



**CORONERS COURT  
OF NEW SOUTH WALES**

<b>Inquest:</b>	Inquest into the death of Jade
<b>Hearing dates:</b>	15-18 July 2024
<b>Date of findings:</b>	24 June 2025
<b>Place of findings:</b>	Coroners Court of New South Wales, Lidcombe
<b>Findings of:</b>	<b>Magistrate Joan Baptie, Deputy State Coroner</b>
<b>Catchwords:</b>	CORONIAL LAW – Death of 3-year-old First Nations child - family known to DCJ - staffing and resources at DCJ - domestic violence - need for multiagency cooperation - cause and manner of death
<b>File number:</b>	2018/00170231

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<p><b>Non publication order:</b></p>	<p>Non-publication orders made pursuant to s 74 of the <i>Coroners Act 2009</i> and/or the incidental powers of the Court apply in this matter and are available on the Court file. Copies are also annexed to these findings.</p>

<b>Findings:</b>	<p><b>The identity of the deceased</b></p> <p>The person who died was Jade.</p> <p><b>Date of Death</b></p> <p>Jade died on 30 May 2018.</p> <p><b>Place of Death</b></p> <p>Jade died at Redacted Street, Muswellbrook.</p> <p><b>Cause of death</b></p> <p>The cause of Jade's death was Bilateral Bronchopneumonia with known circumstances indicating neglect as a significant contributing factor.</p> <p><b>Manner of Death</b></p> <p>Natural Causes.</p>
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**Recommendations:**

1. To the Chief Executive, The Benevolent Society: The Benevolent Society review the training, and messaging, to TBS Brighter Futures practitioners around the need for strict compliance with the mandatory reporting obligations under the *CYP Act* having regard to these findings.
2. To the Secretary: The Secretary consider issuing a directive to all Brighter Future’s providers emphasising strict compliance with mandatory reporting obligations having regard to these findings. As part of recommissioning all family preservation services DCJ should, having specific regard to these findings and recommendations made in this inquest, recognise and emphasise that family preservation providers hold mandatory reporting responsibilities under the *CYP Act*, reflecting this in contracts, program specifications and other program implementation documentation and activities.
3. To the Minister for Families and Communities: The Minister review these findings and examine the caseworker capacity of the Muswellbrook CSC and consider the other issues canvassed in these findings.

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## **Introduction**

- 1 This inquest concerns the death of a 3-year-old child. Given her age, her name, and the names of her family members, are the subject of a non-publication order. She will be referred to as Jade. Her mother will be referred to as Mel and her father as Declan.
- 2 Jade was born on 5 March 2015 in Muswellbrook. She died on 30 May 2018, at Muswellbrook, in the state of New South Wales.
- 3 Jade died from bilateral bronchopneumonia with known circumstances indicating neglect as a significant contributing factor. She died from an illness which is readily managed in Australia. It is extremely rare for a child to die from such an illness if they are presented for medical intervention in a timely fashion.
- 4 The identity, date and place of Jade's death are not in dispute. This inquest has focused on the manner of Jade's death and the relevant contributing circumstances, including care and protection policies, training and casework of the Department of Communities and Justice and relevant service providers.
- 5 Jade was a daughter, granddaughter and sister and I acknowledge the profound loss and anguish felt and experienced by her family. I would like to express my sincere condolences for their loss of this small child. Her mother described her as a "bubbly, cheeky, determined, sassy little girl who knew what she wanted and how to go about getting what she wanted. She had me wrapped around her little fingers." I hope that Jade's memory has been honoured by the careful examination of the circumstances surrounding her death and the lessons that have been learned from the circumstances of her passing.

## **The role of the Coroner and the scope of the inquest**

- 6 A coroner is required to investigate all reportable deaths and to make findings as to the person's identity; as well as when and how the person died. A coroner is also required to identify the manner and cause of the person's death. In addition, a coroner may make recommendations, based on the evidence deduced during the inquest, which may improve public health and safety.

- 7 This is a mandatory inquest pursuant to section 24 (1) (a) and (d) of the *Coroners Act 2009*, as Jade and her sibling were the subject of reports made under Part 2 of Chapter 3 of the *Children and Young Persons (Care and Protection) Act 1998 (CYP Act)*, within the three years preceding Jade’s death, or there was reasonable cause to suspect that Jade’s death “is or may be due to abuse or neglect.”
- 8 During these proceedings, a brief of evidence containing statements, interviews, photographs and other documentation, was tendered in court and admitted into evidence. In addition, oral evidence was received from numerous witnesses. An expert report was prepared by Professor Dominic Fitzgerald, a Paediatric Respiratory and Sleep Physician.
- 9 All the material placed before the Court has been thoroughly reviewed and considered. I have been greatly assisted by the written submissions prepared by counsel assisting, Mr Chris McGorey of Counsel, Ms Dana McMullen, solicitor advocate on behalf of Mel, and Dr Hayley Bennett, Senior Counsel on behalf of the Department of Communities and Justice (**DCJ**), Dr Katherine Fallah, counsel on behalf of Ms MCS, Ms Jaye Alderson, counsel on behalf of Ms MH, Mr Trent Glover, counsel on behalf of The Benevolent Society. At times, I have embraced their descriptions in these findings.
- 10 A non-publication order was made which prohibits the publication of the names of Jade’s immediate family and the names of staff from **DCJ** and Brighter Futures (**BF**), who were involved in the casework with the family. A non-disclosure order was made in relation to an “Internal Child Death Review” report prepared by **DCJ** with respect to Jade.
- 11 A “Summary of Facts” has been prepared by Mr McGorey. The representatives appearing on behalf of the other parties agree that the summation of the facts in that document provides an accurate account of the documentary and evidentiary evidence. A copy of that document is annexed to these Findings and contains a more detailed account of the facts than are described in these Findings.

### **A Brief Overview of Jade’s Life**

- 12 Jade was the eldest child of Mel and Declan. Jade has a younger brother, “James” and an older half sibling, “Gabby”. Gabby is the daughter from an earlier relationship involving Mel and her former partner.

- 13 Jade is a First Nations person through her paternal lineage.
- 14 It is unclear as to when Mel and Declan began their relationship, however, it would appear to have been in either 2013 or 2014.
- 15 Jade's parents leased a house in Muswellbrook in 2014 or 2015, when Mel was pregnant with Jade. The family were evicted by the real estate agents due to rental arrears and damage to the property (reportedly holes in the walls).
- 16 On 22 August 2016, Mel signed a new lease for the premises on Redacted Street, Muswellbrook, which was described as a small two-bedroom unit. Jade lived in these premises with her mother and brother. Her father Declan was not nominated as a lessee on the lease, however, police and the Department of Community Services believed that he was frequently residing at these premises.

## Background

- 17 Mel was exposed to significant disadvantage as a child and was the subject of a number of reports to the Department of Communities and Justice (**DCJ**) between 1999 and 2009. These reports related to parental neglect, inadequate supervision, exposure to domestic violence and carer substance misuse.
- 18 DCJ initiated proceedings in the Children's Court of NSW, resulting in parental responsibility being allocated to the Minister and Mel being placed in various foster care placements.
- 19 Mel gave birth to her first child, Gabby in 2011, when she was 17 years of age.
- 20 On 19 December 2012, DCJ received a report alleging that Gabby was being neglected in Mel's care. The reporter raised concerns regarding the condition and hygiene of the home and that Gabby and Mel were not visible within the community. DCJ were unable to locate either Mel or Gabby.
- 21 On 9 January 2013, DCJ located Mel and Gabby at the maternal grandmother's home. Gabby had severe sunburn to her face, shoulders, legs, forearms and feet. She was transported to hospital for review and treatment. Treating clinicians were of the opinion that Gabby's injuries were inconsistent with Mel's account. Gabby was removed from Mel's care by DCJ

with concerns relating to Mel's failure to seek medical treatment and her capacity to meet Gabby's basic needs.

- 22 On 11 January 2013, a SDM (Structured Decision Making) Safety Assessment was undertaken by DCJ which concluded that Gabby was "unsafe" in Mel's care. Proceedings were commenced in the NSW Children's Court and final orders were made on 4 July 2013 allocating parental responsibility to the Minister for a period of 12 months and on the expiration of that 12-month period, parental responsibility was to revert to Gabby's father until she attained the age of 18 years. Mel was given supervised contact each month with Gabby.
- 23 On 5 September 2014, Mel advised DCJ that she was pregnant with Jade and that she wanted to keep the baby once it was born. Mel also advised the Department that she had been treated for depression after the removal of Gabby, however, was no longer prescribed medication for depression.
- 24 The report was screened as a Risk of Significant Harm (**ROSH**) report and was considered at the Weekly Allocation Meeting (**WAM**) on 9 September 2014. The meeting determined that there was "no capacity to allocate" the matter to a caseworker and the report was closed due to "competing priorities."
- 25 A High-Risk Birth Alert (**HRBA**) was initiated to ensure that **DCJ** were notified of Jade's birth.
- 26 Jade was born on 5 March 2015, at Muswellbrook District Hospital. A report was made to DCJ (at the time known as Family and Community Services or FACS) notifying the department due to the HRBA. The report was screened as a ROSH report due to Mel's history, the previous removal of Gabby from her care, and concerns regarding her capacity to care for Jade. The ROSH was assigned to the Muswellbrook Community Services Centre (**CSC**). No caseworker was allocated to the family at this time.
- 27 On 6 March 2015, the Aboriginal Maternal Infant Health Service (**AMIHS**) made a referral to the Benevolent Society's (**BS**) Upper Hunter Brighter Futures (**BF**) program.
- 28 On 8 March 2015, Jade was discharged from Muswellbrook District Hospital into the care of Mel.
- 29 A further referral was made by DCJ to the Benevolent Society's BF program on 14 April 2015. The AMIHS referral was accepted by the BS on 15 April 2015. Mel signed an agreement and commenced working with BF in June 2015.

- 30 On 4 August 2015, Declan was admitted as a mental health inpatient at Maitland Hospital. The mental health record indicated that he had a history of cannabis use, appeared to be slightly dishevelled and difficult to understand, with ongoing suicidal ideation and one previous overdose. He had “violent thoughts towards others,” with distorted perception and paranoia. It was noted that he was unable to remain in his accommodation due to damage occasioned from him punching walls.
- 31 In summary, he was assessed to have a “dysfunctional background and poor family support with background of homelessness and abandonment, early onset drug use with possible drug induced psychosis. Past use of synthetic drug use.”
- 32 On 13 August 2015, a report was made to DCJ raising concerns about Declan. These concerns included his mental health presentations, his volatile and aggressive behaviour, his paranoia and suicidal ideations, possible post-traumatic stress disorder (**PTSD**) and being the subject of Community Corrections supervision due to being convicted of being in possession of a knife (kitchen knife) in a public place and theft.
- 33 The report also raised concerns about Mel’s “capacity to act protectively.”
- 34 As a result of this ROSH report, a DCJ caseworker engaged with Mel from August 2015 until February 2016.
- 35 On 15 October 2015, Jade was assessed as being “safe with a plan”. A further assessment was completed on 11 November 2015, which assessed Jade’s risk as being “high” in Mel’s care (‘moderate’ risk for neglect and ‘high’ risk for abuse).
- 36 On 16 February 2016, Declan attended a psychiatric review with the Community Mental Health Service (**CMHS**). Declan’s participation was assessed as being unproductive, with him presenting as hostile and derogatory.
- 37 On 25 February 2016, a Risk Reassessment Decision Report assessed the risk to Jade as being ‘moderate’. DCJ closed the file and made a referral to the Upper Hunter Family Support Service seeking support for Mel surrounding budgeting and her attendance at the Positive Parenting Program.
- 38 In August and September 2016, the Community Mental Health Service again attempted to engage with Declan in response to a request from Declan’s GP to review him for “continuing management of psychosis – drug induced and

bipolar disorder” in the context of him being non-compliant with his prescribed medications.

39 Declan failed to engage with the CMHS and the service ceased their attempts at engagement in late September 2016.

40 On 22 August 2016, Mel signed a private lease for the property in Redacted Street, Muswellbrook. Declan was not listed as a tenant.

41 On 15 January 2017, James was born to Mel and Declan. Mel was now the sole carer for two children under the age of two.

42 On 3 April 2017, Declan’s GP made another referral to the CMHS in Maitland requesting that they review Declan, noting that he had been non-compliant with his prescribed medication regime, being quetiapine and sodium valproate for the last six months.

43 On 3 May 2016, the CMHS advised that they had not been able to make contact with Declan.

44 On 8 June 2017, a notification was received by the DCJ ‘Hotline’ regarding the state of the house where Mel and her children were residing. The report indicated that there were numerous hazards within the house, including the unhygienic and unclean interior of the house. In addition, there was no cot or bedding, the children were not clothed (even though it was a cold day), food, bags of rubbish and broken glass were scattered on the kitchen floor, with cockroaches infesting the area. Jade was seen playing unsupervised on the driveway of the premises in the rain. Photographs of the state of the premises were provided to police after Jade’s death. In addition, there were reports of an unknown male yelling and making threats to Mel and the children.

45 This report was assigned to the Muswellbrook CSC, with a response required from that CSC within 72 hours.

46 Despite this 8 June 2017 report requiring a 72-hour response, the ROSH report was considered at the Muswellbrook CSC WAM on 14 June 2017. The Manager Client Services (**MCS**) and a Manager Casework (**MCW**) attended the meeting. The ‘concerns’ regarding the family were recorded as including, “Screen in for ‘inadequate basic care’. The household which Unknown (3) and Unknown (4 months) are living in presents numerous hazards to the children, including access to poisons (bleach), cigarette butts which the baby is getting hold of, broken glass on the floor and decaying food. The children are also inadequately dressed for the weather. Screen in for ‘inadequate supervision’ as Unknown (3) was standing out in the rain on a

communal driveway unsupervised. This presents a risk due to her age and vulnerabilities.”

- 47 A decision was made during this meeting that the ROSH should be held over until 20 June 2017, to obtain further information.
- 48 On 20 June 2017, the ROSH report was again considered. In attendance at this meeting was the **DCJ MCS**, “Ms MCS”, **DCJ MCW**, “Ms EL”, the Brighter Futures Child and Family Practitioner (**CFP**), “Ms MH” and the Brighter Futures Case Manager (and Team Leader), “Ms BFTL”. No additional material appeared to have been available, and the meeting determined that Mel and the children would be referred to the Benevolent Society’s Brighter Futures Program (Muswellbrook) and DCJ would close their file.
- 49 On 27 June 2017, DCJ Brighter Futures Assessment Unit (**BFAU**) made a referral to the Brighter Futures Intake and Brighter Futures Assessment Unit. At that time, BFAU was responsible for reviewing and processing referrals from both DCJ and community pathways. The BFAU would provide lead agencies, such as the Benevolent Society with the relevant child protection history of the family, to assist in determining their eligibility for the program. An email confirmed that the referral met the criteria for entry into the Brighter Futures program.
- 50 The referral was accepted by the Benevolent Society and assigned to its Upper Hunter Brighter Future Service. A Child and Family Practitioner (**CFP**), Ms MH was assigned to provide casework to the family under the supervision of Ms BFTL (Team Leader).
- 51 Between 11 July 2017 and 30 May 2018, Ms MH engaged with Mel. Ms MH conducted around eleven successful home visits (about one per month), as well as phone and text messaging communication, until Jade’s death on 30 May 2018.

### **List of issues considered during the inquest**

- 52 The following list of issues was prepared before the proceedings commenced and were considered and provided focus during the inquest, namely:

## **Jade's death and circumstances in the family home on 30 May 2018**

- A. Regarding Jade's death on 30 May 2018:<sup>1</sup>
  - i. How severe would Jade's symptoms likely have been in the day or days before her death?
  - ii. Is it likely Jade would have survived had she been presented for a medical review in the day(s) before her death or during morning of 30 May 2018?
- B. Regarding the care in the home in the weeks or month before Jade's death.<sup>2</sup>
  - i. Was the Mother's capacity to appropriately cope and to meet Jade's needs significantly compromised (with or without the Father's assistance)?
  - ii. Was there a significant deterioration in the quality of care in the home in the weeks or month before Jade's death?

## **DCJ prior engagement with the family**

- C. What engagement did the Secretary for the Department of Communities and Justice (DCJ) (*previously FACS*) have with the Mother between 2011 and mid-2017?
- D. Were there missed opportunities in DCJ's response to reports received between 2014 and mid-2017 including:
  - i. Premature closing of cases and
  - ii. Missed opportunities for referrals to improve parental capacity?

## **Brighter Futures prior engagement with the family**

- E. What periods of time was the Benevolent Society's Brighter Futures Program (**Brighter Futures**) engaged with the Mother before mid-2017 and what type of work did it undertake with the Mother?

## **Decision making/response at Muswellbrook CSC in June 2017**

- F. In about June 2018 what proportion of ROSH reports considered at Weekly Allocation Meetings (**WAMs**) by the Muswellbrook CSC were referred to

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<sup>1</sup> Without being exhaustive this considers (i) evidence of the Mother's reports to Brighter Futures in the weeks before Jade's death, (ii) evidence of the parents' accounts about Jade's death about how Jade presented in the day(s) before her death, (iii) the findings in autopsy and (iv) the opinions of Dr Dominic Fitzgerald.

<sup>2</sup> Without being exhaustive this considers (i) past DCJ intervention with the Mother's first child, (ii) condition of the residence during 2017, (iii) Jade's illness and cause of death and (iv) the condition of the premises as found on 30 May 2018.

Brighter Futures by Muswellbrook CSC and then closed, as compared to those assigned a DCJ caseworker response?

- G. Regarding the decision of the Muswellbrook Community Service Centre (**CSC**) in late June 2017, to (a) refer Jade's family to Brighter Futures and (b) to close its case (**the Decision**) in response to a ROSH report made 8 June 2017 (**June 2017 ROSH Report**):
- i. What risks reasonably arose for Jade and her sibling at that time (based on information that was available or reasonably available to DCJ)?
  - ii. Was the Decision reasonable given those risks?
  - iii. Assuming DCJ had not closed its case, what might DCJ casework with the family have looked like (e.g. frequency of caseworker contacts and potential duration of engagement)?
- H. As to how the Decision was arrived at:
- i. What information was considered by the Muswellbrook CSC decision makers outside the June 2017 ROSH Report (e.g. were DCJ records made between 2011 and mid-2017 considered)?
  - ii. What conclusions did the Muswellbrook CSC decision makers reach about the risks to Jade and her sibling in the home without DCJ intervention? What was documented in regards to that assessment of risk?
  - iii. Was there a requirement to carry out (a) a risk assessment or (b) safety assessment decision report before closing a case (with or without a referral to Brighter Futures)? Was that done in Jade's case?
  - iv. Regarding the referral made to Brighter Futures:
    1. What service did the decision makers expect Brighter Futures would provide to the family and what was the goal of the referral?
    2. What were the decision maker's expectations as to (a) the potential duration of Brighter Futures' engagement with the family and (b) the frequency of the Brighter Futures caseworker's contact with the family during that engagement?
    3. Did the guidelines for referral require there be a documented risk assessment or safety assessment decision report before referral? Did the guidelines preclude a referral if the risk was

assessed at a certain category (e.g. “high”, “very high” and/or “unsafe” or “safe with plan”)?

4. Did DCJ, in its referral to Brighter Futures, provide sufficient particulars about the Mother’s background, the removal of her first child and the reason for that removal, to enable Brighter Futures to properly assess the family and potential risks to be alert for?

- I. Was the decision making adversely impacted by:
  - i. An inadequate appreciation by the decision makers of the risks posed to Jade and her sibling?
  - ii. Caseworker capacity/workload at the Muswellbrook CSC at that time?

**Brighter Futures’ engagement between mid-2017 and May 2018**

- J. Were there deficiencies in the Brighter Futures acceptance of the referral, case planning and its response to specific events between mid-2017 and May 2018, including:
  - i. Regarding the removal of the Mother’s first child:
    - 1. Was the Brighter Futures team aware of the earlier removal when it accepted the referral in mid-2017?
    - 2. Was information about the earlier removal contained in records previously made by Brighter Futures and, if so, did the Brighter Futures team review those when the referral was accepted in mid-2017?
    - 3. Did the Brighter Futures team involved with the Mother in mid-2017 to May 2018 learn of the earlier removal during their engagement (e.g. from statements by the Mother)? If so, what did they do in response to learning that?
    - 4. Should the earlier removal been factored into planning around frequency of face to face contact with the family and identifying risks to be alert around (e.g. possible medical neglect)?
    - 5. Were there any missed opportunities to request further information about the Mother and the family from DCJ?
  - ii. Should Brighter Futures have notified DCJ about the concerns raised with the Mother, and observations made of her, by Brighter Futures workers during their home visits on 8 March and 22 March 2018?

- iii. Should Brighter Futures have escalates its intervention when the Mothr cancelled or rescheduled home visits between late March and May 2018; including when the Mother cancelled a scheduled home visit on the morning of 30 May 2018? If so, what might that have involved (e.g. report to DCJ if the Mother would not consent to home visit occurring as scheduled?).

### **Current arrangements**

- K. Regarding the Musswellbrook CSC to present:
  - i. How does its current caseworker capacity, and allocation of ROSH to caseworkers for response, compare to that which existed in June 2017?
  - ii. Have DCJ practices and training changed since June 2017 in ways that are likely to enhance DCJ manager and caseworker’s appreciation of risk in neglect cases? If so, how?
  - iii. How might the Muswellbrook CSC respond assuming it received the 2017 ROSH now? How might that differ as compared to how it responded in mid-2017?
- L. Regarding Brighter Futures, have there been changes to its practice and procedures since Jade’s death that likely change how it assessed a referral, planned casework and its engagement with a parent in circumstances like those that arose in Jade’s case? If so, in what are those?

### **Other**

- M. Are there any other lessons that can be derived from Jade’s death?

### **Events on 30 May 2018**

- 53 Jade’s last known attendance at her GP, Dr Mullins, occurred on 11 October 2017, after Jade had reportedly swallowed a 5-cent piece.
- 54 Mel gave an account to Police that Jade had a ‘cold’ about two weeks prior to 30 May 2018, however, she had made a full recovery. Mel also stated that Jade had developed cold or flu-like symptoms within the week prior to her death.
- 55 Mel indicated that on 29 May 2018, Jade had a ‘chesty’ cough, a sore throat, lethargy and a reduced appetite. Mel stated that when she put Jade down to

sleep that evening, Jade did not have a temperature but recalled that her voice sounded “unwell” or “affected”.

56 Jade woke up at around 7am and had a drink. Her father, Declan arrived for a visit. Jade asked for another drink of milk and then fell asleep.

57 At 7.48am on 30 May 2018, Mel sent a text message to Ms MH at Brighter Futures stating, “Hey. How are you? Jade is currently sick at the moment. I think its (sic) the flu with the sound of her voice, could we do a phone call or reschedule for when she gets better. I’ve been up most of the night with her. I have to get her medicine today.”

58 At 8.34am, Mel contacted the Brooks Medical Centre and arranged an appointment for Jade that afternoon.

59 At 8.52am, Mel messaged Ms MH stating, “Sorry. Didn’t meant to call. James had my phone. I called the doctors when they opened, and they said that Jade can see the emergency doctor this afternoon. Still getting medicine though, Declan got paid today so I just called him up and he’s seeing if a pharmacy open yet.”

60 At 9.20am, Declan attended the Muswellbrook pharmacy and purchased Nurofen, Gastrolyte and Duro-tuss, and returned to the unit. Jade was given Nurofen soon afterwards. Mel and Ms MH exchanged further text messages. At 9.25am, Ms MH messaged Ms TS, and advised Ms TS that the home visit had been cancelled for that day.

61 Shortly before 2pm, Mel attempted to wake Jade to get her ready for her medical appointment. Jade did not respond, and Mel noticed that Jade’s eyes were partially open. Mel thought that Jade was drowsy and still waking up. Jade had not bathed for several days, and Mel took her to the shower to assist her in waking up. Mel held her under the shower, however Jade remained unresponsive. Mel told Declan to contact triple zero.

62 At 2.03pm, Declan contacted triple zero.

63 At 2.09pm, ambulance paramedics arrived at the unit. Mel, Declan and James were in attendance. Mel was noted to be in a highly distressed state.

64 Paramedics entered the lounge room and found Jade lying on her back on the floor. She was not breathing and was cold to the touch. Her teeth were

tightly clenched. The paramedics commenced CPR and noted that Jade had a ‘non-shockable rhythm.’ Jade was transported by ambulance to Muswellbrook Hospital where resuscitation attempts continued until 2.43pm, when she was declared deceased.

65 Police and paramedics reported that the home was in an extremely squalid state. They noted significant amounts of rubbish, rotting food in the kitchen, together with the associated stench, clothing and other items strewn throughout the living areas and large numbers of cockroaches throughout the unit.

66 Police and paramedics noted that Jade’s hair was cut short and infested with headlice. Clumps of her hair were found on the floor in the lounge room and the bathroom areas. Mel told the responders that she had cut Jade’s hair the week before as she had not been able to cure her head lice issues.

### **Cause of Jade’s death**

67 On 1 June 2018, Dr Jane Vuletic, Senior Staff Specialist in Forensic Pathology conducted an autopsy. Dr Vuletic concluded that the cause of Jade’s death was “Bilateral Bronchopneumonia (Streptococcus Pyogenes/Staphylococcus Aureus)” on a background of neglect.

68 Dr Vuletic prepared a post-mortem report which noted the following:

- a. A CT scan showed no evidence of skeletal trauma and there “were no signs of injury”.
- b. There was no evidence that her death was due to anything other than natural causes.
- c. An external examination showed “an extreme head lice infestation” and her hair had been cut short in a crew cut style.
- d. An internal examination showed “bronchopneumonia in both lungs. Microbiological testing of both lungs was reported to show the presence of Streptococcus pyogenes and Staphylococcus aureus which are both respiratory pathogens. There were no viral pathogens detected.”
- e. “Sections of the heart and liver showed necrosis, the pattern indicating an episode of cardiovascular collapse a number of hours

prior to death, which was “consistent with septicaemia secondary to the documented bacterial infection in the lungs”,

- f. "Biochemical analysis of a sample of vitreous fluid showed a raised level of urea indicating renal failure. The level of beta hydroxybutyrate was raised and is likely to indicate a period of starvation prior to death. The presence of food in the stomach does not indicate when the last meal was eaten as gastric emptying time is often delayed in conditions of illness, trauma or stress."
- g. The toxicological examination showed a therapeutic level of Ibuprofen. "There was no evidence of alcohol or common drugs of abuse".

69 Professor Dominic Fitzgerald, Paediatric Respiratory and Sleep Physician, provided an expert opinion in a report dated 2 October 2021.

70 Professor Fitzgerald noted that Jade’s symptoms were not consistently documented and that it is probable that Jade had been unwell with an initial viral infection for at least a week, possibly longer. He was of the opinion that Jade would have become “more lethargic, had a fever, been coughing, refused food, and had less fluids to drink, reduced urine output, become pale and cool to touch in the peripheries and finally become unresponsive”.

71 He commented that Jade was likely to have become more unwell, with a more serious bacterial infection, being pneumonia, which would have evolved over days. It is also likely that her condition deteriorated precipitously in the 12 to 24 hours before death.

72 Professor Fitzgerald opined that the “likely sequence of events, supported by the history of a runny nose a week prior to the death, would have been an initial viral upper respiratory tract infection preceding a secondary bacterial infection in the lungs. This may occur with local inflammation of the respiratory tract, altered mucosal defences against bacteria residing in the airways (or skin) and the bacterial infection within the lung resulting in pneumonia due to streptococcus pyogenes and staphylococcus aureus”.

73 He noted that “Bacterial pneumonia may be complicated by fluid collections in the pleural space” as seen at autopsy, and “such pleural collections compromise the effective expansion of the lung, reduce the ability to breathe deeply, and compromise gas exchange, thereby contributing to respiratory failure and death. These pleural collections would be drained in

a child with pneumonia as they may be infected with bacteria, a complication of pneumonia known as empyema.”

- 74 Professor Fitzgerald commented that “The combination of pneumonia with renal failure and starvation would reflect the progression of an untreated bacterial infection with dehydration related to poor oral intake of fluids and reduce blood volume, reduced left ventricular function (ability of the left side of the heart to pump effectively), falling blood pressure and reduced perfusion of vital organs such as the kidney, brain and heart. Poor blood perfusion of the kidney from low blood pressure results in renal failure, poor urine production and elevated salts (electrolytes e.g. potassium) in the blood which can contribute to abnormal heart rhythms and cardiac arrest”.
- 75 Professor Fitzgerald noted that the consequences of dehydration evolve usually over days not hours in this setting of pneumonia.
- 76 Professor Fitzgerald opined that Jade’s “condition was not appreciated in Jade’s mother’s statement and the time sequence of deterioration is vague. The notes by the ambulance officers are consistent with the view that Jade had been extremely ill for some time when they started their resuscitative efforts. The inability to resuscitate Jade and the post mortem findings are consistent with her being very unwell for longer than was appreciated by her mother.”
- 77 He stated that it is “extremely uncommon for a previously well child aged 3 years to die from bacterial pneumonia when presented to medical care in New South Wales” and it was beyond doubt that “with a more timely presentation Jade’s death was almost certainly avoidable.”
- 78 Professor Fitzgerald agreed with Dr Vuletic that ‘neglect’ was a contributing factor to Jade’s death. He stated that “the neglect is seen as multifactorial and not necessarily all attributable simply to maternal parenting deficiencies and poor perception of the presence of and consequences of illness.”
- 79 On the balance of probabilities, there is evidence which allows the Court to be satisfied that Jade died from “bilateral Bronchopneumonia (Streptococcus Pyogenes/Staphylococcus Aureus) on a background of neglect.

**Department of Communities and Justice, Muswellbrook Community Service  
Centre (CSC)**

- 80 Every CSC in NSW is based on a hierarchical supervision structure. A Manager Client Services (**MCS**) has overall responsibility for the supervision of the CSC's casework team. A Manager Case Worker (**MCW**) reports directly to the MCS. A MCW has direct supervision of the caseworkers that have been assigned to the MCW.
- 81 A caseworker usually has the most direct contact and engagement with a family. At Muswellbrook CSC in mid- 2017, there were 13 caseworker positions allocated to child protection teams, which could respond to Risk of Serious Harm (ROSH) reports.
- 82 The DCJ "Helpline" receives reports from mandatory reporters and members of the public. These reports are assessed and may be allocated to a CSC as a ROSH report. Allocated ROSH reports are considered by a triage manager (MCW) and a triage caseworker at a pre-Weekly Allocation Meeting (pre-WAM). The pre-WAM triage process involves the review of records held by DCJ about the child or parent, as well as accessing additional information from other sources, such as medical or education providers. In some cases, the case may be closed at the pre-WAM stage.
- 83 In other cases, the triage manager will identify ROSH reports which are to be considered at the Weekly Allocation Meeting (**WAM**). The WAM is a weekly meeting where active ROSH reports are reviewed by the MCS, the triage MCW and the triage caseworker.
- 84 The purpose of the WAM is to determine what type of response should be provided to each ROSH report. The available options include,
- a. Allocating the matter to a caseworker for a face-to-face safety and risk assessment (**SARA**), and or,
  - b. Referring the matter to a non-government organisation, or a DCJ funded service, such as the Brighter Futures Program, and or,
  - c. Closing the ROSH report, or
  - d. Holding the case over to the next WAM to obtain further information to support future decision making.
- 85 In determining whether ROSH reports are allocated to a caseworker for face-to-face assessment with the family, consideration is given to a caseworker's

current case load; as well as the urgency and magnitude of risk disclosed on the available information.

- 86 If a ROSH report is assessed as warranting a caseworker safety assessment, but there is no capacity to allocate the case to a caseworker due to case load, the matter may be held over to a subsequent WAM. If a matter has not been allocated, transferred, referred or closed within 28 days of the ROSH report being made, it cannot remain at the WAM stage and must be closed without further action being taken.
- 87 After a matter is allocated to a caseworker for assessment, the caseworker will usually undertake a home visit and complete a SARA based on a standardised decision-making tool.
- 88 The possible outcomes of the safety assessment component of the SARA are: “Safe” without a plan, “Safe with a plan” or “Unsafe” (even with planning the child was still assessed as being unsafe in the placement).
- 89 Within 30 days of completing the safety assessment component of the SARA, the Risk Assessment component of the SARA must be completed. The possible outcomes of a Risk Assessment are “low”, “moderate”, “high” or “very high”.
- 90 The 8 June 2017 ROSH Report was considered at two WAMs at the Muswellbrook CSC. At the second WAM, the decision was made to refer the family to the Benevolent Society’s Brighter Futures Program at Muswellbrook, (**TBS BF Program**) and close the file at DCJ.

### **The differences between casework provided by the CSC compared with the casework provided by the Brighter Futures Program**

- 91 Under the CSC model, a majority of the CSC’s caseworkers are assigned to undertake statutory child protection responses. The typical response commences with a safety assessment (as part of a SARA) due to a ROSH report being received. Some cases progress to a stage requiring an exercise of DCJ’s statutory powers, specifically, initiating proceedings before the Children’s Court of NSW for consideration of ‘care’ orders. A minority of the CSC’s caseworkers are assigned to the supervision of placements directed by the Children’s Court and known as Out of Home Care placements.
- 92 In practice, the CSC model provides a short-term statutory child protection response. DCJ caseworkers do not usually undertake direct casework with

the family for the purposes of enhancing parenting capacity in the home over the medium to long term. DCJ typically relies on external agencies or non-government organisations to deliver the longer term casework.

- 93 The Brighter Futures Program is designed as a future oriented program specifically directed to the development of parental capacity. The program is not intended to provide statutory child protection casework of the kind provided by DCJ.
- 94 Brighter Futures Program caseworkers are not vested with statutory powers to compel a parent to engage or submit to an assessment nor participate in the implementation of a case plan. The casework and assessments are intended to be directed to capacity building with the parents. The program does not conduct assessments as provided in a SARA, nor does it provide a **SARA** style safety plan.

#### **The criterion for referring matters to the Brighter Futures Program in July 2017**

- 95 Prior to July 2014, a family that was the subject of a ROSH report was not eligible for a referral to the Brighter Futures program. In July 2014, the guideline was amended to allow the referral of families the subject of a ROSH report, with certain exceptions. By 2017, the majority of referrals from DCJ at Muswellbrook CSC to the Brighter Futures program were for children that were the subject of a ROSH report.
- 96 Eligibility for the Brighter Futures' program is governed by Guidelines issued by DCJ. The *2015 Brighter Futures' Guidelines* were in force as of June 2017 and were superseded by the *2017 Brighter Futures' Guidelines* in July 2017.
- 97 The Guidelines state that a referral could be made:
- a. Directly to a service provider, or
  - b. Where a Safety and Risk Assessment (SARA) had been undertaken by a CSC caseworker who had assessed the safety decision as "safe" and the risk assessment as "high" or "very high", or
  - c. As part of a 'step down" referral following Intensive Family Preservation Service (**IFP**) engagement.
- 98 The criteria for a referral pursuant to the *2017 Brighter Futures' Guidelines* included the following:

- a. The family has at least one child under 9 years of age at home, or the family are expecting a child who will be at high risk of entering the statutory child protection system, and
- b. The parent's capacity to parent, or the child's safety and wellbeing might be impacted by domestic/family violence, substance misuse, parental mental health issues or lack of parenting skills, and
- c. The family has been the subject of three or less ROSH reports in the preceding 12 months, with a safety and risk assessment having been completed within the last 28 days where the safety rating is "safe" and the family's final risk level is assessed as "high" or "very high", but there is no current risk of the child being removed from the family, or
- d. There has been a "step down" referral from an IFP provider which was successful and there is no longer a risk of removal of the children.

99 The criteria for excluding a participant family included:

- a. Where the risk of significant harm is so high that a Brighter Futures service is unlikely to adequately ensure a child's safety, although the guidelines provide no specific guidance as to how this determination is to be assessed, or
- b. Where there are indications of long-standing, deliberate physical or physical abuse/harm in the family, or ongoing risk of child sexual abuse, or
- c. If a household member or adult with care responsibilities is the subject of current criminal proceedings relating to an allegation of abuse or neglect or a child, or
- d. Where the safety of workers or others working with the family would be seriously compromised and the service provider could not reasonably manage the risk to their staff.

100 The criteria for eligibility appeared to be broadly framed and appeared to permit the referral of families where a child may be at "high" or "very high" risk in the home.

## The Brighter Futures program

- 101 DCJ contracts 16 non-government service providers or “lead agencies” to provide the Brighter Futures Program across NSW.
- 102 The Brighter Futures program is intended to provide family preservation services. It is offered as a voluntary “short term” early intervention program for “vulnerable families” with children aged between 0 and 9 years and considered to be at high risk of entering or escalating within the statutory child protection system. It aims to reduce the rate of ROSH re-reports and the rate of entry into, and the length of time spent in, statutory out of home care (**OOHC**).
- 103 A Brighter Futures’ provider will assign a practitioner to provide casework to the child and their family. Casework with the family will typically last up to 12 months, although it may continue for up to 24 months. The primary focus of the casework is on improving parenting skills and capacity in the home. This is achieved through engaging in home visits, supporting the family to engage with other services and develop supportive networks. In addition, it focuses on providing practical support and advice to families about appropriate care for their children.
- 104 In 2017 and 2018, The Benevolent Society was contracted by DCJ as the lead agency for the provision of the Brighter Futures program in the Upper Hunter region.

### Referral of Jade’s case to Brighter Futures

- 105 In June 2017, DCJ formally made the referral of Jade’s case to the Brighter Futures Assessment Unit (**BFAU**) in Parramatta on 22 June 2017. As part of the referral process, DCJ required the BFAU to be satisfied that the referral was in accordance with the Brighter Futures Guidelines. The BFAU applied the 2015 Brighter Futures Guidelines which were relevant to this assessment conducted on 27 June 2017. This referral was made without a caseworker SARA being conducted.
- 106 The referral email from DCJ to BFAU contained the following information:
- the family had been known to DCJ since 2014,
  - Children aged 2 years, 3 months,

- prior removal of Gabby in 2013 (“6yo was removed from her mother's care due to failure to seek medical attention and concerns about mother’s parenting”) and the outcome of the related Children’s Court proceedings,
- provided a summary of the information reported to the Helpline on 8 June 2017 (the **2017 ROSH Report**),
- prior referral to the TBS Upper Hunter Brighter Futures’ program in 2015 and the report on 12 August 2015, including “concerns for 2yo due to Father’s mental health issues and unpredictable, volatile, aggressive behaviour and concerns around Mother’s protective capacity around this.”,
- chronological list of reports made to the Helpline regarding Mel during her childhood,
- notation that the “lead agency” (TBS Brighter Futures) was responsible for determining if the referral should be accepted, with the information provided in the referral email intended to assist it, if needed, to gather information under Chapter 16A to determine the family’s eligibility.

- 107 The arrangement between the Muswellbrook CSC and the TBS Upper Hunter BF service did not appear to stipulate how quickly a referral should be made to the support service after receipt of the ROSH or a WAM referral. In Jade’s case, the first home visit was conducted two weeks after the referral was made.
- 108 Despite being inconsistent with the intent of the legislation, a referral to a support agency without a SARA being undertaken, had the effect of empowering a support agency to attend a home for the purpose of conducting a home visit.
- 109 A support agency such as BF is a mandatory reporter under the legislation. A support agency support worker is mandatorily obligated to report any concerns to the DCJ Helpline.
- 110 There are clear limitations on a BF support worker conducting a home visit or providing services, as the support worker is not attending in the capacity of a statutory child protection responder. Rather, they are attending to provide a voluntary service focused on building parenting capacity. A referral to BF for support services is dependent on the parents’ voluntary participation with the service and the parents cannot be compelled by BF workers to engage with the service. It was never intended that the role of a

support agency would be used to substitute for a statutory protection assessment.

111 The Benevolent Society (TBS) conducted a critical incident review after Jade's death. The review determined that further information should have been sought regarding the prior removal of Gabby from Mel's care. The review concluded that the risk of medical neglect was a matter which required consideration to determine the family's eligibility and ongoing engagement with the family.

112 Ms MH gave evidence that:

Q. Is the fact that the mother's first child had been removed by the Secretary, that would be a significant matter?

A. Yes, in this particular case though, it had already gone through an assessment, Mel had gone through an assessment for Jade previously, and so we also take that into account that she had been – she had received that case work and that she had received that case work support and that the – and that the department had determined that she was capable of providing care to Jade and future children at that stage. (emphasis added).

113 It is unclear from Ms MH's testimony which assessment she was referring to in her evidence. Muswellbrook CSC undertook a number of assessments in 2015 – 16, including a *Risk Reassessment Decision Report* on 25 February 2016. Each of these assessments were conducted and prepared in the absence of Declan. In early October 2015, the CSC caseworker, Mr MN stated that he had to carry out a "safety assessment to assess how Declan's mental health will impact Jade." Declan did not attend any assessment review with Mr MN after this time. On 11 November 2015, Mr MN completed a *Risk Assessment Decision Report*, where he assessed the "Final Risk Level" as "High", consisting of a "Moderated" risk for neglect and a "High" risk for abuse.

114 As at June 2017, the ROSH report concerned issues of neglect, as well as a report of potential domestic violence against Mel and Jade. Given Mel's personal history of being a survivor of domestic violence as a child, it is concerning that little or no weight appears to have been afforded to this potentially harmful and debilitating environment, by either the CSC or BF, during the referral process. Indeed, it was not known whether Declan was residing at the home or was a frequent visitor.

115 The evidence confirms that by 2017, TBS Upper Hunter BF service went beyond merely providing an intensive family preservation service. The **BF**

service was providing a de facto child protection response when the Muswellbrook CSC lacked capacity to allocate a caseworker in response to a confirmed ROSH report. Despite the seriousness of the June 2017 ROSH Report regarding Jade's family, and the lack of any meaningful assessment, it was unlikely that the BF service would have declined the referral.

116 Ms EL stated in her written statement that:

“By June 2017, BF was carrying cases that were much higher risk. I cannot say whether they were still considered an early intervention program, but certainly by this time they had stopped operating as an early intervention service.”

117 Ms BFTL stated:

“Yes I agree that BF was used to provide services greater than early intervention. However, I also consider that during 2017 the relevant guidelines were vague about appropriate referrals. [The Brighter Futures] guidelines were reissued and had the effect of excluding a lot of referrals that would have previously been sent through...”

118 The evidence is unclear as to what would have occurred to Jade's case if the referral to BF had been declined by that service after the CSC had made a referral and closed its case.

### **Brighter Futures Child and Family Practitioner's engagement with Mel from July 2017 – May 2018**

119 Ms MH, Child and Family Practitioner, engaged with Mel from 11 July 2017 until 30 May 2018. During this period, 10 home visits were conducted with Mel. The first home visit occurred on 11 July 2017. Mel did not permit Ms MH to enter her home, and they spoke at the front door. Ms MH was concerned with Mel's presentation and the possibility that she may have been drug affected. Ms MH contacted the police requesting that they conduct a welfare check on the occupants of the house. Police conducted a check and reported no concerns. On subsequent visits, Ms MH did not observe any overt signs of drug use, except possibly on 22 March 2018. She gradually developed a rapport with Mel.

120 During the third home visit on 7 August 2017, Mel told Ms MH that her real estate agent had initiated proceedings before the Tenancy Tribunal, due to

the state of the unit and rent arrears. On 17 August 2017, Ms MH provided support to Mel before the Tribunal and the proceedings were adjourned.

- 121 On 2 September 2017, Ms MH developed a BF Resilience Plan, which largely focused on obtaining brokerage funds to assist with repairs and cleaning the residence and avoiding eviction. In addition, the Plan noted that Mel was a single parent with significant levels of anxiety and appeared overwhelmed.
- 122 By mid-September 2017, the Tenancy Tribunal proceedings were withdrawn with the assistance of Brighter Futures and the Hunter Tenants Advice and Advocacy Service.
- 123 On 2 November 2017, a second BF Resilience Plan was prepared by Ms MH. The additional goals outlined in the Plan included assisting Mel to address her “anxiety with her medical practitioner” with Mel to “attend GP’s appointments to address her current and historical levels of anxiety. Mel to consider a referral to an appropriate counselling professional”. Ms MH noted that Mel would “benefit from greater supports in the area and accessing additional local activities such as playgroup and library time. This would benefit Mel to respond more to her children’s needs to have contact with other children and places. Mel’s anxiety prevents her ability to do these things on a regular basis.”
- 124 Significantly, Ms MH noted that Mel presented with signs of moderate anxiety and had disclosed struggles with anxiety during the assessment period, stating that Mel would benefit from “addressing her anxiety between her medical practitioner and a professional counsellor/psychologist. While Mel has some reasonable coping strategies in place, she also has well ingrained avoidance strategies in place as a coping mechanism. These include remaining inside the property at length, avoiding phone calls on a regular basis and not engaging in the community from a fear base of overthinking her parenting on display.”
- 125 Ms MH’s notes confirm that contact frequency with Mel would be “fortnightly”. Her notes also refer to the ongoing concern that Mel’s “GP appointment pending – lack of sleep, anxiety...”
- 126 The real estate agent conducted an inspection on 15 December 2017. Ms MH and the Hunter Services representative were present to support Mel. Mel confirmed that she was covering her rental payments, however, was not consistently paying arrears. The real estate agent was satisfied with the state of the premises.

- 127 On 18 January 2018, Ms MH conducted her seventh home visit with Mel and her family. Ms MH noted that Mel and James looked tired, and Mel reported “feeling a little bit down lately and overwhelmed at times.” Mel confirmed that she had not attended her GP for a mental health care plan or review of her mental health.
- 128 On 31 January 2018, Ms MH advised Mel that her case plan was “up for review”. Mel enquired whether she “had to stay open with the program, with Ms MH advising that she did have the option to close. Ms MH discussed that there were no immediate concerns, provided she followed up with her mental health if necessary.” Mel was provided with her options, including a referral to Muswellbrook Family Support.
- 129 On 7 March 2018, Ms MH received information that suggested that Jade had been left unsupervised, and that Declan had been verbally abusive towards Jade, and that police had attended the home due to reports of screaming. Ms MH consulted with her Team Leader, Ms BFTL. They agreed that Mel should be presented with this recently acquired information and provided with the option of continuing with an additional three-month Resilience Plan.
- 130 A third Resilience Plan was developed by Ms MH and dated 8 March 2019. Ms MH noted that the plan included engaging Mel “in reviews of the common parenting strategies and learnings from previously attend parenting courses in a manner that is direct to Mel and her children.” In addition, Mel was “to complete the necessary paperwork for Jade to attend (pre-school) in time for her to start on either 15/3/18 or 22/3/18. Mel has been offered two days.”
- 131 On 22 March 2018, Ms MH attended Mel’s home and noticed that Mel had bruising under her eyes and ‘scabs’ and bruising on her arms. Mel disclosed to Ms MH that she had consumed alcohol the previous weekend when she visited her grandmother in Newcastle. Ms MH recorded her concerns as to whether Mel was using methylamphetamines.
- 132 On 28 March 2018, Mel cancelled the home visit, which was scheduled that day, citing ‘illness’.
- 133 On 4 April 2018, Ms MH attended at Mel’s home and a further discussion occurred regarding her recent black eye. Ms MH noted that when she attempted to enter Jade’s bedroom, Mel quickly shut the door, stating that she was embarrassed that some cockroaches were present in the house.

- 134 On 1 May 2018, Ms MH attended Mel's home to collect immunisation records for Jade's pre-school enrolment. She did not gain access to the home; however, she was able to see inside the lounge room and kitchen.
- 135 From March to May 2018, the primary focus of the Brighter Futures plan was to support Mel to enrol Jade at Muswellbrook Preschool in mid-March. Jade never attended preschool as planned.
- 136 Between 3 May and 30 May, various phone calls or text messages were exchanged between Mel and Ms MH. Many of these calls related to attempts to schedule home visits, as well as confirming the progress of Jade's enrolment at preschool.
- 137 On 25 May 2018, a text message exchange confirmed that Jade had head lice and would be unable to attend preschool until her condition had cleared.
- 138 On 28 May 2018, a case file note stated that Mel was advised if the "next home visit was cancelled, a cold call would then be completed due to the cancellations."

**Should Brighter Futures have made a ROSH report following the 22 March 2018 home visit?**

- 139 The BF's primary objective in assisting families is to increase the capacity building of parents to reduce the risk of their children being removed from their care and being placed in statutory out of home care.
- 140 The evidence indicates that Ms MH was able to establish a rapport with Mel over a number of months during 2017-18. This was particularly significant given Mel's personal childhood history and the removal of her first child, Gabby.
- 141 On 31 January 2018, Ms MH indicated to Mel that her case plan was due for review. They discussed the options of closing her case or continuing with BF or accepting a referral to Muswellbrook Family Support.
- 142 On 8 March 2018, Ms MH discussed the report received from police regarding Declan's behaviour. Mel denied the allegations, however agreed to receive assistance from BF for a further three months, "as she did not want to close with worries listed and unaddressed."
- 143 On 22 March 2018, Ms MH observed Mel to have bruising under her eye(s), scabs on her arms, and small bruising on her arms which Ms MH thought

may be consistent with her having been grasped on her arms by a third party. Mel also attempted to conceal the bruising to her eyes by wearing sunglasses, which she removed after being requested to by Ms MH. Mel also admitted to having consumed alcohol the weekend before at her grandmother's home.

144 Ms MH made contemporaneous notes which reflect her concerns that Mel may have been using methylamphetamines, given the scabs on her arms and her “slightly hyper” appearance. It is noted that Mel did not have a history of drug misuse. Ms MH also doubted Mel’s explanation for the bruising to her eyes and suspected that they had been occasioned due to violence rather than accident.

145 Ms MH discussed her concerns with Ms BFTL, her supervising Team Leader. Ms MH indicated in her statement that:

“Upon discussion with my team leader, we decided not to report the matter to DCJ, considering the following:

a. My observations, while concerning, were based on suspicions of substance use by Mel and did not provide concrete evidence of immediate risk or harm to the children. I did not observe any immediate risk to the children during my visit;

b. There was a need to balance the potential benefits against the risk of further alienating Mel from the support system, which could have been detrimental on the children’s welfare; and

c. The voluntary nature of the Brighter Futures program necessitated a careful approach to maintain engagement with the family, especially given Mel’s history of distrust towards authorities and her fear of losing her children.”

146 It is accepted that maintaining a trusting relationship was an important and reasonable consideration in Mel’s case. It does not however obviate the requirement to report reasonable and significant concerns regarding a child, even if those concerns are based on suspicion or unverifiable facts. The paramount consideration should be the safety, welfare and wellbeing of a child who is under the care of a parent. The reporting requirement is designed to ensure that suspicions that potentially give rise to a risk of significant harm are reported to the Helpline to enable the Secretary to determine whether further investigation or assessment is required.

147 Section 27 of the *Children and Young Persons (Care and Protection) Act 1998*, (the Act), requires a mandatory reporter (in this case, a professional

worker providing children's services), who suspects on reasonable grounds that a child is at risk of significant harm, must make a report to the Secretary for DCJ, as soon as is practicable.

148 Ms Susan Mattick, the Executive District Director for DCJ, confirmed that the Secretary's view was that the application of the *Mandatory Reporters' Guide* should have led to the conclusion that the observations made during the 22 March 2018 home visit, and the potential risks indicated by these observations, satisfied the risk of significant harm threshold of "inadequate supervision" and should have resulted in the making of a mandatory report to the Helpline.

149 Ms BFTL gave oral evidence during the inquest, stating:

"Additional factors contributing to the decision to not report was additional pressure from the funding body (DCJ) to not be "over reporting" for matters that would be remaining open with BF for ongoing case management and also due to the known capacity of the Muswellbrook CSC to allocate matters."

150 Ms BFTL continued, stating:

"Information was being provided at monthly management meetings within the Benevolent Society to the leadership team from the CPO by the Regional Manager. I think this is known as Community Partnership Officer. However, I am not one hundred percent sure. It is the position that oversees our program with DCJ as the funding provider. The information included concerns with rates of reporting within the Brighter Futures program. Further, it was that Brighter Futures needed to focus on managing the risk through the provision of the Brighter Futures program. I understood that some reports being made were within the threshold of risk for Brighter Futures to manage. Further, the number of reports made to the helpline was also being captured in our data rates of reporting for open or recently closed families. I also note that [post March 2018] the Brighter Futures Guidelines were reviewed with an outcome being the imposition of restrictions on referral eligibility. It is important to note that Brighter Futures was working with too high a level of risk. For example, a family cannot be referred if they have received a 24-hour report within the past 12 months that has not had a Safety and Risk Assessment completed by DCJ."

151 Ms BFTL's reference above to "concerns with rates of reporting within the Brighter Futures' program" related to families which were already the subject of ROSH reports or had been assessed to be at high risk. In addition, Muswellbrook CSC was routinely receiving more ROSH reports than it could

allocate to a caseworker for assessment, and it was unlikely that a further report to the Helpline by a BF practitioner would result in a caseworker being allocated.

152 Both Ms BFTL and Ms MH were of the view that if a mandatory report had been made by a BF's support worker, Muswellbrook CSC would in all likelihood have requested that BF continue with its engagement with the family, rather than opening a file and allocating a caseworker. In some cases, rather than making a report, a BF's practitioner would contact the CSC and discuss the case.

153 Ms BFTL gave oral evidence that there was an "overarching message" from regional managers not to lodge mandatory reports regarding families that they were already engaged with, however, her decision to advise Ms MH not to report her concerns to the Helpline was not ultimately the reason for her decision or advice.

154 Ms BFTL gave oral evidence as follows:

"Q. Well just to clarify with you. When you've stated in the statement, "Additional factors contributing to the decision not to report", it seems to be that you're pointing to overreporting and that being discouraged as something that factored into your decision not to report?

A. Yes

Q. But as I understood your earlier evidence, you said that that wasn't necessarily part of -

A. I, I honestly, I don't believe that it did implement my decision on that day and that occasion, but the overarching informational messaging that we did receive over that time period was not to be overreporting and things as well.

Q. Can you just elaborate on what the messaging was around that?

A. Yep. So the CPO – apologies, I really can't remember what that actually stands for, but the CPO is the DCJ funded position that oversees the program for Brighter Futures for the region. They would provide feedback and information to the regional manager as Brighter Futures and there were the comments made around that Brighter Futures were overreporting families, that we do work in that respace. If we are working with families, we need to be comfortable to work within some of that respace and not report everything if we're going to continue working with families, or word to those sort of effect.

Q. Can you recall when that messaging began or occurred?

A. It's generally quite a consistent message whilst I was a team leader. It's also that's capture in our data reporting as well around families where re-reporting has occurred and things as well.

Q. Just to understand how you were made aware of that, and you've said the CPO communicated that to the regional – was it the regional manager?

A. Yes, regional manager, yeah”

155 Ms MCS, DCJ Manager Client Services (MCS), confirmed in her oral evidence that “there was an education campaign that DCJ were doing with funded service providers where they were trying to reduce re-reporting of matters that were already open on issues that were already known.”

156 It is unlikely that a DCJ caseworker would have been allocated Jade's case at Muswellbrook CSC had a mandatory report been made by BF to the Helpline regarding the 22 March 2018 home visit due to staffing limitations.

157 On one view, DCJ appears to have interpreted section 34 of the “Act” broadly, and in so doing has effectively abrogated their responsibilities to families by referring inappropriate cases to support agencies. Agencies such as BF have become defacto type of child protection agency, undermining the intent of the legislation.

158 This situation is exacerbated when those defacto agencies are “educated” not to comply with section 27 of the “Act”. The potential consequences of such arrangements mean that appropriate cases are not escalated, and care proceedings are not considered nor commenced in the NSW Children's Court. Children's Court care proceedings require a further allocation of caseworker resources and scrutiny of the efforts made to ensure the safety, welfare and wellbeing of children at risk.

### **Muswellbrook CSC caseworker capacity in 2017-18**

159 In June 2017, the Muswellbrook CSC was assigned 189 ROSH reports. Thirty-four of those ROSH reports were allocated to a caseworker for a safety and risk assessment (SARA). Thirty-seven of those ROSH reports were closed following a referral to a DCJ funded service or non-government agency. One hundred and eighteen of those ROSH reports were closed due to “competing priorities”, that is, they were closed due to a lack of capacity to allocate the case within the required 28-day allocation period.

- 160 On 14 June 2017, 26 matters were considered at the first WAM meeting that considered Mel's family's ROSH. Of those 26 matters, only two were allocated to a DCJ caseworker. Both cases were assessed as urgent and involved perceived "high" risk circumstances.
- 161 On 20 June 2017, 28 cases were considered at the second WAM. None of these cases were allocated to a DCJ caseworker for a safety and risk assessment. Ten reports were closed, with a further 3 cases being referred to the Brighter Futures program. The remaining cases were held over to the next WAM.
- 162 Ms "EL", was a Muswellbrook caseworker during June 2017. In her evidence at the inquest, Ms "EL" confirmed that ROSH reports which had been received and which she regarded required a face-to-face assessment by a caseworker, were referred to Brighter Futures due to the unavailability of caseworkers at Muswellbrook.
- 163 Ms EL was asked what she perceived contributed to this lack of capacity at that time. She stated that,
- "I guess in my opinion it would've been an increased level of reports. We've seen reporting of child protection concerns increasing every year for a number of years now. We had - I guess capacity would've also been impacted by the severity or the complexity of the matters that we were carrying. So we were carrying much more complex matters."
- 164 Ms EL continued, stating,
- "Matters were going out, doing that initial safety and risk assessment weren't leading to a moderate outcome and the ability to close and therefore have a very quick turnaround of allocated matters that were open and closed." This resulted in having "to carry matters for much longer which obviously impacted on the caseworker's capacity to take on new matters. We had an increase in court matters which obviously again takes much more time for a caseworker than non-court matters. I think, from memory, speaking specifically to Muswellbrook, we may have had less staff, but I couldn't tell you if that's entirely accurate. Yeah, I guess there are a number of factors that change capacity."
- 165 Ms EL confirmed that the above situation relating to June 2017 was "pretty common". Ms EL stated that even if Brighter Futures could technically accept a referral during this period of time, they might not have the capacity to accept the referral. In that circumstance, the ROSH referred case would be held over to the next WAM to determine capacity. Ms EL confirmed that

they could “only hold matters for 28 days and we needed Director approval post hat to keep them open.” Ms EL agreed that if they “weren’t able to allocate a caseworker response and Brighter Futures wasn’t able to accept it” the matter would be closed.

166 Given the number of matters being considered at both WAM meetings in June 2017 and the lack of caseworker capacity, it is unlikely that Jade’s matter would have been allocated to a caseworker if it had been held over for a further consideration at a subsequent WAM.

167 The information prepared for, and contained in, the WAM summary regarding the 2017 ROSH report and the family’s history was very limited. Ms EL gave evidence that it was her practice at the pre-WAM stage, to review a ROSH report and peruse the relevant available electronic records, including any past reports. In addition, the WAM team had access to a computer to check records if required.

168 Ms EL commented further that in her experience the caseworkers involved in the WAM process at Muswellbrook appreciated the risks associated with Jade’s 2017 ROSH report and the history of neglect. She stated “I would say that an allocation decision can’t necessarily be reflective of the significance that we understood there to be in terms of risk in the home. There were matters that we knew to be very, very high risk with significant harm either occurring or likely to occur to children that we could not allocate.... I wouldn’t consider it fair to infer that because we didn’t allocate, we didn’t accurately appreciate the risk.”

### **Children and Young Persons (Care and Protection) Act 1998**

169 Section 8 of the *Children and Young Persons (Care and Protection) Act 1998*, the “CYP Act”, sets out the objects of the Act:

“The objects of this Act are to provide --

- a. that children and young persons receive such care and protection as is necessary for their safety, welfare and well-being, having regard to the capacity of their parents or other persons responsible for them, and .....
- c. that appropriate assistance is rendered to parents and other persons responsible for children and young persons in the

performance of their child-rearing responsibilities in order to promote a safe and nurturing environment.”

170 Section 30 of the “CYP Act” directs:

“On receipt of a report that a child or young person is suspected of being at risk of significant harm --

- a. the Secretary is to make such investigations and assessment as the Secretary considers necessary to determine whether the child or young person is at risk of significant harm, or
- b. the Secretary may decide to take no further action if, on the basis of the information provided, the Secretary considers that there is insufficient reason to believe that the child or young person is at risk of significant harm”

171 The statutory obligation imposed on the Secretary for DCJ clearly requires that an assessment is to be undertaken to determine the veracity of a ‘screened’ ROSH report. It may be that the triage process for a WAM by the relevant CSC, familiar with a particular family, may provide some form of assessment. A SARA, specifically a Safety and Risk Assessment, is DCJ’s own assessment tool. It has been perceived to be an effective tool for assessing the likelihood of ongoing significant risks of harm to a child, however this tool was not being completed on a significant number of fresh Helpline reports due to staffing shortfalls and workloads at Muswellbrook.

172 It was clear from the evidence in this inquest that the abovementioned statutory obligations could not have been satisfied where cases were closed without a SARA being prepared or the matter being allocated directly to a DCJ caseworker.

173 The closure of a verified ROSH report due to lack of capacity was never within the contemplation of the legislation. It is a practise which appears to have evolved within DCJ and CSC offices, with no legislative basis or justification.

174 Section 34 of the “CYP Act” directs that:

- “1. If the Secretary forms the opinion, on reasonable grounds, (emphasis added) that a child or young person is in need of care and protection, the Secretary is to take whatever action is necessary to safeguard or promote the safety, welfare and well-being of the child or young person.
2. Without limiting subsection 1, the action that the Secretary might take in response to a report includes the following -

- a. providing, or arranging for the provision of, support services for the child or young person and his or her family,
- a1. Offering alternative dispute resolution.....
- b. development, in consultation with the parents (jointly or separately), of a care plan to meet the needs of the child or young person and his or her family that .....
- c .....
- d. seeking appropriate orders from the Children’s Court”.

175 It is unclear what constitutes “reasonable grounds” pursuant to the “CYP Act”, however, it must necessitate some form of factual or evidentiary basis for justifying a belief or suspicion that a report has veracity. It must provide that basis before a decision can be made to provide or arrange “support services”.

176 It is also unclear on what basis, (and in the absence of a SARA), a CSC can determine that the risk of significant harm is potentially too high for a referral to a support service (such as the BF).

177 As noted above at paragraph [160], Muswellbrook CSC was unable to place a significant portion of the ROSH reports allocated to it. As at June 2017, 17.99% of the ROSH reports allocated to Muswellbrook CSC were allocated to a CSC caseworker for a safety and risk assessment, 19.58% were closed following a referral to a DCJ funded service or non-government agency, and 62.43% were closed due to “competing priorities”, being a lack of capacity to allocate the matters within the requisite 28-day period.

178 These limitations at the Muswellbrook CSC, appeared to be indicative of a pattern experienced across NSW.

179 In the *Biennial Report of the death of children in New South Wales: 2018 and 2019* (24 August 2021) (**2021 Biennial Report**), the Ombudsman NSW discussed the findings and recommendations of Deputy State Coroner Grahame in the *Inquest into the death of AP* (2020) and the *Inquest into the death of Z* (2021). Her Honour found in the latter inquest that:

“...it remains the position [in 2021] that DCJ does not provide a statutory response to around 70% of children who are the subject of a Risk of Significant Harm report....this state of affairs is both shocking and completely unacceptable...[DCJ’s statutory responsibility for protecting children and young people] cannot be shifted by creating a culture where overworked or under-skilled staff can close reports, claiming a lack of

resources or “competing priorities.” These issues must be acknowledged at the highest level and solutions found if resourcing is indeed the issue.”

180 In the 2021 Biennial Report the Ombudsman NSW stated:

#### **10.6.2. Premature closure of high-risk cases**

Our reviews of deaths in 2018 and 2019, as well as internal reviews conducted by DCJ of its involvement with families where a child died in circumstances of abuse or neglect, have *frequently identified the premature closure of ROSH reports and cases by DCJ as an issue of concern*. In a recent submission to the NSW Parliamentary Inquiry into the Child Protection and Social Services System we noted that information published by DCJ shows that, in the 12 months to 30 June 2019, the overall average percentage of children reported at ROSH who were ‘seen’ by a caseworker was around 29%. We also noted that it has been some years since DCJ reported publicly on the number of cases it closed ‘due to competing priorities.’

Our concerns about the premature closure of child protection reports – observed through our death reviews and examination of coronial inquests held in relation to reviewable child deaths – have not changed. It is apparent that demand exceeds available resources in this area, and DCJ finds it necessary to prioritise cases. However, the fact remains that this system requires judgements about which children – of those assessed as reaching the threshold of being at risk of significant harm – receive a response. (italics and underline added).

181 On 5 July 2024, the NSW Ombudsman released a report *Protecting children at risk: an assessment of whether the Department of Communities and Justice is meeting its core responsibilities (2024 Ombudsman Report)*.

182 The NSW Ombudsman stated:

“Over the past six years, DCJ’s caseworkers have seen more children reported at ROSH but the proportion of children seen face-to-face by a caseworker has dropped from 29% (26,196 of 92,007 in 2017-18) to 25% (27,782 of 112,592 in 2022-23) with significant variation in performance across DCJ’s districts. The number of children reported at ROSH who do not receive a face-to-face response has also increased by 29% (from 65,811 to 84,810).

Despite data that three quarters of the children reported at ROSH did not receive a face-to-face response, DCJ was unable to provide other information showing whether (or the extent to which) this was based on a

view that a child was not at ROSH or its limited operational capacity to provide face-to-face response to every child at ROSH.

DCJ was unable to provide data to show that the most urgent and/or serious cases receive the most immediate and appropriate response. Nor could it provide data showing what (if any) support was provided to each of the 84,810 (in 2022-23) children reported at ROSH who were not provided a face-to-face caseworker response.

On average, where children were seen face-to-face by a caseworker, less than half are substantiated at harm or risk of significant harm.”

- 183 The Secretary has not as yet responded to the **2024 Ombudsman Report**.
- 184 Evidence was received which indicated that caseworker positions remained unfilled, and **CSCs** were unable to retain staff over longer periods of time. Ms EL noted the impact of having to deal with so many cases involving significant risks of harm to children and not having the capacity to intervene.
- 185 Ms EL stated in oral evidence that:
- “I don’t think it recognises the, I guess, the human toll that it takes looking at all of the various reports, and you can see from these WAM documents what other matters were being referred. Nothing there is minor or, you know, insignificant. They are all concerning...And to have to review than many matters, week in, week out, of children who are at significant risk where often they’ve been re-reported multiple times and we still haven’t managed to get out there, that we do not have the caseworkers, either the hours or the human bodies to go out to assess what is happening for those children, yeah, that toll is quite significant. So to consider that we have that an allocation decision alone is reflective of what we perceived the risk to be, no, I don’t think that that’s accurate.”
- 186 Evidence was given on the Secretary’s behalf which outlined a number of initiatives which are being considered or trialled by DCJ to fill staff shortages in rural and remote areas since Jade’s death. Considering the reported numbers of face-to-face contacts made by the CSC, as noted above, does not suggest that the initiatives have met with success. It certainly does not suggest that a child today is any more likely to be assessed for risk and allocated to a caseworker than a child in 2018. Indeed, it would appear that there are greater numbers of risk reports currently being received.
- 187 It is particularly troubling that DCJ are unable to provide information stating what, if any support services have been provided to children reported as

being at ROSH who did not receive face-to-face engagement from a caseworker over the last six years.

188 The NSW Children’s Court and the NSW Coroner’s Court have both repeatedly raised concerns over the last two decades about the lack of assessment of risk, allocation of resources, allocation of cases to non-government organisations and the resulting lack or limited oversight of those cases, and the closure of cases due to “lack of capacity.”

189 It is little surprise then, that the community is still waiting for DCJ to provide a response to the profoundly concerning issues cited by the NSW Ombudsman in the 2024 Ombudsman Report.

## Considerations

190 A number of personal and systemic issues failed Jade.

191 Jade’s mother, Mel, had been the subject of a lengthy involvement with the forerunner of DCJ as a child. Significantly, she had been exposed to neglect and domestic violence from the age of 5 to 15 years.

192 At 17 years of age, she had given birth to her first child, Gabby. After Gabby’s removal from her care, Mel understandably admitted to experiencing depression.

193 Her decision to advise DCJ of the impending birth of Jade was both profound and significant, given her history. The response from DCJ was to provide no support. A decision was made by DCJ to raise a High-Risk Birth Alert (HRBA).

194 After Jade’s birth, and despite the HRBA, DCJ caseworkers did not directly engage with Mel to support her and Jade. Mel and Jade were referred to Brighter Futures, initially by the Aboriginal Maternal Infant Health Service, and subsequently by DCJ.

195 By the time Jade was 5 months old, the DCJ Helpline had received a ROSH report concerning the behaviour of Declan. This report raised concerns about Declan’s mental health, his drug misuse, his physical aggression and his poor compliance with his prescribed medication. This resulted in a DCJ caseworker working with Mel from August 2015 until February 2016. At no time during this period of engagement did DCJ acknowledge or provide assistance to Mel regarding the likely domestic violence in the home and the implications for Jade and her younger brother.

- 196 Declan refused to engage with the DCJ caseworker during this period. He was reported by his doctor to want to “hurt other people”. Despite this, the focus by DCJ was not on his inability to engage or provide a safe environment for his child, but rather focused on Mel’s ability to provide a safe environment for Jade.
- 197 Between mid-2015 and mid-2017, Mel ensured that Jade was seen by her local GP for non-urgent health matters. By January 2017 when James was born, Mel was caring for two children under the age of 2 years. She was 23 years of age.
- 198 Mel’s history as a mother, included examples of child neglect concerning her eldest child. By June 2017, there were concerns regarding neglect, but also the possibility of her children being the subject of abuse and victims of domestic violence, whether that was verbal only or otherwise.
- 199 The ROSH report on 8 June 2017, raised issues about the state of the home, but significantly also referred to complaints from neighbours regarding a male, yelling and verbally abusing Mel at the home. Despite Mel’s own personal history regarding domestic violence, and the known impact of domestic violence on children, DCJ did not have the capacity to undertake a risk assessment (or a SARA), nor assign this matter to a caseworker.
- 200 On behalf of DCJ it is submitted that there was no evidence, and as such the Court could not find that during 2017 at the Muswellbrook CSC, management were closing files as there was no capacity to allocate matters to caseworkers which had been referred to a WAM. The uncontested evidence of Ms BFTL stated that at some of the WAMs she attended, there was no capacity to allocate matters to caseworkers.
- 201 The evidence confirms that the cases that were allocated to a caseworker from a WAM, were focused on addressing immediate issues or risks in the short term. Once it was determined by the CSC that those immediate risks had been addressed, the case was either closed or referred to an external/ non-governmental organisation to provide assistance to the family over the medium to long term.
- 202 Jade was a child who had been the subject of casework supervision by Muswellbrook CSC between August 2015 until February 2016. The length of time of this casework supervision would lead to a conclusion that this was a medium to longer term intervention. During this period of time, the CSC caseworker assessed the family as being at medium to high risk.

- 203 The Secretary for the DCJ accepted in evidence that the casework response during this period was inadequate and was ceased prematurely given the unresolved risks posed by mental health, drug use and possible domestic violence in the home and prior instances of neglect within the family.
- 204 Just over one year later, the same or similar concerns were reported to the Helpline.
- 205 It was clear that Mel was vulnerable and susceptible to acute deteriorations in her coping and parenting capacities, which meant the ongoing possibility of risk of neglect for her children.
- 206 Despite these circumstances, the decision was made by DCJ to refer Jade's case to Brighter Futures without a further risk assessment. The relevant history of this family made it a real possibility that they would present on future occasions with a high and persistent risk to the welfare and well-being of their children. Relapse is a significant reality to families such as Mel's.
- 207 On behalf of DCJ it has been submitted that this court should not find that by 2017, the Brighter Futures program was providing a service which went beyond providing "an intensive preservation service". It was submitted by DCJ that the *2015 Brighter Futures Guidelines* contemplated that that service could provide an "intervention along a continuum, and also that it would address child safety, in addition to, parental and family support and intervention more generally."
- 208 The uncontested evidence of Ms EL was that by mid-2017, BF were no longer operating as an early intervention service and were receiving referrals for cases that were "much higher risk". Ms EL's evidence, together with the absence of any SARA assessment (which may have provided a BF support worker with an appreciation of the risks in the family's home), did not appear to accord with the purpose and objectives of the *2015 Brighter Futures Guidelines*. If DCJ's argument was accepted that the reality was in keeping with the *2015 Brighter Futures Guidelines*, it points to the "vagueness of those guidelines and the disconnect between its drafting and underlying objective. That (vagueness) permitted a practice to evolve that went beyond what was intended when those guidelines were enacted."
- 209 Ms Susan Mattick, on behalf of the Secretary, concluded that the children were at a very high risk and that a caseworker SARA was warranted. It is accepted that the decision to refer the matter and close the case did not result from a lack of appreciation of the risks posed by neglect, or an adequate review of the family's history, by the triage team. The primary factors related to significant capacity limits at the Muswellbrook CSC and

the arrangements and practices that existed at the time, including referring high risk matters to BF.

210 In a case such as this, that referral appeared to be irreconcilable with the Secretary's statutory obligations under the *CYP Act*.

211 Section 34 of the *CYP Act* contemplates a more robust intervention where the risks to the welfare and wellbeing of a child or children are not being met. These interventions may include a formal Parenting Plan or the initiation of proceedings before the NSW Children's Court. These proceedings may result in the temporary or permanent removal of children where the risk to the child to remain under the care of their parent is deemed to be too great.

212 In circumstances where one child has already been removed from a family, the possibility that proceedings will be initiated are more pronounced.

213 The evidence in this inquest compels a conclusion that the Muswellbrook CSC was understaffed and not capable of dealing with the volume of ROSH reports being received. Brighter Futures at Muswellbrook were also experiencing capacity issues by mid-2017, given the evidence of Ms MH that she could not provide additional home visits to Mel given her caseload.

214 The evidence also compels a conclusion that simply increasing staff numbers would not address the systemic inadequacies of the care and protection casework by DCJ.

215 The system was clearly at breaking point, with BF service providers perceiving that their training was encouraging them not to report further examples of ROSH concerning families that they were currently engaged with in 2017.

216 In the Inquest into the death of "Z", 10 March 2021, Deputy State Coroner Grahame stated:

"The current case closure system fails vulnerable children. Sometimes that failure happens because we close files before properly assessing the danger the child faces, as in "Z's" case. If caseworkers are regularly unable to even make contact with children that have been assessed as being at risk of significant harm, the issue must be taken up by the Minister as a matter of urgency. We cannot accept case closure policies which conceal the nature of DCJ's statutory failure to protect vulnerable children. While cultural change may have occurred, there is still a troubling acceptance by senior management that DCJ will just never be able to see all of the children who are identified as at risk of significant harm.

The result of the early failure to properly assess the situation of children such as “Z” means that appropriate staff never even consider whether a child should be removed.”

- 217 Two BF service providers gave evidence that during 2017, they had been given the impression by their management that they should be sparing and not over-report ROSH reports with DCJ Helpline regarding current clients.
- 218 Their evidence was unchallenged.
- 219 There is no evidence that Muswellbrook CSC had commenced or encouraged this practice. It can be inferred however, that such a practice may well have been a response to, or perception of, how to manage excessive workloads.
- 220 Both Mel and Declan appeared to lack the insight and capacity to adequately provide for their children without additional support and assistance from others. Mel was socially isolated and experiencing undiagnosed anxiety. Declan was not prepared to address his significant mental health and drug dependency issues.
- 221 Declan has chosen not to participate in these proceedings.
- 222 The BF support worker, Ms MH, attempted to support Mel regarding her need to provide a safe and clean environment for her two children and encourage Mel to enrol Jade in pre-school. It is accepted that Ms MH was dealing with a significant case load at the time she was assisting Mel and her family.
- 223 It would appear from the evidence that the caseworkers at Muswellbrook CSC were overworked and overwhelmed by their caseloads. They appeared to be dedicated and hardworking individuals who were not receiving support from senior management in DCJ.
- 224 I am not of the view that any individual should be criticised in this very unfortunate death of such a small child. I accept that a number of individuals involved with Jade’s case will have experienced extreme regret and trauma.
- 225 Broad systemic changes are required by DCJ and other referral services. These clearly include filling excessive staff vacancies, providing improved systems and training to staff, improving staff resourcing and policies and complying with their statutory obligations. Continuing with the same processes and practices will result in further poor outcomes for families and staff.

## The need for Recommendations

226 At the conclusion of the evidence, Counsel Assisting circulated draft recommendations to the parties.

227 These draft recommendations are:

(1) To the Chief Executive, TBS: TBS review the training, and messaging, to TBS Brighter Futures practitioners around the need for strict compliance with the mandatory reporting obligations under the CYP Act having regard to the findings in this inquest.

(2) To the Secretary: the Secretary consider issuing a directive to all Brighter Futures' providers emphasising strict compliance with mandatory reporting obligations having regard to the findings in this inquest.

(3) To the Minister for Families and Communities: the Minister review these findings and examine the caseworker capacity of the Muswellbrook CSC and consider the other issues canvassed in these findings.

228 DCJ responded to the draft recommendations by noting that it is in the process of recommissioning all family preservation services. In April 2024, DCJ published their paper "Redesigning Family Preservation in NSW". The paper sets out the department's intention to discontinue the arrangement with BF and to substitute an arrangement with two new family preservation entities, being 'Families Together' and 'Aboriginal Family Preservation'. As such, DCJ submits that recommendation two is redundant and unnecessary. It was submitted that "DCJ expects to commence procurement activity for new providers in early 2025".

229 Six months later, there has been no indication of the implementation of these new family preservation services.

230 DCJ submits that if the court was to make recommendation 2, it could consider reframing the recommendation to read, "As part of recommissioning all family preservation services, DCJ should recognise and emphasise that family preservation providers hold mandatory reporting responsibilities under the Care Act, reflecting this in contracts, program specifications and other program implementation, documentation and activities."

231 DCJ also question whether this Court may properly make a recommendation directed to the Minister for Families and Communities, where the Minister was not identified as a party with sufficient interest in these proceedings.

- 232 It is my conclusion that the Secretary received the appropriate notification that the Department had sufficient interest, which was the appropriate and necessary advice under the *Coroners Act*. In those circumstances, it is not necessary for the Minister to be provided with a separate sufficient interest notification.
- 233 The Benevolent Society (TBS) are not opposed to draft recommendation 1. TBS submit however, that this recommendation is not necessary, in light of recent reforms to their policies and procedures, together with additional staff training since Jade's death.
- 234 TBS submit that they have provided the NSW Government with input to assist with the process of redesigning and recommissioning the Family Preservation services across NSW. TBS note that the referral process has been streamlined and consolidated through the introduction of the Universal Referral Form that combines the eligibility and referral requirements for Family Preservation Services in NSW.
- 235 TBS note that they have instigated changes which include guidance to workers in respect of mandatory reporting through its internal child protection policies and procedures, and ongoing instruction and training to workers through mandatory inductions; as well as training, instruction and mentoring provided through team meetings and group and individual supervision.
- 236 TBS state that all staff are required to undertake two training modules of mandatory training to ensure they understand the Mandatory Reporter's Guide.
- 237 On behalf of Mel, it is submitted that in addition to the draft recommendations, the Court should consider the following:
- (1) To the Secretary, Department of Communities and Justice: the Secretary consider mandating that all Brighter Futures, or equivalent programs, develop and implement comprehensive domestic and family violence screening and response policies, accompanied by regular and ongoing frontline staff in screening for and responding to domestic and family violence.
  - (2) To the NSW Government: that urgent action is taken to ensure that all recommendations made by the Family is Culture Review concerning the provision of early intervention services are implemented in full.
  - (3) To the Chief Executive, The Benevolent Society: TBS consider requiring regular, ongoing training in screening for and responding to domestic and

family violence as part of the Domestic and Family Violence Implementation Plan.

- 238 It is accepted that there was a risk of domestic or family violence occurring in Mel's home between at least 2015 until 2018.
- 239 It is noted that Mel acknowledges that in February 2024, the Executive indicated that recommendations as to the mandatory use of Domestic Violence Safety Assessment Tools (DVSAT) by caseworkers and case managers, and referrals to appropriate domestic violence related services were imminent. A number of changes to the DVSAT tool have been formalised. See the inquest into the death of Michelle Michel.
- 240 Domestic and family violence is the bane of our community. It is imperative that DCJ recognises through staff training that the likely perpetrator will avoid engagement with caseworkers. It is also imperative that the victims of the abuse are provided with recognition and access to support services. It is hoped that these improvements are urgently facilitated.
- 241 The tenor of the proposed alternate recommendations are supported, however, this inquest has not obtained evidence which provides a foundation for the recommendations proposed on behalf of Mel.
- 242 It is my view that there is a need for recommendations to be made in this case. The situation at the time of Jade's death does not appear to be significantly different to the current situation. Indeed, it is not clear what the current situation is.
- 243 As at mid-2017, Muswellbrook CSC lacked the capacity to assign a caseworker to a family which had previously presented with significant and time intensive issues related to risk to the children. A family that returns to crisis does not usually require fewer intensive services. In this situation, it is questionable why a joint approach involving both DCJ caseworkers and BF support services was not activated. The only rational inferences are the lack of capacity at Muswellbrook CSC and a practice of referring higher risk clients to NGOs, and closing the case at the CSC.
- 244 Once a case is closed at a CSC the Secretary bears no further responsibility under the *CYP Act*.
- 245 At the time of the inquest, it would appear that little has changed. Mr Nathaniel Taylor, Director of Community Services and Principal Officer New England Community Services, gave evidence that capacity limitations continue to exist and that an arrangement had been implemented where another CSC within the New England District has been tasked to respond to

ROSH reports deemed to have an urgency and requiring a response within 24 hours if the Muswellbrook CSC lacks that capacity. The response cited by Mr Taylor would not have captured Jade's case which had been allocated a 72-hour response time.

246 The Coroner's Court is aware from other inquests conducted recently that the capacity issue is widespread and chronic. The impact on caseworkers and allied service providers is unsustainable.

247 The impact on small children is too often fatal.

248 Too often the Department and some media seek to blame the parent or parents solely. The sad reality is that some of these parents require the assistance of DCJ because they themselves experienced inadequate parenting and abuse or neglect. The cycle becomes transgenerational.

249 Mel could see her parental inadequacies, and despite her traumatised history, sought out the assistance of DCJ.

250 I am persuaded that there is a need for recommendations to be made in this case.

## **Conclusions**

251 A combination of factors led to Jade's death, including squalid living conditions, undiagnosed and untreated mental health issues, and the effects of ongoing domestic violence. Jade's health was likely to have been impacted for a number of days prior to her death, and her symptoms were either not recognised or not reported by her parents.

252 Jade's death was wholly preventable.

## **Closing Observations**

253 Before turning to the findings that I am required to make, I would like to acknowledge my gratitude to Mr Chris McGorey of counsel and Ms Alana Galasso, solicitor, for their significant assistance generally and specifically in terms of written submissions, commitment, support and preparation of this case.

254 I would also like to acknowledge and thank the Officers in Charge of this investigation, Detective Sergeant Steve Benson and Detective Senior Constable Simone Bottrill for their assistance and commitment to the case.

255 Finally, I would like to again record my most sincere condolences to Jade's family and her extended family.

### **Findings pursuant to section 81(1) of the Coroners Act 2009 (NSW)**

I make the following findings pursuant to section 81 (1) of the *Coroners Act 2009* (NSW):

#### **The identity of the deceased**

The person who died was Jade.

#### **Date of Death**

Jade died on 30 May 2018.

#### **Place of Death**

Jade died at Redacted Street, Muswellbrook.

#### **Cause of death**

The cause of Jade's death was Bilateral Bronchopneumonia with known circumstances indicating neglect as a significant contributing factor.

#### **Manner of Death**

Natural Causes.

### **Recommendations**

4. To the Chief Executive, The Benevolent Society: The Benevolent Society review the training, and messaging, to TBS Brighter Futures practitioners around the need for strict compliance with the mandatory reporting obligations under the *CYP Act* having regard to these findings.

5. To the Secretary: The Secretary consider issuing a directive to all Brighter Future's providers emphasising strict compliance with mandatory reporting obligations having regard to these findings. As part of recommissioning all family preservation services DCJ should, having specific regard to these findings and recommendations made in this inquest, recognise and emphasise that family preservation providers hold mandatory reporting responsibilities under the *CYP Act*, reflecting this in contracts, program specifications and other program implementation documentation and activities.
  
6. To the Minister for Families and Communities: The Minister review these findings and examine the caseworker capacity of the Muswellbrook CSC and consider the other issues canvassed in these findings.

I now close this inquest.

A handwritten signature in black ink, appearing to read 'Joan Baptie', written in a cursive style.

Magistrate Joan Baptie

Deputy State Coroner

24 June 2025