing of views, sharing of information and ability to vocalise various views with input from independent people where necessary.

*MCS - JCPRP*

337. The JCPRP MCS was at the highest level of decision making other than a director in relation to Jacob and his placement or care. He was the ultimate decision maker for Jacob while he was in the care of JCPRP, and the JCPRP MCS was the manager of Manager A. He conceded that Jacob's parents' recent drug history ought to have had more focus, also the fact that his father had a previous history of domestic violence. He now considered that would have allowed them to have explored the use of urinalysis and hair follicle testing to get a baseline.

338. The JCPRP MCS was initially reluctant in evidence to place Jacob's case in the complex case category. He said that Jacob was different to their normal physical abuse cases. Physical abuse cases at that time made up about 5% of the workload, and when babies came into the program it was usually the result of horrendous abuse, with retinal haemorrhaging, subdural haematoma, Jacob didn't present necessarily with the highest level of inflicted injuries that would normally be observed at that stage.

339. He continued to maintain that it wasn't a complex case compared to what the team usually dealt with, although also agreed however it was an unusual case. He appeared to have placed a lot of weight at the time of the decision making on the fact that, in his view, there were a lot of people involved with the care of Jacob, having access to Jacob and handling Jacob. Thus, there was potentially, it can be inferred, in his mind, the possibility that others had inflicted the harm. It was difficult to understand how he had formed this view on the evidence known at the time or now. The JCPRP MCS focused in his evidence on an inability of the CPU to date the bruises, and the same issue with the subarachnoid haemorrhage; the bleed in the skull couldn't be aged.

340. Yet in his initial statement, he noted that this was an uncommon situation. It wasn't usual for him to be consulted about the management of specific cases, other than in a particularly complex or traumatic case. He then conceded that Jacob presented as a slightly more complex case than others. He agreed that in relation to Zest, Manager A

did not have the delegation to approve that expenditure. The JCPRP MCS acknowledged that he also was also unable to approve the funding, he could approve the concept, and the team must then approach CSC for the funds.

341. He gave evidence in relation to the Premier's memorandum, as part of the State Plan from 2015, in which was the concept to remove children as the last resort. He mentioned a target, to reduce removal rates of children from family.

342. He said that Zest had been used by CSC in the past to provide the type of supervision and support proposed for Jacob. The JCPRP MCS also was sometimes hesitant in his evidence, he wasn't agreeable with the notion that he may have been asked to attempt to request the money for Zest because he was the MCS and therefore had a greater prospect of securing the funding. He did agree that a second presentation with new injuries was rare. He did agree that he was perhaps better placed to successfully obtain approval for the additional money given his higher role.

343. The JCPRP MCS couldn't recall saying words attributed to him by Manager A that is, he wouldn't remove a baby because of a bruise on the foot, but he believed it sounded feasible that he could have said that.

344. The JCPRP MCS was of the view that because of the way DCJ were doing things then, they probably missed a lot of opportunities. The JCPRP MCS continued to say that what the team had at that time was in essence was a bruise on a foot without any explanation, it could have been accidental, or alternatively, it could have been inflicted.

345. It was explored with the JCPRP MCS that although he determined ultimately not to commence proceedings to remove Jacob, the plan involved Zest being in the home, and increased hours of Zest. This evidence was difficult to follow, because he acknowledged the approval for Zest had to come from others, and yet that was part of his plan for safety. He did not step into the meeting that Manager A was asking him to attend and, on the MCS (Parramatta CSC)'s evidence, the MCS (Parramatta CSC) took this as a sign that the JCPRP MCS didn't hold heightened concerns for Jacob's matter and was happy for Manager A to manage the situation, and that affected the MCS

(Parramatta CSC)'s assessment of whether he needed to be involved beyond approval of the financials. The JCPRP MCS did not see the basis for the MCS (Parramatta CSC)'s conclusion. It should be noted that the JCPRP MCS, at the time of the meeting, was in a prearranged meeting for staff recruitment for caseworkers, to try and get more staff on the ground. It was explored in evidence that the meeting for Jacob could have been rescheduled to allow him to be present, but this wasn't something that was done.

346. The decision that needed to be made at that time was to start proceedings to remove Jacob or not to remove him. Once that decision was made not to remove Jacob, the process appears to have fallen apart. Zest ceased by 3 August 2018. There was no requirement for a family member to stay in the house and supervise Jacob's parents with Jacob. There was no other service attending the home from 3 August 2018. The JCPRP MCS said he was not aware of this. Group Supervision occurred on 7 August 2018, and the JCPRP MCS could not recall any discussion on Zest no longer being in place. Between 27 July and 7 August 2018 he did not have further involvement with Jacob.

347. He was asked as follows:

*"Q …And do you accept that in the event that if had you known Zest would not be funded beyond 3 August, as you've said earlier, that would have required a review of the Safety Plan*

*A Correct.*

*Q and if there were no other services that are ready to step into place, that would likely have meant removal of Jacob?*

*A Correct."*

348. The JCPRP MCS indicated that 5% of cases were physical harm in mostly infants, under 12 months, but when asked about Jacob at the corrected age of one week at the time of first injury, he agreed that is a smaller category. The second infliction of injury also put Jacob in a much smaller category.

349. The JCPRP MCS was in a very difficult role, he was stepping into a matter where he was not the case manager, but was being asked to ultimately make a decision whether to

proceed with removal. These are significant steps to take in any case, and an example of the very hard decisions that are required to be made.

350. This was difficult evidence for the JCPRP MCS to give, and there is no doubt that Jacob's case has affected him greatly. It should be noted that the JCPRP MCS was trying to make the best decision he could at the time. However, what is clear from this evidence is that the nature of the first injury, as being a very significant example of injury on a premature baby presenting with a bleed in his brain was not fully comprehended at the time. The second injury was another serious example of unexplained injury by mere virtue of it being the second injury, and an extremely suspicious injury at that. This appeared to have been a lost or misunderstood fact at the time of the making of the decision.

351. Further, it is important that senior decision makers understand the importance of reaching out to the treating teams, particularly if there is CPU involvement. They provide expertise upon which to make an informed decision. There was a great deal of misinformation being disseminated at the various meetings about the medical status of Jacob. This could all have been clarified by the medical team, making for much sounder decision making.

*Zest*

352. Zest staff also gave evidence. Ms King gave evidence of her three shifts with the family. She wasn't fully aware of the injuries Jacob had previously and wasn't fully briefed about them. She undertook some visual inspections of Jacob on 2 August 2018, and she observed a scratch on Jacob's nose. The relevance of this evidence was that she was not across the full reasons for her to be there.

353. Ms Queenie Rapuza was also a Zest worker and worked with Jacob on about 6 occasions, the last being 3 August 2018. She was instructed to check the body of Jacob, but she was not aware of the reason why. She checked Jacob when he was found to have the bruises on his foot, however, she didn't record it. In evidence she said perhaps she didn't really check everything. She remained certain that she didn't see anything. No one from DCJ nor Zest told her how to undertake the examination of Jacob. She was not asked to observe Jacob's mother's hands.

354. Ms Miriam Carfi was a manager at Zest. She agreed that there was no specific training given to staff, they were just told to check Jacob. She was told that Jacob had recent injuries including bruising to the face, but was not told that he presented with a subarachnoid haemorrhage. She was told to monitor the interactions between Jacob and his parents. For the initial period of 20 to 23 July 2018, the first three days of Zest involvement, there were no summaries provided by workers as to any examination for injuries. On 24 July 2018, Jacob presented to the CHW with the bruises. Ms Carfi was not told about that further injury. She gave evidence of a number of cancelations by Jacob's mother on that basis that they were out. On one occasion Jacob's mother said that she went to the doctor's so herself and her partner could get a mental health assessment done. On these occasions the worker was cancelled. It is the case that amongst the workers, when notes are recorded they are inconsistent. An example of this was where a scratch on Jacob's nose was seen in the morning, but was not seen by the afternoon worker.

*Director of Operations - JCPRP*

355. The JCPRP Director of Operations gave evidence. She was not specifically consulted about Jacob but she was made aware of him at the time by Manager A. She noted in evidence that a baby who was under a Safety Plan who had further injuries needed a reassessment of the situation. The first Safety Plan should have been reviewed, and the second opportunity was when the baby had new injuries. Zest were only engaged for 2 weeks. The arrangement was for a Zest worker on a casual basis to attend the home for 2-4 hours at a given time. One person in the morning and one person in the afternoon-evening and that occurred for about 2 weeks up until 3 August 2018. The JCPRP Director of Operations was disappointed in the circumstances that Jacob was not escalated to her level of authority.

*Casework specialist - JCPRP*

356. A JCPRP Casework Specialist also gave evidence. She participated in the two Group Supervisions for Jacob. This practice was new at that time. She gave evidence that there were possible health conditions that might be a contributing factor to Jacob's bruising. She thought it was a blood or health condition he might have, and there was a lot of questions and information they needed to gather from NSW Health. She also noted that there was a discussion during that meeting that "*medical staff potentially*

*overly concerned*", that was a notation that was spoken about, but she could not recall in what context. Manager A said it was someone playing the Devil's advocate. However, that explanation sounds somewhat unusual given the nature of what was being discussed. She confirmed that the staff from Parramatta CSC were not invited or in attendance.

*JCPRP Caseworker 1*

357. JCPRP Caseworker 1 was supervised by Manager A and the JCPRP MCS above him. He was asked to interview Jacob's parents and to develop a Safety Plan. He was told prior to the meeting that Jacob's father had no police record. He did go on to ask some questions and was not very aware of MERIT and what that meant, although inconsistencies presented, he did not seem alive to those. However, he was stepping in for Jacob's case manager and so in part would have thought that the follow up would be completed by her. He would make observations of challenges Jacob's parents might have, and raise concerns such as drug and alcohol use, or domestic violence if they became apparent.

*CS – Caseworker – CSC Parramatta*

358. Caseworker CS worked with DCJ as a case worker in April 2017 to April 2019 and was the case manager for Jacob, however had been firstly assigned Jacob's brother. Caseworker CS was informed about the injuries initially found on Jacob and that Zest would be engaged in the home, and noted that this was a very unique situation as it was not known to CS before. Jacob's brother was a notional assignment, in that Jacob was the main concern. There was no invitation for CS to be invited to be part of the Group Supervision meetings.

359. Jacob's care was transferred on 9 August 2018, but here was no awareness that Dr Marks had expressed concerns over his mother's attachment and mental health nor that she recommended a referral to Tresillian.

360. Caseworker CS did speak to Jacob's mother about the marks on her hands, and was told that they were as a result of the "*drips and things*" that were needed as a result of her health concerns. Caseworker CS was unaware that the CPU had not accepted those explanations.

361. Caseworker CS was invited to go with DA to see Jacob and his mother after the second notification of injury. Caseworker CS understood that they were attending as the caseworker for Jacob's brother. Caseworker CS was also present at the meeting Manager A had with Jacob's parents, and recalled him saying that this [was] at the highest level of risk that he was comfortable with, therefore understanding this was serious. But it was clear from the evidence that CS was in a state of confusion as was a relatively new staff member. On the one hand the information was that Jacob was high risk, CS wasn't exactly sure of the role of JCPRP and was also being told that the case would be transferred to her.

362. Caseworker CS also noted that there was a feeling of pressure to get cases closed where they could, to free up capacity for other cases. It was not that the caseworkers wanted to be doing those things, but there was discussion at a general level for the need to do that, get cases out to places like Brighter Futures where possible.

363. In relation to Jacob, there was advice that there had been a referral to Telopea, which had been made by the JCPRP team. Caseworker CS assumed they were trying to get agreement from the family to agree to do this, to then do the referral. Some of the evidence which raised concern over practices was Manager A's continued attempts at trying to make time for a handover. Manager M asked her in an email "*[CS], are you free tomorrow morning? I don't know why they want to do a handover.?*" Caseworker CS did not recall receiving that email. If anything, CS recalled wanting a handover, but this wasn't happening. Caseworker CS understood that JCPRP were being regularly updated with important information such as the Brighter Futures referral, and remained of the understanding that there was much more continuing communication with JCPRP than there was.

364. Caseworker CS was able to see Jacob at a home visit on 16 August 2018, outside the interview situation. Caseworker CS was able to explain that Jacob's mother had declined the live in support, in that her partner was off work and she didn't want to go into an inpatient kind of stay, there was a wider family network that was of importance to them as well.

365. Caseworker CS agreed that Jacob's case was unusual, in essence there is no safety assessment undertaken and Jacob was being referred to Brighter Futures before he had arrived in their care as a case. Caseworker CS indicated that this was a unique circumstance where there hadn't been responsibility for the case from the start. The standard practices were not being followed because this was not the usual practice, and although not responsible, was following direction in this particular case. Caseworker CS agreed with Counsel Assisting where he suggested that to do so was to put the cart before the horse.

366. The evidence that related to the risk assessment and safety plan for Jacob between CS and Manager M was confusing, difficult to follow and at the end of questioning it remained unclear why a further risk assessment wasn't completed, and why a thorough Safety Plan was not completed prior to Jacob being referred to Brighter Futures and the CSC ceasing involvement. Information provided in a Safety Assessment Decision Report that was completed included such things as: "*the initial injuries were unexplained, however, Dr Marks said the bruising to Jacob's eye and body are impact injuries but could not specify the amount of force*" and a further notation "*There was another small mark on Jacob's foot observed, however was not deemed significan*t." Caseworker CS was relying upon the fact that another ROSH report was not completed, therefore it was not to be considered a significant injury, and this was as early as 21 August 2018.

367. Caseworker CS agreed that there should have been further detail included in the report and that using the words "*not significant*" was not appropriate in the circumstances. They raised that they were feeling overwhelmed and confused, this being very new to them. Caseworker CS also indicated that they were not intending to put a positive light on matters such as why Jacob's mother was not in the hospital, but there had been a change to practice at the time and DCJ was moving away from making quick negative assumptions about families, to ensure it was not an unpleasant read for the families.

368. It appeared from this evidence that from the meeting CS had with Jacob's mother aa great deal of weight was put on Jacob's mother's explanations for various matters, despite evidence to the contrary.

369. Caseworker CS was also able to explain that the role assigned was as a short-term caseworker, initial response only. The children would stay in CS's practice only for a short period of time and then would move to another caseworker, if necessary, in the CSC.

*Manager M – MCW – Parramatta CSC*

370. Manager M was senior to CS, and was the equivalent role of Manager A, however with CSC. She was supervising Jacob's brother's case, and then Jacob's. She gave evidence that the involvement of Zest in this case wasn't unusual, however what was unusual was the fact that Zest were being asked to check Jacob from head to toe. She wasn't aware if it was part of a plan at that point, and she said that Zest could be funded for significant periods of time if necessary, in her experience.

371. She agreed that early on in her involvement she was made aware that JCPRP was considering removal of Jacob. Manager A suggested that he would like to make that decision jointly with CSC. She was aware that there were significant concerns surrounding the safety of Jacob at that time. She agreed in evidence that it was clear to her that JCPRP short of removing Jacob, was at the highest level of concern for his safety.

372. She was of the understanding that JCPRP had decided that there was not enough evidence to proceed to removal, she understood this from what she recalls Manager A told her. His evidence was to the effect that he did not state this. Her recollection was that in discussions with Manager A that they discussed Brighter Futures. It was her account that Brighter Futures had the capacity to manage care for Jacob.

373. The flavour of the evidence of Manager M was that there was not an independent assessment of risk undertaken for Jacob before a decision was made to refer him to Brighter Futures and close the file. She was relying on her peers' and colleagues' assumptions or assessments. She was reliant upon the fact that JCPRP had not removed Jacob. That course of action, or inaction in this case, caused Manager M to form the view that Brighter Futures was appropriate in this case. Manager M appeared to rely heavily on undocumented conversations with Manager A about Jacob. However, her recollection with what was said by Manager A does not sit neatly

with the evidence of what Manager A said he was doing, and documented he was doing.

374. Manager M agreed that the understanding she had represented a dramatic turnaround and change in Manager A's position.

375. The evidence of Manager A on these issues is preferred. Manager A was actively attempting to get support in the form of additional funding for Jacob. He was writing to try and get a handover. He pushed more than once to talk about Jacob. Manager M did not have any documentation to support her position that Manager A had changed his position in relation to risk, or that he was told or supported referral to Brighter Futures with a closure of case promptly following that referral. That evidence is at odds with contemporaneous documentation.

376. Manager M was not aware of Dr Marks recommendations for the family to attend Tresillian. Manager M was not aware of the issue about markings on Jacob's mothers' hands.

377. Manager M said to CS "*Brighter Futures won't take it because it's safe with plan*" and agreed that she was intending for CS to review the safety assessment. She had communicated through that communication that she wanted a referral to Brighter Futures. She agreed that through this approach she was communicating that the sticking point is the assessment has him safe with a plan. She further agreed in questioning "*Q Are you not communicating to her that "We need an assessment that says he's safe without a plan?" A Yes*"

378. Manager M agreed that she was responsible for the referral to Brighter Futures and it would have been preferable to undertake a risk assessment prior to doing so. Manager M had very limited knowledge of the case of Jacob when instructing CS to take certain steps. She was unaware that CS had made just one home visit between 9 August and 28 August 2018. She also agreed it was striking that Brighter Futures were asking questions such as about the whereabouts of police information about Jacob's father, when the CSC didn't and hadn't asked those questions. Manager M had little or

no independent assessment and understanding of Jacob's case. She made many assumptions without referring to core material.

*MCS – Parramatta CSC*

379. The MCS (Parramatta CSC) gave evidence that he was the decision maker about funding additional Zest support. He was of the understanding that Jacob had complications from his prematurity which meant he was more vulnerable to injuries, and that was his understanding after speaking with Manager A. He also understood that Jacob had vulnerabilities in relation to potentially bruising easier and brittle bones.

380. He was also of the understanding that there was a further complicating factor of a number of people being around Jacob. He was aware Jacob's aunt and uncle providing care, and Jacob's brother having some interactions with Jacob, and as such that might have been "*rough for a toddler*".

381. He gave evidence that he had not experienced a case of an infant presenting on two separate occasions with new injuries. He believed Jacob was high risk and vulnerable. However, he was concerned that Zest was not the right agency to use, and normally that was not a service that they would engage to monitor for injuries. The MCS (Parramatta CSC) raised the issue that they were worried about the level of injuries that had occurred to Jacob but there was a lack of clarity, or they were unsure about how those injuries had occurred. He agreed however that in the case of an infant there is rarely definitive evidence as to who inflicted the injury.

382. The MCS (Parramatta CSC) did not follow up with Manager M or CS about the level of concern that existed for Jacob, but agreed that in hindsight he should have. He also agreed that the CSC team should have been more diligent in the review of information, and many options should have been considered.

*Caseworker - Brighter Futures*

383. If a child needed a plan Brighter Futures would take the case, but usually with DCJ also in place, until the child was safe without a plan.

384. Ms Gray gave evidence on the part of Brighter Futures. She was a caseworker for Wesley Mission's Brighter Futures program. She explained Brighter Futures were usually engaged to provide support to families, to provide case management and help develop parenting skills, referring them to services if needed. They would see the family at least weekly. She was told by CS that DCJ didn't have any current concerns for the Jacob and Jacob's brother and that it was more that they wanted someone to provide support to the family as they exited from being under the scrutiny of DCJ. Brighter Futures were not asked to monitor Jacob for signs of injury.

385. Ms Gray recalled clearly that CS said that there were no safety concerns for Jacob.

386. Ms Gray then met with Jacob's mother and noted that she seemed relaxed and happy to talk with Ms Gray, and that this visit occurred on 21 September 2018. The next visit was on 9 October 2018, after two cancelled visits at the request of Jacob's mother. When Ms Gray attended, Jacob was initially sleeping, and then he started to cry. His mother went into the bedroom and picked him up. He was wearing a onesie, a knitted cotton-type suit, covering his feet, legs and arms. He was quite unsettled, and she held him in the crook of her arm, Ms Gray did not hold Jacob at all.

387. Ms Gray gave this evidence of the day before Jacob died:

> *"I could see his face and he was – he looked like he had – his face was screwed up so he looked like he was in pain. But she was explaining to me as she was trying to settle him that he'd had a lot of wind the day before and also a bit of congestion. And so, she mentioned heaving taken him to the doctor the day before …"*

388. And;

> *"Q: Did anything about it strike you as unusual or?*
>
> *A: No, not really. He looked like he – he was drawing his legs up as well which babies tend to do when they have wind. [His mother] got a dummy for him from - for him and that seemed to settle him a little bit but he was still quite distressed. And so, she said that she was going to try and take him to the doctor that afternoon once her sister returned with [Jacob's brother]."*

389. She explained he had the dummy but didn't seem completely comfortable with it. She thought it wasn't familiar to him, although she said she did not find that unusual being a young baby of his age and development. She went on to say that he would stop crying and then become unsettled again. She didn't notice anything out of place, and she said she was present for about 45 minutes. She thought Jacob's mother was glad to have support to get to upcoming appointment. She wanted to find play groups for Jacob's brother and some financial assistance because they had registration or some other expense coming up.

390. Ms Gray was conscious of Jacob being a premature baby and so did not want to give advice, instead she spoke to her of the need to take him to see the doctor. His mother said she would once her sister returned.

391. Brighter Futures were engaged in a very limited role, and performed that role to the best of their ability in the circumstances, in a case that required much more intervention, oversight and involvement by DCJ.

*Detective Senior Constable Tiffany Duane - JCPRP*

392. The evidence of Detective Senior Constable Tiffany Duane was in relation to the investigation undertaken by her as part of the JCPRP team. Detective SC Duane did not appear to fully grasp the significance of the first injury, nor was there a very extensive investigation undertaken. She did not think it useful to contact Blacktown Hospital, even though she considered it possible that he had suffered injury there. She did not obtain records from there. She did not speak to the extended family who attended the family function. Detective SC Duane did not provide date details of the known records on the COPS system relating to Jacob's father, even though she accepted that would have been information that JCPRP could have used.

393. There was no recollection of observations made of the mother or her hands.

394. Detective SC Duane said this:

> "*We were still – we had to determine if there – if there had been a criminal offence committee. And at that time we didn't have any evidence to say there was definitely a criminal offence that had been committed, so going*

*and speaking to the hospital staff in the hypothetical sense that none of them would ever tell – say that something had happened in the hospital. Speaking to all the family members, it would be highly unlikely that any of them would say "oh yes, sorry I dropped the baby." I couldn't see how that would further any investigation at that time. We hadn't closed the investigation. We just put it on a backburner and let DCJ take over – or take the lead from that point*."

395. Although Detective Duane admits that part of her role was to determine if there had been the commission of an offence and any charges would arise, she also agreed that she was there in the role to investigate to assist in the protection and safety of Jacob. However, it appeared that the focus was on whether or not charges were quickly apparent, and when they were not, a back seat was taken.

*Missed Opportunities*

396. There were missed opportunities by the JCPRP team, and later the Parramatta CSC, to obtain information about Jacob and his parents:

a. Jacob's father's bail report and any information about his dealings with police from the NSW Police Force. It remains unclear why the bail report was not requested by the JCPRP DCJ casework team after the 16 July2018 interview. It would have revealed his recent drug related offending and that Jacob's parents had not been truthful in their reports about the same. It may also have resulted in urinalysis being required as part of safety planning. This was a significant missed opportunity.

b. Speaking with nursing and social worker staff, and reviewing hospital records, about Jacob's parents' visitation of Jacob while he was admitted to Westmead Hospital NICU and Blacktown Hospital SCN and the possibility he might have suffered his head injuries before his release on 10 July 2018. Information from the hospitals was not obtained until the later stages of JCPRP's involvement in Jacob's case. These inquiries would have enhanced the team's understanding around attachment issues that were evidence to the staff at Blacktown Hospital, and the implausibility of the suggestion that Jacob was injured before his release from Blacktown Hospital.

c. Speaking with extended family members including Jacob's maternal aunt and his maternal grandparents about the care arrangements for Jacob's brother when Jacob's bruising was first noticed, the possibility he was injured by others at the gatherings, and what support they could offer the parents in the care of Jacob. Awareness about Jacob's brother's care was important as it informed what confidence the casework team could have about the lack of reports about Jacob's brother's care. There appeared to be no idea of Jacob's brother's circumstances, and that in essence he was being cared for by extended family on an almost full time basis.

d. Requiring Jacob's mother to undergo an expert attachment and mental health assessment as recommended by Dr Marks. The recommendations, being made by a senior clinician with considerable forensic child protection experience, were deserving of significant weight and should have been actioned without delay. Had Jacob's mother declined these assessments, that would have been a matter tending against the suitability of the Safety Plan option.

397. Reasonable attempts were not made to source available collateral information. This should have occurred. It would have permitted better scrutiny of the reports made by Jacob's parents and better informed the appreciation of risk. The importance of this increased even more when Jacob presented with additional bruising on 24 July 2018.

*Ms Pamela Brunner - DCJ*

398. In the view of Pamela Brunner, the institutional representative for DCJ, the new bruising on 24 July 2018 should have prompted an immediate review of the 18 July 2018 Safety Assessment Decision Report. Doing so would likely have led to the conclusion that Jacob he was "unsafe". In evidence, Ms Brunner explained:

> *"…I think the development of a Safety Plan became sort of a bit of an extra story to it, when we actually needed to be taking a really close look at actually what was the [18 July 2018 Safety Assessment], and if you then move forward to when we obtained the second injury information we - that really should have identified a yet further opportunity to undertake a safety assessment review, that is, we should have started from scratch, what are*

*the dangers that we're identifying, and what's the evidence that supports whether we can make a decision that Jacob is safe or unsafe*."

399. Further, concerning structured decision making generally, Ms Brunner stated:

*"…I think documentation is a key undertaking when you are transferring information or even recording information. It's a key component. It also, I think in our experience in the way we work with our caseworkers is that documentation and thinking through both the how and why you make decisions actually structures your thinking into the decisions, that it structures the information that you have, it enables people to view whether you've got gaps, and it then structures how you've made your decision about what the next elements are, so when you miss key pieces of that documentation and how you made decisions, I think it really, it then leads anybody beyond that period to be vulnerable to have missed all of that key summary."*

## Evaluation of the evidence

### *Weight given to Dr Marks' concerns about the new bruising*

400. The discovery of the new bruising on 24 July 2018 should have caused the Secretary to assume Jacob's care and to begin care proceedings. That considers:

a. Jacob's age and vulnerability.

b. This was the second occasion in less than 2 weeks that Jacob had presented with bruising/injuries he could not have reasonably caused himself.

c. Jacob was checked before his release from the CHW on 19 July 2018. There was no doubting that the new bruising was suffered after his release while he was in his parents' care. Nor could it be attributed to accidental contact during a family gathering.

d. As with his earlier injuries, his parents could not adequately account for how the bruising was caused although the Safety Plan mandated their supervision of Jacob. His parents denied knowing of the bruising, or noticing Jacob being distressed referrable to him being injured, before the CPU review.

e. The new bruising showed Zest engagement, and DCJ safety planning, had not prevented further harm to Jacob.

f. The CPU team conveyed significant concerns about the new bruising. That concern prompted Dr Marks, the CPU's Senior Staff Specialist, to immediately contact Manager A. The concerns were deserving of significant weight given Dr Marks' experience and dealings with Jacob and his parents.

g. Concerns were now being raised about his mother's hands and the possibility it indicated drug use.

h. The nature of second injury itself was very concerning in nature.

401. There is no doubt that Dr Marks was extremely concerned at Jacob's new bruising and in him remaining in his parents' care. This was corroborated by a number of witnesses. In evidence, Dr Pathmanandavel said:

*"Q. Were you present when Dr Marks spoke to the [JCPRP] team?*

*A. Yes.*

*Q. And how did Dr Marks convey the information? Did she express concern and what about?*

*A. Yes. I think Dr Marks was very concerned as well. I think the main reasons for her concern was, as I said earlier that, you know, he had previously unexplained injuries. Now there were new unexplained injuries during a period of time when some supervision arrangement has been in place. I guess our concern is that that supervision arrangement is insufficient to ensure his ongoing safety and that still isn't a good explanation for why multiple bruises have appeared on this child. He's certainly too young developmentally to be engaging in any kind of activity that might cause them to happen in the natural course of events. So I guess the response Dr Marks was advocating for was an escalation of [JCPRP]'s involvement or action in this particular matter.*

*Q. Do you recall what was communicated from [JCPRP] as to what might happen or otherwise?*

*A. I think that they suggested that they thought appropriate supervision was in place. I guess they were taking it under advisement, but it wasn't immediately clear that new or further action would be taken.*

*Q. Did you and Dr Marks discuss that afterwards?*

*A. Yeah. I guess that was surprising to us. We thought this was a very concerning pattern, but probably warranted an escalation involvement, so yeah."*

402. This evidence broadly accords with that of DA. Caseworker DA said she spoke with Dr Marks before her call with Manager A. Caseworker DA described Dr Marks sounding angry and expressing "*serious concerns*" at Jacob remaining in his parents' care.

403. The CPU team weren't merely concerned at the new bruising. They were also concerned at Jacob's mother's report that she was not aware of the bruising and her reaction to it. In evidence, Dr Pathmanandavel said:

*"Q: And just in terms of your observations of the mother, was there anything that stood out in your mind on that occasion?*

*A. I guess one thing that was concerning was that an explanation couldn't be provided and I suppose that that was concerning to us. It didn't see as concerning to her, but yep.*

*Q. When you say, "it wasn't as concerning to her", what do you mean by that?*

*A. I suppose a lot of the time when people find new injuries on children, they're concerned as to where that might come about. It would be distressing for a lot of parents and that didn't - that struck us as not being the case here.*

*Q. The reaction you saw in the mother?*

*A. Yes. But I suppose all of that is also consistent with the earlier concerns that Dr Marks had raised and which had led to her suggesting the involvement of mental health professionals and Tresillian, because I guess*

*while it's our specialty to examine children, it's not really our area of practice to deal with those things specifically in parents."*

404. Although Dr Marks' concerns were taken seriously by Manager A and the JCPRP team, ultimately Dr Marks' views seemingly didn't receive the full weight they deserved and most importantly required in terms of the subsequent casework response.

405. Although Manager A understood Dr Marks was concerned at the new bruising, he considered her advice was equivocal in some respects. In evidence, Manager A said:

*"[Dr Marks'] opinion on the bruise on the phone call was that it shouldn't be there. She was unable to tell me any information or tell us, I apologise, any information as to how old it could've been; when could it have been caused. Was it in the last hour? Was it in the last day? Was it inflicted injury? Could it have been an accidental injury? The only information I was able to obtain was that it shouldn't be there."*

406. Further in his evidence, Manager A said:

*"…In relation to the discussions had on the 24th, one of the challenges with that was - and I did - and I assure, your Honour, placed a lot of weight and I respect Dr Marks immensely on her - her opinion and her perspective. But on that date, unfortunately, she was only able to use the phrase, it should - the bruise shouldn't be there. Now, I probed her on what that could mean, and obviously, you know, she was very- she couldn't go past that particular phrase on that - this particular injury. I contacted her again on the 25th again just to see if she'd had any more - more perspective, but she couldn't move past, in her opinion, the bruise shouldn't be there. So whilst a lot of weight's placed on that opinion, it doesn't really, I think, for us in the DCJ - it didn't - it wasn't a huge - it was difficult there to kind of understand, "Is this an inflicted injury? Is it likely to be inflicted? Could it have been an accident? Could it have been related to a bruising disorder?" There was a lot of grey around that - that opinion. I don't begrudge her for that opinion. That was her opinion…..*

*Q. Yeah, but do you think generally it's understood that it would be very difficult for a doctor to assertively say something was actually inflicted as*

*opposed to merely saying it shouldn't be there? Do you have a difficulty with understanding that a doctor who is still treating a child and a family in effect would - I would've thought, could rarely say, "This is absolutely inflicted by this person." You accept that that's not their role.*

*A. Absolutely, and they - I've never had an occasion where they will say that, but for Dr Marks, I had the benefit of working with her over hundreds of cases and respect her immensely. She would usually use a phrase that would be in the line of, "Suspicious of inflicted injury." So that - that would be a phrase that she would normally use that would help guide us, and that - that would be a phrase across all the reports that she's written that she would - she would normally use. So when she uses a phrase like, "It shouldn't be there," that is - that's different from what she would normally say, and she was unable to kind of give me any more detail than that. So whilst I appreciate that yes, the doctor can never - would never say and couldn't say, "This person did it and this is definitely inflicted," the wording that they use is - is very different sometimes."*

407. This answer highlights the fact that there was a misunderstanding of the true nature of the injuries that Jacob had been subject to. There was a clear lack of medical understanding of the information that Dr Marks and her team had passed to DCJ. Manager A was an advocate for Jacob. He fought to keep him with Zest supervision. He advocated for the JCPRP MCS to be involved in the negotiations for extension. He tried to have a handover of the case. He did not fully comprehend the gravity of the risk that Dr Marks was expressing. I accept that she did make very clear her views, and the evidence results in a finding that those who dealt with Dr Marks should have been aware that she was strongly of the view that an intervention was required following the second injury to prevent further injury to Jacob. Manager A did not appreciate or understand this was in fact what was being communicated to him. He could have relied more heavily of the expertise of the CPU to give him the confidence to support removal of Jacob.

408. The investigations undertaken before Jacob's discharge on 19 July 2018 revealed no evidence of a bleeding disorder. The possibility a bleeding disorder contributed to

Jacob's bruising had been excluded. As to when the new bruising was occasioned, Jacob was checked before his discharge on 19 July 2018 and did not have the bruising then. It was evidently caused after that discharge. Information that a bleeding disorder may have impacted or effected the appearance of injury on Jacob none the less made its way into meetings and presented an incorrect detail into the factual matrix that may have caused those making the decision to doubt the fact that these were unexplained and very likely inflicted injuries.

409. The significance attributed to the new bruising may have been qualified in the JCPRP's view because of the absence of direct advice that it appeared intentionally inflicted. This may have impacted how Dr Marks' views were conveyed and considered in the second Group Supervision session on 25 July 2018. The tenor of the evidence in relation to this would support that this in fact did occur.

410. A clinician, a treating doctor in a hospital will rarely give advice in definitive terms. It was dangerous to use the absence of direct advice to this effect in the assessment of risk. Even if Dr Marks did not say the bruising was "suspicious" that was the clear effect of her advice. This was also self-evident given it was not readily conceivable how Jacob might have been accidentally injured on the sole of his foot; his mother could not reasonably account for how it was caused; and this was the second occasion in less than two weeks that Jacob had presented with injuries. It is clear the JCPRP casework team also did not properly appreciate the CPU's concerns regarding Jacob's mother's reaction to the bruising.

411. Jacob's case highlights the importance of caseworkers having at the forefront of their mind that bruising in infants, who are not yet walking or independently rolling, which is not adequately accounted for by a caregiver, must be treated with utmost seriousness. That is especially so when the infant has presented with injuries in the past which the caregiver has not reasonably accounted for. It is unlikely a clinician can precisely determine when a bruise or bleed was inflicted, or whether it was intentionally inflicted rather than accidentally suffered, based on examination alone. This is something it is apparent that senior supervisors in DCJ should be aware of in order for them to make these critical life and death decisions. Caseworkers should explore with a clinician their views about the significance of the location of bruising,

the likelihood it was caused during normal handling and whether the account given by the caregiver reasonably accounts for the injury, as opposed to whether it might be theoretically possible.

412. This advice should be considered together with the account of the caregivers as to when the bruising was first noticed; when the infant was last examined and whether the bruise was seen then; and the level of concern exhibited by the parent. These circumstances may inform the inferences that can be drawn as to when and how the bruising was caused.

413. Including CPU clinicians in the second Group Supervision may have enhanced the JCPRP's consideration of their advice and concerns. Making contact with the CPU team to explore the issue further may have assisted in clarifying the position. Inclusion of child protection clinicians in future group supervision sessions, along with enhanced training of caseworkers about unexplained injury cases involving infants, would be beneficial.

*Examination of Jacob's mother's hands.*

414. Although the new Safety Plan agreed to on 24 July 2018 stipulated that Jacob's mother was to have her hands medically examined, neither the JCPRP DCJ nor Parramatta CSC teams ever followed this up with his mother. The JCPRP DCJ casework team could not account for this. This was a significant missed opportunity. It may have shed light on his mother's drug use at the time and led to other actions including requiring protections such as requiring urinalysis.

*Cessation of the Zest engagement and the 31 July 2018 meeting*

415. Manager A said he informed CS on 26 July 2018 that the JCPRP's decision to continue with the Safety Plan required an increase in the number of daily hours of attendance by Zest. The implication is that but for ongoing Zest engagement the JCPRP would have removed Jacob. This led to the extension of Zest's engagement by one week only.

416. The cessation of Zest's engagement on 3 August 2018 meant there was no longer daily checking of Jacob for injury. The cessation of that service should have prompted a

thorough re-examination about whether the Secretary ought to assume Jacob's care and begin care proceedings.

417. The key evidence about this is drawn from the emails between 26 and 31 July 2018 involving Manager A, the JCPRP MCS, Manager M and the MCS (Parramatta CSC), along with the evidence of Manager A, the JCPRP MCS and the MCS (Parramatta CSC) about the same.

418. Decision making at this point fell into a grey area. The JCPRP was responsible for Jacob's casework and most informed as to his risks but could not itself approve funding for a critical part of the Safety Plan. Approval for the latter fell to Parramatta CSC, which was less informed of Jacob's risks although it understood key aspects of Jacob's case as reflected in the MCS (Parramatta CSC)'s email on26 July 2018 expressing concern at there being "*2 suspicious injuries so close together*".

419. When Manager A was informed that Zest's engagement would only be funded for one additional week, he sought a meeting with the MCS (Parramatta CSC) and the JCPRP MCS to discuss that matter. Ultimately the JCPRP MCS did not attend.

420. According to Manager A, he wanted the JCPRP MCS at the meeting to advocate for the continuation of Zest. Manager A seemingly felt unable to advocate for Zest's continuation in the JCPRP MCS's absence. He viewed the JCPRP MCS's attendance as important as he was at the MCS (Parramatta CSC)'s level.

421. According to the JCPRP MCS, he did not appreciate from their communications that Manager A was concerned at the cessation of Zest and wanted his help to advocate for its continuation.

422. According to the MCS (Parramatta CSC), he considered the JCPRP MCS's non-attendance indicated that the continuation of Zest's engagement was not viewed as significant by the JCPRP. Otherwise, he would have expected the JCPRP MCS's direct engagement on the matter.

423. It is concerning that a disconnect arose between Manager A, the JCPRP MCS and the MCS (Parramatta CSC) about such an important aspect of Jacob's safety planning.

424. The decision not to extend Zest beyond 3 August 2018 should have prompted the responsible JCPRP DCJ *and* Parramatta CSC managers (MCW and MCS) to reexamine the safety assessment and whether Jacob ought to be assumed into care. That included reviewing the 18 July 2018 Safety Assessment Decision Report to determine if Jacob remained 'safe with a plan' or was now 'unsafe'. This did not occur. This was a significant omission.

425. It is of concern that Dr Marks' recommendations that Jacob's mother's attachment to Jacob and her mental health be assessed, weren't discussed or given prominence in the discussions had on 31 July 2018 and the MCS (Parramatta CSC) gave evidence he wasn't aware of Dr Marks' recommendation about Tresillian.

*Decision to make a referral to Brighter Futures on 7 August 2018*

426. This was a significant point in Jacob's casework. As of 7 August 2018, formal transfer of Jacob's case to Parramatta CSC had not yet occurred. On this date Manager M directed CS to complete a referral to Brighter Futures. The decision to prepare a Brighter Futures referral was made with a view to ParramattaCSC discontinuing its engagement, assuming Brighter Futures accepted the referral and became engaged.

427. Manager M gave evidence that the possibility of a Brighter Futures referral was discussed with Manager A before 7 August 2018. Manager M had no recollection of being told or knowing about the CPU's concern about Jacob's mother's hands and the possibility it was an indicator of drug use by her. Had she known that, she would not have considered a Brighter Futures referral to be appropriate and would have viewed that as a significant matter as regards Jacob's safety.

428. The decision on 7 August 2018 to make a referral to Brighter Futures was largely based on Manager M's review of the earlier 18 July 2018 Safety Assessment Decision Report and the 27 July 2018 Risk Assessment Decision Report. The Parramatta CSC casework team had not reviewed in depth the records made by the JCPRP DCJ casework team or received a handover. A more thorough review of Jacob's case by Parramatta CSC before deciding to proceed with a referral was required at this point, especially when deciding to cease DCJ caseworker engagement.

429. Dr Marks' recommendations for a mental health assessment for Jacob's mother and a Tresillian referral also weren't considered in this decision, nor was the fact that the CPU had concerns about Jacob's mother's hands and that a request for a medical examination about this had not been followed through, nor any referral to address serious attachment issues.

430. Although a referral to the Telopea Service had previously discussed with Manager A, a referral with a view to DCJ stopping caseworker engagement once the referral service became involved had not been discussed with him. It is difficult to conceive he would have supported that proposal when he had sought extension of the Zest engagement. Consistent with that fact, there is no evidence of emails or file notes of discussions that mention that action being discussed with Manager A.

431. Manager M and CS viewed the referral to Brighter Futures, with a view to Parramatta CSC closing Jacob's case, as normal practice. It is concerning if the Secretary was opting to rely on external services like Brighter Futures to provide supervision to infants who are at risk of physical harm in the home, in lieu of DCJ caseworker supervision.

*Limited casework undertaken by the Parramatta CSC*

432. The comparison between Parramatta CSC's casework compared to that of the JCPRP DCJ team when it was responsible for Jacob's case is stark. It can be seen through:

a. The lack of home visits – between 9 August 2018 and 25 September 2018, CS conducted two home visits only. Most of their contact with Jacob's parents was by phone.

b. The lack of caseworker sighting of Jacob – CS only sighted Jacob once (during the 16 August 2018 home visit).

c. A lack of urgency and escalation when his parents repeatedly failed to present Jacob to scheduled medical appointments and rescheduled Ms Gray's home visits, especially in September 2018.

d. Prematurely closing Jacob's case once the Brighter Futures caseworker became engaged.

433. This lack of intensity reflected the Parramatta CSC's underestimation of the risks to Jacob. The JCPRP, particularly Manager A, was concerned at the risk to Jacob and how that could be managed, as shown by him arranging three Group Supervision Sessions to discuss Jacob's case.

434. Greater collaboration between the two teams before 7 August 2018 would have enhanced the Parramatta CSC's appreciation of the risks. They were at the time operating in silos. It was as though the work done by the previous group was being treated as over, instead of forming a continuum of care provision. The missed opportunities for greater collaboration between the teams included:

a. Inclusion of Parramatta CSC in the JCPRP's conferences with the CPU team between 13 and 19 July 2018.

b. Inclusion of Parramatta CSC in the JCPRP's Group Supervision sessions.

c. Introducing the Parramatta CSC team to the CPU team when case was transferred.

435. DCJ's Sibling Case Coordination Mandate protocol required both DCJ casework teams be jointly involved in conferences, Group Supervision meetings and internal discussion to ensure coordinated management. This protocol was not adhered to in Jacob's case.

436. A review of Parramatta CSC's involvement with Jacob highlights the underestimation and mis-categorisation of the risks to Jacob. As submitted, I agree there were significant failures and inadequate care taken by the Parramatta CSC team namely:

a. It should have been evident to the Parramatta CSC that there were risks attaching to Jacob's case when it was transferred given that the case had originally been with the Paramatta JCPRP owing to Jacob's presentation with suspicious injuries.

b. Before transfer, the Parramatta CSC team knew about both sets of injuries Jacob had presented with. It had been provided photos of Jacob's injuries. It had also arranged for Zest's engagement owing to the concerns about Jacob.

c. CS was present at the JCPRP's meeting with Jacob's parents on 26 July 2018 during which Manager A conveyed his significant concerns about Jacob's injuries, including those he presented with on 24 July 2018. At no time did

the concerns raised in that meeting, and afterwards in discussions between Manager A and CS, make their way into decisions for Jacob's future care.

437. Other issues that were evidence failures in CSC care were:

a. Not thoroughly reviewing JCPRP's casework records or seeking other records from police about Jacob's father's criminal history.

b. Not properly availing itself of the opportunity for a handover which Manager A attempted to arrange.

c. Not consulting the JCPRP about its decisions to refer Jacob to Brighter Futures, to discontinue the Tresillian referral, not to investigate further the Telopea referral option which was initially raised with Manager A by the MCS (Parramatta CSC) and, ultimately, to close Jacob's case.

d. Not appropriately acting on the concerns directly raised with it by the CPU team (e.g., concerns reported by Ms Knight on 15 August 2018).

e. Insufficient curiosity and scepticism about Jacob's mother's explanations for missed reviews and appointments.

f. An unwillingness to consider the objective evidence presented to them, which remained largely unexplained as to the infliction of injuries and manner of harm.

438. The 21 August 2018 Safety Assessment Decision Report outcome was unsatisfactory in several respects. Many matters were portrayed in a positive light as regards Jacob's parents, namely:

a. Although reference was made to a marking on Jacob's foot (24 July 2018), the concerns that Dr Marks reported about the injury (which DCJ caseworker CS made a contemporaneous note about) were not mentioned. It was not accurate to describe the marking as insignificant. The report had no other information about the 24 July 2018 injury presentation.

b. The assertion Jacob's parents' "*remained cooperative with [DCJ], agreeing to Safety Plan, utilising extended family, having ZEST in the home and agreeing to home visits and support from Brighter Futures*" did not address the many missed medical appointments, failure to attend for hand checks on the

mother's part, unwillingness to engage with Tresillian and issues surrounding potential drug issues. Regarding the support given by extended family, there is no evidence this occurred nor was this followed up, save that the Jacob's brother was being cared for by them. The extended family were not a protective factor for Jacob.

c. The assertion that neither parent had current drug and alcohol issues did not address the CPU's concerns about Jacob's mother's hands on 24 July 2018, nor did the report mention those concerns.

439. Manager M accepted Parramatta CSC should have completed its own risk assessment before deciding on the Brighter Futures referral and conducting the safety assessment review. The 21 August 2018 Safety Assessment Decision Report was superficial and wholly unsatisfactory. It portrayed many matters in an overly positive light and did not reasonably convey the risks for Jacob. At that point there had been inadequate review of JCPRP's records by the Parramatta CSC team, and insufficient direct dealings with his parents and Jacob by the Parramatta CSC team, to properly inform the latter of the risks to Jacob.

440. The review carried out by CS was probably influenced (consciously or otherwise) by Manager M's request. That fact of the request, and it being done to facilitate a Brighter Futures referral, likely indicated to CS that Manager M herself was satisfied Jacob was safe without a plan. That then shaped how matters were considered and presented in the review.

*Disconnect between the level of concern held by the CPU and Parramatta CSC*

441. There was also a striking disparity of concern the CPU held for Jacob as compared with that of Parramatta CSC. The CPU team were concerned at Jacob's missed appointments and consistently notified the DCJ casework team. The CPU team also carried out a home visit on 31 August 2018 after Jacob had not been presented for scheduled reviews on several occasions. This was not normal practice. It was done because they were very concerned about what might be happening to Jacob in the home. Remarkably, notwithstanding its involvement and the concerns it had raised with the casework teams, the CPU team wasn't even notified when Jacob's case

transferred to Parramatta CSC or before Parramatta CSC determined that his case could be closed.

442. The Parramatta CSC seemingly did not view the CPU team, and its views, as important features of Jacob's casework or act accordingly.

*JCPRP police investigation*

443. The JCPRP's police officers were responsible for investigating whether criminal offences may have been committed against Jacob and, if so, whether criminal charges should be laid. Detective SC Duane likely informed the JCPRP DCJ casework team that, in her view, "*Jacob's injuries could have been caused by a number of potential people, including by people that had visited him prior to being discharged from hospital*" or by "*small children*" (e.g.at family gatherings). By 19 July 2018 the JCPRP police were no longer actively investigating Jacob's injuries. At that point, the JCPRP police had interviewed Jacob's parents and considered advice provided during the CPU/JCPRP conferences. DSC Duane, in her first statement, said:

> "*Given that the CT scan was done on Friday 13 July 2018, and that the incident which caused the brain bleed is believed to have occurred sometime within the week prior, I was unable to determine if the injury occurred prior to, or after, Jacob's discharge from Blacktown Hospital*."

444. Further, in relation to the bruising and swelling around Jacob's left eye, DSC Duane stated:

> "*In relation to the bruising and swelling around the eye, given that doctors are not able to put a time-frame on bruises, I was unable to narrow down the field of suspects which includes staff from Blacktown Hospital as well as all of the family members present at [the maternal grandmother's] house on the evenings of Tuesday 10 July 2018 and Thursday 12 July2018, and those present at [Jacob's mother's] sister's house on Wednesday 11 July 2018*".

445. The investigating police at that point had not:

a. Spoken with Blacktown Hospital staff about the possibility Jacob may have been injured while there or sought the Hospital's records to review those about the same.

b. Attempted to speak to the family members present at the family gatherings on 10and 11 July 2018, most particularly the maternal grandparents and his maternal aunt.

446. The justification for ceasing the investigation did not grapple with:

a. The CPU team's advice was that the outside time frame for Jacob's head injuries was 7 days before his presentation - not that they would have been caused 7days beforehand.

b. Jacob's parents' account that Jacob's bruising was noticed about 30 hours after his release from Blacktown Hospital, during which he had been alone in their care save for the family gatherings, strongly pointed to the likelihood his injuries occurred after his release from hospital. In that time no one had reported seeing Jacob being injured.

c. The possibility Jacob was injured by hospital staff in a special care nursery setting was inherently implausible.

## Conclusion

447. One substantial contributor to this inquest was Jacob's maternal aunt. She sat through the inquest hearing often for the first time details of Jacob's pain and suffering. At times she cried. She went through a difficult process of examination. She gave some of the most moving evidence. She noticed the initial bruising on Jacob's face almost immediately, she said "*Only because when I nursed him, I love looking at the faces of the new born while she (Jacob's mother) didn't*." She wasn't spoken to by DCJ but she could have provided much evidence. She knew that the swimming lessons that her sister spoke about when seemingly making reasons why Jacob could not attend appointment, were not the truth. She expressed her love for her family, she indicated that the sister she had heard evidence about in this inquest was not the sister that she knew. She was and is the carer for Jacob's brother.

448. The inquest was very grateful for her evidence and her bravery in assisting. It is clear that she was a missed opportunity in the process of considering other safety options for Jacob. There was no family statement in this matter, but it was clear that he was adored by his large extended family, and will be greatly missed in life by his brother.

449. Jacob was subject to significant harm while under the protection of DCJ. DCJ closed his case prior to his death. He could be seen as the most vulnerable amongst children in our community. He was born prematurely, spent 11 weeks in neonatal care and then his trouble started when he was sent home with his parents. Three days later he was in hospital with facial bruising and subarachnoid haemorrhaging, that was considered likely an inflicted unexplained injury. He was in the care of our most trusted Child Protection Unit, involving a team experienced in child abuse. They were excellent, and provided appropriate and involved care for Jacob. They went as far as they could to ensure his safety. He should have been safe from that point.

450. The emergency child response team experts, JCPRP -were called in and decided to send him home with his parents. Their story was not closely examined; corroborative documentation was not sought about injury happening elsewhere such as the neonatal ward or a family gathering. Although a history of drug use was disclosed as being in the past, there was no interrogation of this through the obtaining of simple documents such as Jacob's father's criminal record. The JCPRP seemed to place little weight on expert opinion and review available to them. Instead, they made a decision to send Jacob home again with his parents, putting in place a limited service, with no expertise to monitor him.

451. This plan did not work, and he was back on a scheduled review with injuries again considered inflicted. The evidence overwhelmingly supports that at this point the CPU were on high alert, and then directly let the manager of JCPRP know. They wanted to hold Jacob, but could not do so without the immediate involvement and authorisation of that team, who did not come to the CHW.

452. The information about Jacob's mother appearing with unusual markings on her hands, her explanation for which was not accepted by doctors, was not explored. An attachment concern was raised by the CPU and a recommendation for Tresillian referral was given, but not followed through.

453. Jacob was sent home, with an already failed plan. His mother did not attend a doctor to see about her hands. His parents did not accept the referral to Tresillian. The plan was barely adjusted, and by the time of the final meeting of the team of emergency

child response team, there were absolutely no supports in place for Jacob. His parents did not attend many arranged appointments. At times they were not home for the Zest workers. This alone should have raised serious alarms.

454. At the point of the final meeting of the emergency child response team, words were used to the effect that a child was not going to be removed as the result of a bruise on his foot. This was a fundamental misunderstanding of the seriousness of the subsequent bruises found on Jacob. This was a failure to understand the information that the CPU had provided to them. In any event, at that critical time of decision making, no plan was actually put in place for a child that was considered at the highest risk level that DCJ was comfortable holding.

455. There was no adequate, or actually no hand over of Jacob's case, resting at the highest level of risk between the two DCJ teams. One team was relying on old and outdated risk assessment, misunderstandings and misinformation. One team tried to make a hand over happen, tried to get extended care in to help. Both failed.

456. Before Jacob even passed in care to Parramatta CSC they were preparing to close his case and send him to Brighter Futures. When Brighter Futures declined to take him on the first referral because he was a high risk child with a plan, the plan was altered to make him "safe".

457. He was transferred to Brighter Futures, who did what they were asked to do, although his mother was again putting off appointments and failing to comply with dates previously set which may have been a protection for Jacob. Weeks later Jacob was dead. His file closed. No one knew the pain and suffering and injuries that had been inflicted while he remained in the care of his parents.

458. Jacob was our most vulnerable, it hard to imagine one more so. Warnings were clearly evident about the risk he was at. DCJ knew the risk he was at. This is not a case about the benefit of hindsight, DCJ had all they needed to at least attempt to protect Jacob from catastrophic harm.

459. The reluctance of DCJ to initiate care proceedings remains hard to fathom. In this case Jacob would undoubtedly have had options to remain with family. His mother's sister and his grandmother were already caring for his brother. It was the saddest part of the inquest to hear the heartbreak in his aunt's voice after the horror of the full details had been disclosed to her. DCJ who had the expert evidence of the CPU, could not keep him safe with a plan after trying, with the emergence of a second suspicious injury whilst he was in the care of his parents with in house support and supervision. In such circumstances it was extraordinary that proceedings were not immediately commenced and is demonstrative of catastrophic failure of the system and a misunderstanding of the nature of child abuse.

460. The safety of children, particularly infants is generally of paramount importance to those who care for them. The general rule when you are responsible caring for an infant is that you know where they are at all times, who is present and what they are doing. In some ways, care for Jacob or any infant should be seen through a similar lens. Once DCJ were alerted to the significantly high risk, the highest risk that they would hold, simple steps for his safety needed to be taken in their own organisation. As Jacob was being moved around between departmental groups such as caseworkers, MCWs, or MCSs, the question needed to be asked by the last person with responsibility for Jacob's safety; Who has Jacob now? That simple process of passing not a case, but a baby boy whose whereabouts and care needed to be known at all times might have provided the protection Jacob needed. He should never have been passed on until the next person had a firm grasp on him, and the last person was sure that was the case. He should not have been passed out of the system until he was placed in safe hands.

461. The gravity of this inquest was not lost on any institutional party that was an interested party. It was accepted that learnings could be had. However, the importance of remembering Jacob remains.

## RECOMMENDATIONS

462. Recommendations of the kind that are necessary or desirable in relation to Jacob's death are open to be made pursuant to s 82 of the Act.

463. Submissions for the Sydney Children's Hospital Network were received, and it is noted that the findings in essence reflect those submissions. There is an opportunity at this point to commend the work of the CPU. Jacob was visible to that team in a way that felt largely missing throughout this inquest. Dr Marks regularly attends court and coronial hearings in very serious cases of unexplained and distressing injury. She maintained a connection with Jacob, and it was clear that this loss was one that affected her. She did all she could to bring her concerns to the relevant people at DCJ, I accepted her account. She was concerned greatly about the harm that was potentially being inflicted upon Jacob, but maintained her professional role within the system appropriately. She had with her a team of dedicated clinicians, Dr Pathmanandavel, Ms Carman and Ms Knight, who took the extraordinary step of a home visit to Jacob. This allowed a better understanding of the infliction of his substantial injuries, and a finding that he received these after their attendance. It was a piece of the puzzle that they helped answer through their dedication. This is a service which as, Mr Rooney submits, should not be subjected to any higher workload given the limited resources and the need for the main service that they provide. That is a valid point.

464. The Commissioner for Police made a submission that acknowledged a more rigorous investigation into Jacob's injuries could and should have been undertaken. It is accepted that the investigating officers should have spoken to staff of Blacktown Hospital or sought access to Blacktown Hospital records in considering whether Jacob may have been injured before his release from neonatal care. Second, that they ought to have spoken with some family members present at the gatherings on 10 and 11 July 2018 to enquire about the possibility of injury.

465. Whereas this part of the investigation was lacking, the same cannot be said of the subsequent police investigation into the death of Jacob by the OIC. It is fair to say that the investigation has been nothing but exemplary and exhaustive. Much of the evidence brought to the hearing would not have been available but for that work and

commitment of the OIC and her team. This work is commendable, and I thank her and the team for that extensive work.

466. NSW Police have also transformed Jacob's case into a training workshop which is still being developed. They are taking the opportunity of looking at the abuse of a baby. The submissions go into depth about this workshop which is intended to be delivered to all units of the Child Abuse Squad across the state. Detectives working in Police Area Commands and Police Districts who respond to physical abuse matters involving children will also be invited to attend. This is hoped to be extended to all NSW Police Force officers a few times a year. Helpfully the submissions make the suggestion that if the matter is to be referred it is to the Unsolved Homicide Team in the Homicide Squad, and I thank the involvement of the Commissioner for the thought and care given to making what can be best taken from Jacob's death into real response that will matter to other babies.

467. The submissions on the part of DSC Duane have been considered, however her evidence was lacking in understanding of the gravity of the harm that Jacob had been subjected to. There is no basis set out in evidence as to why the findings regarding DSC Duane cannot be made. In noting the submissions, there was no prospect of an offence being proven beyond reasonable doubt when she had not completed a fulsome inquiry, and it might have been that proper investigation might have allowed a better focus to be placed on those if other incidents could be eliminated, such as injury of Jacob by Blacktown Hospital. It is submitted that the answer "*at that stage, with the information we had at hand, I couldn't see how the information would change whether or not we were going to be able to prove anything*" is based on a very cursory investigation that missed salient witness statements being taken and a more vigorous pursuit of evidence.

468. DSC Duane accepted that her role was also to provide information that she would expect would be of interest to DCJ. She failed to perform this role. She was the police officer, she needed to lead the investigation and provide such things as the criminal history. One of the greatest failings in the investigation stage was the failure to engage with Blacktown Hospital. They had a vast amount of commentary and information about Jacob's parents' behaviour, which would have been of great

assistance to DCJ. Her evidence was very concerning, and I reject the submission that if she had given Jacob more time and effort she would not have discovered further evidence, to the contrary, it is known that she would have. There might also have been an opportunity to speak to family about Jacob's brother and his care and the care of Jacob generally. This was a significant missed opportunity. This is all to be taken in the context of a baby who is helpless, and a police officer that sits within the specialist team for urgent child protection.

469. The Secretary and DCJ are to be commended for their engagement in this inquest. This was a difficult matter for it to traverse, particularly given that there were so many errors, and little to commend in the supervision of Jacob leading to his death. The submissions note that the evidence of Ms Brunner indicates that JCPR is now operating in a more effective way, ensuring there is a genuine sharing of information. There is acceptance that there was a failure to obtain Jacob's father's criminal history pursuant to 16A of the CYP Act and neither is it clear why the JCPRP police team did not proactively share the information under Chapter 16A.

470. They have engaged with the recommendations proposed by Counsel Assisting and support the majority of the recommendations however, it was suggested that better wording would be "The relevant guidance and policies be updated with a direction that cases in which an infant has presented with injuries not reasonably accounted for by caregivers, DCJ should retain case management for the child."

471. Submissions on behalf of DA supported the closing submissions of Counsel Assisting, and noted there is no adverse findings to be made expressly against her. It was properly noted that she was a junior caseworker, and was experiencing her first complex case, being a baby with physical injuries. She relied on her superiors. She was not responsible for any significant decision making by the JCPRP during that period. She was honest in evidence and statements indicating that she did not know what to do.

472. The submissions also urge the inquest to have regard to the hard role the caseworker plays. They are expected to engage with the family and support them while trying to protect the child. The submissions support that the police could have been more

proactive in sharing dates of relevant charges. The date of the most recent offence would have been a critical piece of information to share. The presentation of Jacob on 12 July 2018 suggested some willingness on his parents' part to seek help and care for Jacob, giving an impression of being supportive of him. At that time the many deceptions that were being perpetrated by his parents, including the late night trips to the pokies and babysitters, was not something that the care workers could have been aware of.

473. Although it was accepted that there were improvements in detail that could have formed part of Safety Decision Report dated 24 July 2018, the information was made known to Parramatta CSC. They were aware of the new injuries, and of Jacob's mother's hands. Given that the JCPRP were considering removal of Jacob, and Parramatta CSC knew that, it is submitted that Parramatta CSC must have known that he was a high level of risk. Caseworker DA and others uploaded the Chapter 16A requests and other information and records, including the Group Supervision sessions, to Child Story with the expectation that Parramatta CSC would review all the relevant information, not just the risk assessment documentation.

474. I do not accept the submission that the CPU ought to have "voiced their concerns about drug use directly". Jacob's mother was not the patient, and they were already commenting on matters of concern outside Jacob's physical wellbeing. I do not accept that the CPU did anything but appropriately bring important information to the attention of DCJ.

475. The submission that the threat of removing Jacob could or should not be made as a mechanism to force Jacob's mother to attend the GP is a misunderstanding of the evidence and submissions. If that is part of the plan to allow Jacob to go home, it should be enforceable. If that cannot or does not occur, then the plan is not satisfied. There is no suggestion of threat, merely that it is the role of DCJ to indicate what conditions could best ensure the protection of Jacob, and if his parents can't or won't comply, the plan is not implementable and should be revised. The process is one of working with the family to keep it together, which will at times require family to undertake appointment to ensure they are supported, such as for his mother's hands, or to ensure Tresillian is attended to best protect his wellbeing.

476. It is not with the benefit of hindsight that the finding is that the Secretary should have assumed Jacob's care and begun care proceedings on about 24 July 2018 when Jacob presented with new bruising. The team had at its fingertips the expert medical view of doctors and allied health professionals that specialise in child abuse. They did not attribute much weight at all to their findings. There were missed opportunities so many times, even in terms of adequate assessment of risk and an escalation the casework response thereafter, culminating in the closure of Jacob's case on 25 September 2018. Jacob was being harmed while the Secretary was engaged with his case.

477. The submissions for Wesley Mission Brighter Futures notes that this is a non-government agency to assist family in need. It is a service to provide a family preservation service to engage families to enhance the quality of parenting in the home. The program does not involve daily visits, nor an assessment of the kind provided by services such as Tresillian.

478. There is no criticism of this service. It depended on appropriate determinations for referral, accurate referral information and clear collaboration of transfer to the service. It needs to ensure there is continued provision of information and oversight until transfer is complete. Ms Gray did what she was asked to do in the nature of the service that was being provided. Jacob was not a case that should ever have been referred to Brighter Futures, and DCJ should not have made the referral. However, Brighter Futures did question the referral and took Jacob on only after satisfied that their criteria was met. They were not given adequate information about the family, and if they had, they would not have been in a position to offer any service.

## Review of relevant criminal offences in New South Wales

479. In this case at least one of Jacob's parents were present in the home at the time of the infliction of the significant injury to his gum, and they have failed to give any logical explanation for any of Jacob's extensive injuries. There has been no reasonable explanation for the totality of Jacob's healing injuries. There is no explanation of why Jacob was face down following death, or why there was considerable delay in calling 000, obtaining care and assistance for him, and why the parents' account to police and paramedics was not truthful. There is insufficient evidence present that would require

or allow a referral to the Director of Public Prosecutions pursuant to s 78 of the Act upon a review of the current criminal law in relation to Jacob's death.

480. Jacob's death raises for consideration the criminal offences that operate in New South Wales for the protection of infants and children. Outside homicide, wounding and assault offences, the following relevantly arise:

a. A person who has parental responsibility for a child and who, without reasonable excuse, intentionally or recklessly fails to provide the child with necessities of life is guilty of an offence if the failure causes a danger of death or of serious injury to the child: s 43A, *Crimes Act 1900* (max. penalty of 5 years imprisonment).

b. A person who is under a legal duty to provide another with the necessities of life, and who, without reasonable excuse, intentionally or recklessly fails to do so, is guilty of an offence if the failure causes a danger of death or causes serious injury or the likelihood of injury: s 44, *Crimes Act 1900* (max. penalty of 5 years imprisonment) (a person cannot be convicted of both a ss 43A and 44 offence).

c. An adult who knows, believes or reasonably ought to know that a child abuse offence has been committed against another; who knows, believes or reasonably ought to know that he or she has information that might be of material assistance in securing the apprehension of the offender or the prosecution or conviction of the offender for that offence; and who fails without reasonable excuse to bring that information to the attention of a member of the NSW Police Force as soon as it is practicable to do so is guilty of an offence: s 316A, *Crimes Act 1900* (max. penalty of 2 to 5 years imprisonment).

d. A person who intentionally takes action that has resulted in or appears likely to result in the physical injury or sexual abuse of a child or young person, or a child or young person suffering emotional or psychological harm (of a specific kind) or is likely to be significantly damaged, or the physical development or health of the child being significantly harmed, is guilty of an offence: s 227, CYP Act (max. penalty of 2 years imprisonment or 200 penalty units or both).

481. It may be impossible to result in any action in a situation where:

a. An infant suffers fractures, bruises and bleeding while in the care of the infant's parents or caregivers however the infant has contact with multiple persons, including drug associates of the parents, during the period the infant is injured. The injuries occur because the parents have not acted protectively of the infant.

b. An infant's parents weren't directly responsible for some or all the infant's injuries, however one or both were likely aware the infant had been harmed, was in pain or required medical attention although it cannot be precisely determined what each parent knew and exactly when.

c. The precise cause of an infant's injury or death cannot be determined other than that it was not from unexpected natural causes or accidental. One or both parents were present at the time of the event causing the injury or death however neither provides an honest and reliable account about the circumstances of death.

482. The United Kingdom has engaged in legislative reform of relevance to these issues. In its report "*Children: Their Non-Accidental Death or Serious injury (Criminal Trials): A Consultative Report (No.279)"* (30 April 2003), the United Kingdom's Law Commission observed:

> *"*…the Law Commission is consulting on recommendations we are minded to make to the Government to deal with cases in which a child, under the age of 16, has been non-accidentally killed, or seriously injured, by one or other or all of a small group of people, at least one of whom has responsibility for the child's welfare. Research referred to in Part II demonstrates that this is a relatively common occurrence but that in almost 75% of known cases the person who has inflicted the death or serious injury is not prosecuted. The primary reason for this is that the rules of evidence and procedure make it impossible in many cases for fact finders to be given the opportunity accurately to decide which members of the small group of people who must have inflicted the injuries or killed the child is guilty. This is because the present law, as reflected in the decision of the Court of Appeal in Lane and Lane, requires the trial judge to withdraw the case from the jury at the end

of the prosecution case before any of the defendants has given evidence if at that stage the prosecution are unable to establish a 'case to answer' against either defendant." *(R v Lane (1986) 82 Cr App R 5)*.

483. In its final report, the Law Commission stated:

> "…The recommendations in this Report are intended to address a problem which has been recognised for many years by judges, academics and practitioners, and which has been highlighted by the press. It can be exemplified at its most intractable in the following situation: A child is cared for by two people (both parents, or a parent and another person). The child dies and medical evidence suggests that the death occurred as a result of ill-treatment. It is not clear which of the two carers is directly responsible for the ill-treatment which caused death. It is clear that at least one of the carers is guilty of a very serious criminal offence but it is possible that the ill-treatment occurred while one carer was asleep, or out of the room. …It should be remembered that even though one parent may not have struck the fatal blow or blows, he or she may be culpable, as an accessory, either through having participated in the killing actively or by failing to protect the child. In many cases of this type it is difficult, or impossible, to prove even this beyond reasonable doubt and therefore neither parent can be convicted."

484. Although the report concerns the state of law in the United Kingdom, I agree with Counsel Assisting that this also has direct relevance to New South Wales. The Law Commission's inquiry led to the enactment of the *Domestic Violence, Crime and Victims Act 2004* (UK) which, following subsequent amendment in 2012, provides an offence under s 5 of "*[c]ausing or allowing a child or vulnerable adult to die or suffer serious physical harm*".

485. This offence provides that a person ("D") is guilty of an offence if:

1. A child or vulnerable adult ("V") dies, or suffers serious physical harm, as a result of the unlawful act of a person who:

    (a) was a member of the same household as V, and

(b) had frequent contact with V.

2. At the time of death or infliction of serious physical harm:

(a) D was a member of the same household as V and had frequent contact with V.

(b) There was a significant risk of serious physical harm being caused to V by the unlawful act of such a person, and

(c) D caused the death or serious physical harm or:

i. D was or ought to have been aware of that risk,

ii. D failed to take such steps as he/she could reasonably have been expected to take to protect V from the risk, and

iii. The act occurred in circumstances of the kind that D foresaw or ought to have foreseen.

486. For the purposes of this offence:

a. In the case of unlawful death the maximum penalty is life imprisonment and in the case of serious physical injury 14 years imprisonment (s 5(7)).

b. At trial the question whether there is a case for the defendant to answer is not to be considered before the close of all the evidence (a trier of fact is permitted to draw such inferences as appear proper from the defendant's failure to give evidence or refusal to answer a question even if there would otherwise be no case for the defendant to answer in relation to that offence): ss 6(2) and 6A(e).

487. According to a circular issued by the United Kingdom's Home Office on 4 March 2004, about the operation of the offence when it was originally enacted:

"The offence will not apply for example where the death was an accident, or was the result of a cot death (sudden infant death syndrome). Nor will it apply where there was one specific known risk within a household, such as a violent or abusive person, but the child or vulnerable person died or may have died from a different cause. The offence therefore does not criminalise members of the household for allowing the death if the death

was the result of an event which they could not have anticipated or avoided."

488. The significance of this provision is that a caregiver in the home may be found criminally liable for a child's death or injury, and subject to considerable penalty, even absent proof he or she directly caused the same. It is a provision that places responsibility on the caregiver in cases where a vulnerable child has little or as in this case no voice, no protection and is helpless.

489. As submitted after extensive research by Counsel Assisting, Jacob is an opportunity to present to the Attorney General of NSW his case, for review, and if considered appropriate do so (with the assistance of the NSW Law Reform Commission), review the sufficiency of criminal offences in New South Wales, with respect to unlawful injury and death of infants and children. This would include consideration generally of whether there is benefit to the introduction an offence in NSW in similar terms to that in s 5 of the *Domestic Violence, Crime and Victims Act 2004* (UK).

490. This is not a matter that involved any criticism of existing laws, nor did it involve participation of the Attorney General as an interested party. Jacob however has presented as a case study that may be of interest when looking at these types of deaths to highlight the problems that are faced with an infant who is experiencing potential domestic violence in the home but has no voice. The coronial process has the opportunity to share the information gathered in Jacob's case, and in such a case as this, has deemed it necessary and desirable to do so.

491. In the Inquest into the death of Cooper Scifleet, Deputy State Coroner MacMahon made a recommendation on 30 October 2013 in the following terms:

"That the attention of the Attorney General be drawn to the findings and recommendation of the Law Commission in its report *Children: Their Non-Accidental Death or Serious Injury (Criminal Trials)* dated 6 August 2003 and that consistent with the findings and recommendations of that report consideration be given to the enactment of a new criminal offence in New South Wales similar to that of Causing or allowing the death of a child or

vulnerable adult as was created by Section 5 of the *Domestic Violence, Crime and Victims Act 2004* (UK)."

492. The response of the (then) Attorney General (NSW) to this recommendation on 7 July 2014 indicated that further inquiries were being undertaken.

493. This is not a recommendation to make such change, but rather affording the Attorney General the opportunity of considering the information that has come to light through this inquest, and if it is considered appropriate to review current provisions in light of the existing provisions in the United Kingdom.

### Practices and procedures of the Secretary

494. There has been evidence about improvements made to the training and practices of DCJ caseworkers post Jacob's death that the Secretary expects would bear on future casework for infants with suspicious physical injuries. This inquest was to focus on the systems which might improve as a result of the learnings exposed in this case.

495. Submissions were made that it is the position of DCJ that cases where an infant has presented with injuries not reasonably accounted for by caregivers should not result in referral to an NGO and cessation of active involvement by DCJ and/or the closure of the file.

### Recommendation 1

496. The findings are to be provided to the Secretary, and the Minister for Families and Communities, for consideration and review to have the opportunity to carefully consider these findings, Jacob and what occurred in the child protection response.

### Recommendation 2

497. The Secretary consider updating relevant guidance and policies in line with its position with a direction that cases in which an infant has presented with injuries not reasonably accounted for by caregivers, DCJ should retain case management responsibility for the child.

### Recommendation 3

498. The Secretary consider these findings with respect to sufficiency of the procedures around Case Transfers and Sibling Case Coordination, noting Ms Brunner's evidence that a review of the Case Transfer Mandate has been completed and changes made and a review of the Sibling Case Coordination mandate was expected to be completed in 2024.

### Recommendation 4

499. The Secretary consider these findings and give consideration in respect to the training provided to casework teams from caseworker level to MCS level regarding the assessment of the seriousness of bruising in infants that is not reasonably accounted for by caregivers. This extends to examining how there can be greater inclusion of child protection clinicians in Group Supervision sessions and casework discussions, especially in the cases of infants. Consideration should also be given to possibly using Jacob's case as part of scenario-based training of caseworkers.

### Recommendation 5

500. The Commissioner of Police, NSW Police Force, allocate the police investigation into Jacob's death to the NSW Police Force's Unsolved Homicide Team in the Homicide Squad for review and further investigation.

### Recommendation 6

501. That the findings are provided to the Attorney General for his consideration and if considered appropriate to do so, with the assistance of the NSW Law Reform Commission, review the sufficiency of criminal offences in New South Wales with respect to unlawful injury and death of infants and children. This would include consideration generally of whether there would be any benefit to the introduction of an offence in NSW in similar terms to that in section 5 *Domestic Violence, Crime and Victims Act 2004* (UK).

## FINDINGS PURSUANT TO SECTION 81 OF THE ACT

### Identity

The person who died was Jacob.

### Date of death

10 October 2018.

### Place of death

The location of his death was Toongabbie, New South Wales.

### Cause of death

The cause of Jacob's death was an unnatural event involving the application of significant non accidental force in the form of infliction of injury to his head, specifically to his face and gum region, in the process of which, based on expert opinion, Jacob was either deprived of oxygen resulting in suffocation or such infliction of injury was sufficient to cause traumatic brain injury causing death.

### Manner of death

Jacob's death was not the result of accident or misadventure but was a result of the application of significant force by unknown person/s. However, the mechanism by which this force was applied cannot be established on the available evidence.

## ACKNOWLEDGEMENTS

To all who participated in this inquest through the taking of time to prepare evidence, giving evidence, and to the witnesses who had a very difficult role many years after the loss of Jacob. Each of the legal practitioners brought care and thoughtfulness to this matter.

To the team assisting, Ms Yvette Edgell, and Ms Amber Doyle for preparation and presentation of Jacob's matter, and to Mr Chris McGorey for excellent advocacy. Each of the Assisting team took very particular care in Jacob's matter. No task was too big nor too small, he was very important to each of them, and it showed in the quality of their work in the inquest. I thank you each.

A particular acknowledgement and thank you to Detective Sergeant Hannah Packer, State Crime Command who presented an excellent investigation to assist finding answers for Jacob, her work and dedication is a credit to NSW police and to the people of NSW.

I now close this inquest.

To Jacob's family I extend my condolences, what a terrible loss of a precious little person, and especially to his brother, who will greatly miss the loss of the opportunity to have Jacob in his life.

Deputy State Coroner Kennedy