CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of J
Hearing dates:	14 – 15 May 2018
Date of findings:	25 May 2018
Place of findings:	NSW State Coroners Court - Glebe
Findings of:	Magistrate Elizabeth Ryan, Deputy State Coroner
Catchwords:	CORONIAL LAW – death of baby aged four months – sleeping in pram - cause of death – manner of death – was response of NSW Department of Family and Community Services adequate?
File number:	2014/242087
Representation:	Mr C McGorey, Counsel Assisting, i/b the Crown Solicitor's Office. Ms M Barnett of Counsel, i/b Ms Rebecca Jouana for the Department of Family and Community Services. The Parents – unrepresented.
Findings:	**Identity** The person who died is J, born on 23 March 2014. **Date of death**: J died between 16 and 17 August 2014. **Place of death**: J died at 2/7 Grandview Street, Parramatta NSW 2150. **Manner of death:** The manner of J's death is unascertained. **Cause of death:** The cause of J's death is unascertained.

NON PUBLICATION ORDER	A non publication order was made on 14 May 2018 pursuant to s74(1)(b) of the *Coroners Act 2009 (NSW)* not to publish material (including images) which might identify family members in this matter. The names of the relevant people have been anonymised throughout this document.

Table of Contents

Section 81(1) of the *Coroners Act 2009 (NSW)* [the Act] requires that when an inquest is held the Coroner must record in writing his or her findings as to various aspects of the death.

These are the findings of an inquest into the death of J.

Introduction

1. J was only four and a half months old when she died on the night of 16 August 2014 or on the following morning. Her death occurred while she, her parents and her brother were visiting relatives in Sydney.

2. J's death was one which had to be reported to the Coroner pursuant to s 24 of the Act. This is because J was a child in respect of whom a notification had been made under the *Children and Young Persons (Care and Protection) Act 2009* [the CYP Act] in the three years preceding her death. Similar reports had been made regarding her brothers A and M.

3. J's death was also one which required an inquest pursuant to s 27(1)(d) of the Act. This is because the coronial investigation was unable to establish the cause and manner of her death.

The Inquest

4. An inquest is different to other types of hearings. It is neither criminal nor civil in nature. It does not determine whether a person is guilty of an offence and does not make determinations and orders that are binding on parties.

5. A Coroner is required to confirm that a particular death occurred and make findings as to the identity of the person who died, the date and place of death, and the cause and manner of the death. In addition under section 82 of the Act a Coroner may make recommendations that are necessary or desirable in relation to any matter connected with the death, including health and safety.

6. At the inquest into the circumstances of J's death the following issues were examined:

    - what took place in the hours leading up to and after her death

    - whether the response of the NSW Department of Family and Community Services to a report received on 14 August 2014 regarding J and her family was adequate in the circumstances.

7. J's mother, father, maternal grandfather and uncle M attended each day of the inquest. J's parents and a second maternal uncle RW also gave oral evidence at the inquest. The death of this baby girl has deeply saddened her family.

Family background

8. J was born on 23 March 2014 in Bamera in the Riverland region of South Australia. Her mother was aged 21 years when J died. J's father was at that time aged 30 years. When J was born her mother had two sons, A aged two and a half years and M aged 11 months. I will refer to J's parents as 'the mother' and 'the father'.

9. At the time of J's death her parents had been in a relationship for about two years. J's father is also the father of M. The parents subsequently separated. The mother has since had three more children born in 2015, 2017 and 2018.

10. The mother and her seven siblings grew up in NSW in an environment marked by dysfunction, abuse and chronic neglect. The family's extensive child protection history commenced several years ago with a multitude of reports of neglect, domestic violence, environmental and sexual abuse.

11. In 2005 the mother and some of her siblings were removed from their parents' care on grounds they were at risk of serious developmental impairment and psychological harm. The mother lived with foster carers and was diagnosed with moderate intellectual disability, conduct disorder, and attention deficit hyperactivity disorder. When she was 18 years old she moved to South Australia to join her parents, who had relocated there after their children were removed.

12. The mother has a criminal history for aggressive behaviour including an aggravated assault on a child aged 7 years. This 2013 offence involved her punching the face of a child who was visiting the house, after the child had allegedly lit a cigarette lighter. The mother was convicted and received a fine and two year good behaviour bond. Most of her other criminal matters have been dealt with under the NSW *Mental Health Act 2007.*

13. J's father has three other children to two former partners. Although no charges were laid, one of the partners alleged the father had molested their two children, with whom he no longer has any contact. The father's third child is in the care of his mother.

14. Those who are involved in child protection work recognise only too well the intergenerational nature of disadvantage, abuse and neglect. Sadly J's family is no exception. From 2011 to 2014 there were numerous risk of harm reports concerning the capacity of J's mother to care safely for her own children. Families SA (now the Department for Child Protection) received persistent reports of the following kind:

    - that she had used drugs and alcohol throughout her pregnancies with A and M

    - that she did not have the functional skills to care for her children, requiring her own father to actively support her with their feeding, settling and hygiene

    - that her father had to intervene to stop her from shaking A

- her commencement of a relationship with the father, a person who had a child protection history
- that she behaved aggressively with the children
- that the house was very unhygienic with animal faeces throughout
- her 2013 conviction for assault upon a child.

15. Until J's death, proceedings were not commenced by Families SA or the NSW Department of Family and Community Services [FACS] to remove any of the mother's children from her care. Nevertheless for several years Families SA maintained an open file in relation to the family and carried out case work in relation to the mother and her children. Their approach is examined further below.

The trip to Sydney

16. On 7 August 2014 the parents travelled to Sydney with J and M to visit friends and relatives. They stayed for a few nights with a friend. The mother's older child A remained in South Australia in the care of his maternal grandparents.

17. Sometime between 10 and 12 August 2014 the parents and the two children commenced staying with the mother's brother RW and his partner V.

18. At that time RW and V lived in a two bedroom apartment in Parramatta. RW and V have intellectual disabilities and their apartment complex is operated by Northcott Disability Services. At the time, a neighbouring apartment was occupied by disability worker Jeramy Nusco and his partner Emma Nusco. Jeramy provided behavioural support to the tenants of the apartment complex.

19. RW and V slept in the main bedroom of their apartment, with the second bedroom kept as a spare. This is the room in which J and her parents stayed during the visit, with the parents sleeping in the double bed and J in her pram near their bed. J's brother M slept with RW and V in their bedroom. During the family's visit a friend of RW's named Shannon Bland was also sleeping in the apartment on a couch.

20. On Tuesday 12 August J was taken to see GP Dr Adesh Kapoor at a medical clinic in Lethbridge Park, where she was treated for conjunctivitis.

21. On the night of 13 August, according to Emma Nusco, a group of people attended RW's unit, and yelling and music was heard. People were still on the balcony at 5am the next morning.

The risk of harm report, 14 August 2014

22. On the afternoon of 14 August Jeramy Nusco heard a woman yelling in RW's unit. He said it was not V's voice. The woman yelled: '*You fucken go up to the shops. I do all the things in this house. I always do it. You do it'*. Mr Nusco said the yelling and swearing continued for about fifteen minutes. Shortly afterwards Mr Nusco was

told by another Northcott disability worker that the mother had been abusive at the apartment complex's office.

23. That day the Community Services (NSW) Helpline received a risk of significant harm report concerning the children staying in RW's apartment. It reported:

    - overcrowding with seven people staying in an apartment with only two beds, and J sleeping in a pram
    - parental hygiene issues and concern for the parents' capacity to care for the children
    - the house was unhygienic with cat faeces throughout
    - The mother noted to be aggressive towards adults and the children.

24. A further concern was that the children were staying with RW and V, whose child C had been removed from their care in 2012.

25. With regard to the family's sleeping arrangements, the report expressed *'serious concerns with the risks associated with sleeping in prams for extended periods, in particular given that the four month old child would likely be beginning to roll, and sleeping in a pram may pose a smothering risk'*.

26. The risk of significant harm report was assessed as requiring a response within 24 hours, and forwarded to Parramatta Community Services [Parramatta CSC]. However the response within 24 hours did not happen. Instead, Parramatta CSC referred the report to their Weekly Allocation meeting on 20 August.

27. The adequacy of this response is one of the issues examined in this inquest.

Events of 15 August 2014

28. On the afternoon of Friday 15 August 2014 Mr Nusco had a conversation with V, in which she told him the mother had threatened to bash her, but that she probably wouldn't because she was on a good behaviour bond.

29. Earlier that day the family made another visit to Dr Kapoor. Dr Kapoor found J to have a wheezy chest and diagnosed her with bronchitis. He prescribed a liquid steroid for her to be given every four hours, and directed that she be reviewed in three to four days. According to RW, when he gave money to the mother for J's medication she spent it on cigarettes instead. The father reported that they obtained J's medication around 10pm that night.

30. According to RW, during the night of 15 August the mother became very agitated while trying to feed J, and shook her. At the inquest RW repeated information he had given to police on 17 August 2014, that he had seen the mother shaking J '*really hard'* for about three seconds, causing her head to shake back and forth. The mother was yelling '*this baby is not eating'*. The father was present but according to RW, he didn't say or do anything in response.

31. RW also told police that the mother had been very angry with him for making this disclosure. To RW she did not confirm or deny that she'd shaken J.

32. The father too disclosed to police he had seen the mother shaking J on the night of 15 August. The circumstances of his disclosure are discussed at paragraph 67. It is noted that two years earlier FACS received a risk of harm report that the mother was seen shaking her older child A, who was then 11 months old.

33. On the night of 15 August 2014 RW became worried about J and called an ambulance at about midnight. According to the ambulance incident report, the mother too was very anxious because J was not able to drink her bottle and they had been told she could not be given her medication without milk. RW accompanied the mother and J to Westmead Children's Hospital.

34. At 1.09am Triage Nurse Margaret Apap obtained a history that J had had a cough for two days, and that the mother was having trouble feeding her and therefore could not administer her medication. Nurse Apap noted '*child is assessed as having breathing difficulty'* but that '*airway has been assessed as not being at risk'*. Nurse Apap triaged J as category 3, meaning she should be seen by a doctor within 30 minutes. This was on two bases: that J was not feeding properly, and that the mother needed help understanding how to treat J's illness.

35. By 2.06am J had not been seen by a doctor and the mother decided they would leave, saying she would take J to the family doctor. She was reportedly aggressive to hospital staff when they attempted to dissuade her from leaving.

Events of 16 and 17 August

36. On Saturday 16 August the parents took M and J shopping, returning at about 4pm. J was put to bed sometime between 5pm and 8.30pm. She was placed in her pram which was positioned close to the parents' bed. The parents went to bed sometime between 11pm and 2am.

37. RW did not sleep at the apartment on the night of 16 August, instead staying out with a friend Mick Bland. He returned sometime between 10.00 and 11.00am on the morning of 17 August and went to bed.

38. RW told the Court he had only been asleep for a few minutes when he awoke to hear the mother screaming '*the baby is not breathing, call an ambulance'*. RW rang '000' and was given directions how to perform CPR. His call to 000 was registered at 11.11am.

39. Paramedics arrived very soon afterwards to find J lying on her back on the parents' bed with no signs of life. Police officers arrived a few minutes later.

40. Paramedic Virginia Boyn was the first to enter the bedroom. J was lying on her back across the double bed, wearing a jumpsuit. There was vomitus around her mouth. She was pale, had signs of rigor mortis, and was cold to the touch. On the basis that

rigor mortis usually sets in within two to four hours of death, Ms Boyn concluded that J had been dead for some hours.

41. Ms Boyn observed visible lividity in J's hands, fingers and abdomen. Ms Boyn thought this indicated that at the time of her death J had been lying on her abdomen.

42. I should note that forensic pathologist Dr Isabel Brouwer, who performed the autopsy in this case, provided evidence that the position in which an infant died cannot be determined with certainty from the distribution pattern of lividity. This is because if the body is moved soon after death the lividity may move position and become fixed there. From her observations of the distribution of J's lividity, Dr Brouwer concluded that J had been lying on her left side at the time the lividity became fixed, which may or may not be the same position in which she had died. As will be seen, it is likely that J's father moved her from her pram to their bed at some point after discovering she was not breathing, but the time at which he discovered her in this condition, and the time when he moved her, are unclear.

43. At the scene Paramedic Officer Boyn examined J's brother M as well, and found he had an extremely wet nappy. He also had what appeared to be a burn on his foot. Police and ambulance witnesses reported that the mother was highly agitated and was screaming at police throughout their attendance.

44. Police immediately commenced taking statements from the occupants of the apartment. They also interviewed the mother on 17 and 19 August 2014, and the father on 17, 18 and 19 August. These interviews are examined below.

Expert evidence as to the cause of J's death

45. The autopsy examination of forensic pathologist Dr Isabel Brouwer was not able to ascertain a cause of J's death. Dr Brouwer's post mortem examination established the following:

- Evidence of acute bronchitis in the right main bronchus. This condition was not severe enough to have caused J's death.
- No evidence of bronchiolitis or viral pneumonia
- Evidence of previous extradural and subdural brain haemorrhages. These were most likely associated with the normal processes of childbirth
- No external evidence of recent injuries
- A healed or healing fracture of the left posterior rib.

46. J's brain was examined by neuropathologist Dr M Rodriguez, who did not find anything abnormal. Dr Rodriguez commented that the extra- and subdural haemorrhages were common findings in infants and were without clinical significance.

47. Paediatric forensic pathologist Associate Professor John Andrew Munro Gall was requested to review the medical and other evidence. He provided a report dated 22 September 2016.

48. Professor Gall agreed with the finding of Dr Brouwer that the cause of J's death was best described as unascertained. He found no evidence of soft tissue injury to the head, and he agreed that J's chest infection was not severe enough to have caused her death.

49. Professor Gall considered J's fractured rib to be suspicious of non-accidental injury. He thought it '*highly unlikely'* to be the result of a car accident which had taken place a few weeks prior to J's death, and which the parents offered as an explanation for this injury. In Professor Gall's opinion it was more likely the result of fingertips applying excessive pressure to the site. However he was of the view that the fractured rib of itself could not have caused her death.

50. Noting there was some evidence that J was found in her pram with a blanket over her face, Professor Gall could not rule out accidental asphyxia as the cause of death. However there was insufficient evidence to establish this as the cause of her death. This was because there was uncertainty as to the details of J's sleeping environment, including the number and type of bed covers used, the surface on which she was laid to sleep in the pram, the position in which she was found, and whether in fact she had a blanket over her face when she was discovered.

51. Nor could Professor Gall exclude the possibility of deliberate asphyxia, taking into account the following evidence:

    - the likelihood the rib fracture was an inflicted injury
    - previous risk of harm reports in relation to the family
    - evidence of Aaron and RW that they had seen the mother shaking J.

52. Because these possibilities could not be excluded Professor Gall agreed with Dr Brouwer that the cause of J's death could not be given as Sudden Unexplained Death in Infancy, of which Sudden Infant Death Syndrome is a sub-group.

The family's current circumstances

53. On 2 September 2014 the parents returned to South Australia.

54. After J's death A and M were removed from the care of the mother and the father. When the mother's fourth, fifth and sixth children were born they too were removed from her care. Final orders have been made in the NSW Children's Court allocating parental responsibility for A, M and their younger brother to the NSW Minister of Community Services. The three boys live together in NSW in a long term placement with authorised carers.

55. This year the mother gave birth to her sixth child, a girl. The new baby is expected to join her brothers in their placement. The mother's fourth child now lives in South Australia with long term carers.

I turn now to the issues examined in this inquest.

What happened in the hours before and after J's death?

56. The inquest endeavoured to establish whether the evidence was able to disclose a cause for J's death. There was no basis to conclude that further medical evidence would assist in this regard, as the conclusions of Professor Gall and Dr Brouwer are largely consistent and reasonably based. Therefore the key focus of the inquest was the evidence as to what had taken place in relation to J, in the hours before and after her death.

57. The main witnesses who provided evidence on this issue are the mother, the father, and RW. Unfortunately the accounts given by the parents are notable for their variances and inconsistencies. Still more inconsistencies emerged when the parents gave their oral evidence to the inquest. This has significantly impacted the capacity of the court to make relevant findings in the matter.

The mother's accounts of what happened

58. In her police interviews the mother was accompanied by a support person. On 17 August this was her previous foster carer HB, and on 19 August her father.

59. In both interviews the mother described putting J to bed on the evening of 16 August, and being woken the next morning by the father who told her J wasn't breathing.

60. The mother's two interviews contain significant discrepancies about the above matters. She gave conflicting accounts of the time at which J had been put to bed, how and by whom J had been wrapped for bed, and whether J had woken in the night. Only on 19 August did the mother provide the important detail that the father had told her that when he found J not breathing the next morning her head had been covered by one of her two blankets, a brown one.

61. There was further inconsistency regarding the time at which J had been found not breathing, and how the parents had responded. In the first interview the mother variously described the time of discovery as 7.00am, and 10.00am. The father had responded by performing CPR on J '*for about four hours'* until an ambulance was called. They had not called an ambulance immediately because the mother was panicking and didn't know what to do.

62. The mother's evidence to the inquest did not clarify these important matters. She told the Court that J had woken at 2am and that she herself had nursed her and returned her to her pram. However she had left the brown blanket on the ground and did not replace it over J. She described the father telling her soon after 7.00am that J wasn't breathing, but later said this was *'about an hour'* before she rang her father. (Call charge records show her call to her father was made at 11.14am). The

parents had discussed getting emergency help, but didn't do this straight away because she was '*worried about what would happen to my other children'*.

63. In her interviews and oral evidence the mother vehemently denied ever shaking J. She also denied telling the father and RW to retract what they had told police about this.

The father's accounts of what happened

64. The father's accounts are equally unclear. In his interviews to police he described waking around 7.00am on 17 August and sending the mother a text message about an argument they'd had the previous evening. This is confirmed by call charge records showing a text sent at 7.20am. In his second interview on 17 August he told police he had found J not breathing '*about half an hour to an hour'* after he'd sent this text. However in an earlier interview that day he spoke of finding her in this condition at about 10.30am.

65. In his oral evidence at the inquest the father said he had found J with her brown blanket over her face. In none of his four interviews had he mentioned this detail. When questioned about this omission he was evasive, at first stating he didn't know why he hadn't disclosed it at the time, then admitting he'd deliberately withheld it. He couldn't remember why he had done this.

66. Nor could the father recall why he had tried to ring the mother's brother RW at 10.20am on 17 August. He went on to state that he'd found J not breathing very soon after this attempt. When asked why he and the mother had waited a further fifty minutes to arrange an ambulance for J he claimed he didn't know why; nor could he remember what they had been doing during this period.

67. The father's evidence was unconvincing as to another important matter. In interviews with police on 17 and 18 August 2014 he had disclosed that he had seen the mother shaking J. His disclosures were in similar terms to those of RW, namely that on the night of 15 August the mother had been upset because J wasn't drinking her bottle, and had shaken her. The father had not said anything to the mother because he didn't want her to get angry with him.

68. However on 19 August 2014 the father went to Granville Police Station accompanied by the mother and members of her family. Here he told police he had not observed the mother shaking J, because his back had been turned while he was getting J's blankets ready. He had *'not been thinking straight'* when he had twice told police about this event. As to why he had changed his story, the father offered the unconvincing explanation that this was not because the mother had told him to, but because he had simply remembered that it never happened.

Conclusions as the circumstances of J's death

69. In important respects the evidence of both parents lacked reliability and credibility, making it difficult to draw conclusions about matters that are highly relevant to J's death.

70. In assessing the parents' evidence it must be borne in mind that the mother has moderate intellectual delay. It is unknown if the father has been formally diagnosed with cognitive deficits, but it was apparent from his police interviews and evidence in court that he struggled to process information quickly and to express himself. It is reasonable to assume that these factors, and the parents' shock and distress at J's sudden death, together with the natural stress associated with giving evidence in court, contributed to a lack of clarity in their responses and the frequent contradictions that occurred. In addition the amount of time that has passed since J's death cannot have assisted their recollection.

71. Allowing for the above factors, it is nevertheless difficult to avoid the conclusion that the parents were unwilling to address relatively straightforward questions about J's death, such as why they had not rung an ambulance at an earlier stage, and in the father's case why he had changed his evidence about the shaking episode.

72. Given the state of the evidence, I set out as best I can my conclusions regarding the circumstances of J's death.

At what time was J first discovered not breathing?

73. The parents variously provided the time of discovery as around 7.00am and after 10.00am. Their confusion may be due in part to the fact that the father must have awoken around 7.00am to send the mother his text. Whether it was at this time, or a later time, that he discovered J not breathing remains unclear.

74. Certain evidence of RW supports the proposition that the time of discovery was the later time. RW said he returned to the apartment on 17 August sometime after 10.00am and looked briefly into the parents' bedroom, to see them asleep in bed. It was very soon after this that the mother asked him to call an ambulance. In addition RW's friend Shannon Bland told the Court that the mother woke him around 10am that morning and asked him to check J. He did so and saw at a glance that she was not alive.

75. The above evidence of RW and Shannon Bland does not preclude the possibility that the parents found J not breathing at an earlier time. Furthermore there is persistent and disturbing reference in the parents' interviews to the father telling the mother soon after 7.00am that J was not breathing.

76. Unfortunately the evidence does not enable a conclusion as to when J was first discovered in this condition.

Why was emergency assistance not immediately sought for J, and what did the parents do in the meantime?

77. It is established that '000' was called at 11.11am. Even if it is accepted that the parents found J not breathing soon after 10.00am, there followed a substantial period of time in which they did not seek help. They were unable or unwilling to explain this delay, or tell the court what they were doing in the meantime.

78. Considering the evidence as a whole, in particular the mother's disclosure that she was worried about the impact on her other children of disclosing J's death, it appears most likely they panicked and delayed raising the alarm for fear of the likely child protection consequences.

79. It is unknown whether J's death might have been prevented had the parents sought immediate help. This is a question which is often difficult to answer, but in this case it is further complicated by the confusion as to when the parents discovered her condition.

80. If J was discovered not breathing around 10.00am or afterwards, the evidence leaves little doubt she had died by this time. I base this upon the evidence that rigor mortis had developed when paramedics arrived a little more than an hour later. I base this also on Shannon Bland's evidence referred to at paragraph 74. If on the other hand J was discovered not breathing soon after 7.20am, the possibility cannot be excluded that urgent medical attention might have made a difference.

<u>When J was discovered not breathing, how was she positioned and what bedding was in her pram?</u>

81. Evidence of J's sleeping environment would be highly relevant in determining if she had died of accidental asphyxia.

82. Shannon Bland's evidence is that when the mother asked him to check J, he saw her in her pram on her back wrapped in her brown blanket with her head visible. This does not preclude the possibility that when the father discovered her the blanket was over her face, or that he moved her position. Unfortunately however the parents did not provide reliable evidence on this point. The father said the blanket was over her face in his oral evidence, but did not disclose it in any of his interviews. Furthermore at the inquest the mother undercut it by stating she had left J's brown blanket on the ground when she placed her back in her pram at 2am. Regarding how she was positioned when she was discovered, the father first described finding her on her side, then said she was on her back.

83. There is thus no reliable evidence as to how J was positioned when she was found not breathing. As noted, the distribution pattern of J's post mortem lividity does not assist in determining what J's position was at the time of her death.

84. The absence of reliable evidence as to how J was positioned when she was discovered means that it is neither possible to establish accidental asphyxia as the cause of death, nor to exclude it.

<u>Did one or both of the parents inflict injury on J and if so did this contribute to her death?</u>

85. There is evidence that prior to her death J was subjected to physical harm. Professor Gall thought it highly improbable J's posterior rib fracture was the result of a car accident, and noted that the presence of such fractures in infants is a flag for concern that non-accidental injury has occurred.

86. In addition there is cogent evidence that the mother subjected J to shaking on the night of 15 August. RW disclosed this to police on the day of J's death, and confirmed it in his evidence to the inquest. Shannon Bland also told the Court that RW had informed him of it on the night of 17 August. I have no basis to question the reliability of this evidence. Further, on two occasions A disclosed the shaking episode to police. For the reasons given at paragraph 68, I attach no weight at all to his evidence retracting this disclosure.

87. However although I accept that prior to her death J was subjected to physical abuse, the medical evidence establishes that neither the fractured rib nor the alleged shaking episode caused or contributed to her death. Rather, this evidence is relevant to the question whether J's death could have been the result of harm intentionally inflicted on the night of 16 August.

88. There is no doubt that J's death occurred in disturbing circumstances. At the time of her death some of her basic needs, including a safe sleeping environment, were being neglected. Furthermore there is credible evidence she had been subjected to previous physical abuse. For these reasons the possibility cannot be excluded that her death was the result of intentionally inflicted harm on the night of 16 August.

89. However the evidence in this distressing case falls short of enabling a finding on the balance of probabilities that this was the case. The autopsy report showed no recent external injuries. Examination of J's brain revealed nothing abnormal. There was no evidence that either parent had done anything that night with the intention of deliberating asphyxiating her.

90. The evidence that J was being put to bed in her pram, and the documented risks to infants of her age of sleeping in such an environment, strongly suggest that her death was associated with her unsafe sleeping arrangements. However for the reasons given at paragraph 84 above, it is not possible to make a definitive finding that this was the case.

91. The conclusion I reach is that the cause and manner of J's death must remain unascertained.

Was the response of Family and Community Services (NSW) adequate?

92. This issue focuses on the question whether FACS acted appropriately in their response to the Risk of Significant Harm report received on 14 August 2014, three days before J's death. The inquest was assisted by two comprehensive statements of Ms Lisa Charet, Executive District Director for Western Sydney and Nepean Blue Mountains Districts, within the Department of Family and Community Services.

93. Details of the August 2014 Risk of Significant Harm report are given at paragraph 23.

94. On the day the report was received it was screened as requiring a response within 24 hours, and was forwarded to Parramatta CSC. There an officer made an informal phone request to Families SA to find out if there was any ongoing case work in relation to the family.

95. Families SA responded that they had no current concerns about the family and that their case had been closed in October 2013. It appears this was the extent of the information provided. Parramatta CSC therefore determined that the children were not at immediate risk of harm, and referred the report to their weekly allocation meeting of 20 August. By that time Parramatta CSC expected to have obtained further information about the family. Tragically, J died three days before this happened.

96. Ms Charet conducted a review of this matter and concluded that in its response to the August 2014 report, Parramatta CSC underestimated the risks to the children, J in particular. In Ms Charet's view:

'Based on the information available … a field response was needed and a safety and risk assessment of the family should have been completed within the 24 hour response time to assess the safety of J and her siblings and to make any further casework decisions for the family'.

97. In addition Ms Charet thought it would have been appropriate for Parramatta CSC to have made a formal 'Interstate Request for Information' through FACS' Interstate Liaison Unit. Such requests made on an urgent basis have a turnaround time of 24 hours.

98. Had this been done, it is likely Parramatta CSC officers would have become aware of the family's significant history in South Australia of neglect, poor hygiene and transience – matters closely related to the concerns raised in the August 2014 report. This would have indicated an increased level of risk, and would heighten concerns '*for the level of cumulative harm experienced by the children'*.

99. Furthermore, in Ms Charet's view it would have been helpful for officers to know that in South Australia, the parents needed direction and assistance from many sources in order to meet the most basic physical needs of their young children – sources which were not available to them during their Sydney stay.

Changes made by Parramatta CSC and FACS

100. The death of this baby girl is a tragedy, and it is right to consider whether anything could reasonably have been done to prevent it. The Court was informed that since J's death Parramatta CSC has introduced changes which, had they been in place in 2014, would most likely have resulted in a face to face assessment of J's family within 24 hours of receiving the August report.

101. The changes are:

- The formation of a Triage and Response Team of six case workers who do not conduct a case load. The Team's role is to respond to high priority matters by conducting immediate assessments and home visits. This means that an immediate response is able to be made to reports like the August 2014 one, without the need to defer action until after the weekly allocation meeting.

- Deployment of increased staff for the Interstate Liaison Unit, to improve information sharing between the states and to speed up response times. The need for such improvement was highlighted in the Royal Commission into Institutional Responses to Child Sexual Abuse. Had sufficient resources been available in 2014 this would have enabled Parramatta CSC to obtain the information they needed within a faster timeframe.

- Development of new learning resources for FACS case workers about safe sleeping. These are aimed at increasing the skills of case workers to identify unsafe sleeping practices when they make home visits, and to help families to change such practices. It was submitted that this resource has heightened case workers' awareness of the risks associated with pram sleeping.Question of recommendations

102. It is a positive sign that FACS has acknowledged the inadequacy of the response to the August 2104 report. This was a missed opportunity for case workers to review a home environment in which very vulnerable children were dependent for their care on adults who were arguably incapable of providing it. Of course it is not possible to know what the outcome would have been had J and her family been visited and assessed the following day. There is however a chance it could have led to action which would have meant J was still alive today.

103.The changes that have followed FACS' review of this matter are aimed at providing a better response to families like J's, in which young children are exposed to significant neglect and abuse. For this reason I have determined it is not necessary for me to make recommendations in this particular area.

104.Questions may well be asked as to whether it was appropriate for J to have been in the care of her parents at all. However it is beyond the scope of this inquest to examine the adequacy of Families SA's response to this family's protracted history. I will make only the following comments.

105.While the parents no doubt loved their children, hindsight clearly shows they were incapable of understanding and meeting their most basic needs and protecting them from harm. This is evidenced by years of documented concerns about the mother's inability to cope with the needs of her young children without the active assistance of her father and of support workers from Disability SA, the Salvation Army, and Families SA.

106. On this basis there are grounds to be critical of the approach of Families SA between 2011 and 2014, which appears to have preferenced the development of safety plans to minimise the risks to the children, over taking statutory action to remove them from their parents' care.

107. However it is fair to acknowledge that had statutory removal action been attempted during those years, its success could not be assured. Case workers at Families SA and Disability SA had frequent contact with the family and made regular home visits in response to risk of harm reports about neglect and hygiene. At such visits the reported result was often that the children appeared healthy and the home environment was reasonably clean. It appears also that the maternal grandfather

was active in ensuring the mother and her children attended health and welfare appointments with case workers, and sought medical assistance when necessary.

108. I will close by acknowledging the sadness of this little girl's death, and by thanking all who have assisted this inquest. These include Counsel Assisting Mr McGorey and Ms Mooney of the Crown Solicitor's Office, as well as the legal team representing the Department of Family and Community Services.

109. Thanks also are due to the Officer in Charge Detective Tim Miller for his assistance with the coronial brief, and his work in enabling the members of J's family to attend and participate in the inquest.

Findings required by s81(1)

As a result of considering all of the documentary evidence and the oral evidence heard at the inquest, I am able to confirm that the death occurred and make the following findings in relation to it.

The identity of the deceased
The person who died is J, born on 23 March 2014.

Date of death
J died on the night of 16 August 2014 or the morning of 17 August 2014.

Place of death
J died at 2/7 Grandview Street, Parramatta NSW 2150.

Cause of death
The cause of J's death is unascertained.

Manner of death
The manner of J's death is unascertained.

I close this inquest.

E Ryan

Deputy State Coroner
Glebe

25 May 2018