



**CORONERS COURT
OF NEW SOUTH WALES**

Inquest:	Inquest into the death of ML
Hearing dates:	5 – 8 August 2024
Date of findings:	4 March 2025
Place of findings:	Coroners Court of New South Wales, Moree
Findings of:	Magistrate Joan Baptie, Deputy State Coroner
Catchwords:	CORONIAL LAW – Death of 17 month old First Nations child - family known to DCJ - staffing and resources at DCJ - domestic violence - need for multiagency cooperation - cause and manner of death
File number:	2019/00354026

<p>Representation:</p>	<p>Counsel Assisting, Mr Tim Hammond, instructed by Yvette Edgell and Alana Galasso of the NSW Crown Solicitor’s Office</p> <p>Ms Michelle Fernando, instructed by Shalina Perera of Legal Aid NSW, for [REDACTED] (family)</p> <p>Mr Ian Fraser, instructed by Maria Panos and Joshua Vardanega of Norton Rose Fulbright, for the Department of Communities and Justice</p> <p>Mr William de Mars, instructed by Phillip Nixon of DCJ Legal, for the Commissioner of Corrective Services NSW</p> <p>Ms Elizabeth Lambert, instructed by Ellena Kalomiris and Craig Norman of the Office of the General Counsel NSW Police Force, for the Commissioner of Police, NSW Police Force</p>
<p>Non publication order:</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>
<p>Findings:</p>	<p>The identity of the deceased</p> <p>The person who died was ML</p> <p>Date of Death</p> <p>ML died between 9 and 10 of November 2019.</p> <p>Place of Death</p> <p>ML died at [REDACTED], Moree.</p> <p>Cause of death</p> <p>The cause of ML death complications of acute bronchiolitis arising from Respiratory Syncytial Virus (RSV).</p> <p>Manner of Death</p> <p>Natural Causes.</p>
<p>Recommendations:</p>	<p>None</p>

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Introduction

- 1 This inquest concerns the death of a 17-month-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 ML . Her mother will be referred to as Laila and her father as Mike.
- 2 ML was born on 9 June 2018 in Toowoomba. She died between 9 – 10 November 2019, at Moree, in the state of New South Wales.
- 3 ML likely died from acute bronchiolitis following respiratory syncytial virus (RSV) infection.
- 4 The identity, date and place of ML 's death are not in dispute. This inquest has focused on the cause and manner of ML 's death and the relevant contributing circumstances, including policies, training and collaboration of various NSW government departments.
- 5 ML was a daughter, granddaughter, niece, sister and cousin to many. Various family members and friends have participated and contributed during these proceedings, 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 who brought her family back together. Her mother, Laila, said “she made a big impact on our lives during the short time she was here.” I hope that ML '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 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. Four experts provided reports and gave evidence either individually or as part of a conclave of experts.

- 8 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 Tim Hammond of Counsel, Ms Elizabeth Lambert, counsel on behalf of the Commissioner of Police, Mr William de Mars, counsel on behalf of the Commissioner of Corrective Services, and Mr Ian Fraser, counsel on behalf of the Department of Communities and Justice (DCJ). At times, I have embraced their descriptions in these findings.
- 9 A non-publication order was made which prohibits the publication of the names of ML's immediate family and the names of staff from DCJ 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 ML. In addition, a non-publication order was made relating to a number of documents held by Corrective Services NSW (CSNSW) and admitted into evidence in these proceedings.
- 10 ML was described as having big brown eyes and a bubbly personality. Her family have spoken about how much she was loved and that they miss her dearly. Laila said " ML you will never be forgotten. You are loved and missed by all the family".

A Brief Overview of ML's Life

- 11 ML was the youngest child of Laila. ML has two older sisters, who have been given the pseudonyms, ■ who is now fourteen years of age and ■ who is now 20 years of age. ■ and ■ are the children from an earlier relationship involving Laila and her then partner. ML was the daughter of Mike.
- 12 ML's parents met each other at high school and commenced an intimate relationship in 2013.
- 13 Mike has six children from previous relationships, however, it would appear that ML had not met those half-siblings.

Background

- 14 Laila and Mike identify as First Nations Persons from the land of the Kamilaroi people. Laila grew up near Moree and Mike spent his childhood in the Namoi region.
- 15 As a child, Laila's family came to the attention of DCJ (DOCS/FACS as it then was), after DCJ received reports that she had been neglected and abused by her father.
- 16 Mike was the youngest child of nine siblings. His family came to the attention of DCJ when Mike was as an infant due to his mother becoming the victim of a domestic violence related homicide. Mike and his siblings were then cared for by his extended family. Some years later, reports were received that Mike and some of his siblings were the victims of sexual abuse from a person known to the family.
- 17 It is reasonable to conclude that these early experiences, informed Laila and Mike's later views about DCJ.
- 18 A year after the sexual assault notification, Mike, then aged 11 years, became dependent on drugs and alcohol and came to the attention of the NSW Police Force (Police) for criminal behaviour. As an adult, Mike was charged with numerous property and domestic violence offences. He was first incarcerated in 2010 for domestic violence offences against his then partner.
- 19 Prior to ML's birth, DCJ had received five 'Helpline' reports in relation to Mike during the period 2008-2013, and a further nine 'Helpline' reports were received from 2014 until 2017.
- 20 From the time of ML's birth until her death, DCJ received eleven reports in relation to her family which were assessed as being Risk of Serious Harm (ROSH) reports, and five non-ROSH reports were made to the DCJ 'Helpline'.
- 21 In 2018 the family were living in Tenterfield in northwest NSW.
- 22 On 20 April 2018, Police were contacted by neighbours and attended the premises. Police applied for an Apprehended Domestic Violence Order (ADVO), nominating Laila as the person in need of protection. On 26 April 2018, a Final Order was made for a period of 2 years, requiring Mike not to assault, harass, intimidate or destroy property in Laila's possession.
- 23 On 2 August 2018, Laila attended at the Police station in relation to a heated argument between Mike and herself. As she left the Police station, she

crossed the New England Highway unsafely with ML in her arms. A report was made to the DCJ 'Helpline'.

- 24 Glen Innes Community Services Centre (CSC) was allocated to assist the family, due to their geographical proximity and prior involvement with the family. Three ROSH reports were received during August 2018; however, the reports were not actioned until 18 September 2018.
- 25 Police records indicate that they had attended twelve domestic violence related incidents involving Laila and Mike in the six months preceding 16 September 2018.
- 26 On 17 September 2018, Mike was charged with a number of domestic violence offences against Laila. At the time Mike assaulted Laila, Laila was holding ML and the other two children were present in the house.
- 27 Mike admitted his guilt and was sentenced to a period of imprisonment of 18 months commencing on 17 September 2018 and concluding on 16 March 2020, with a non-parole period of 9 months, concluding on 16 June 2019. Upon his release, Mike was directed to accept the supervision of CSNSW Community Corrections Officers (formerly the Probation and Parole Service). At the time of his sentencing, Mike was the subject of an earlier ADVO, made on 26 April 2018. This ADVO was varied on 11 October 2018, adding additional conditions and remaining in force for a period of 3 years.
- 28 On 18 September 2018, Ms "NW", a DCJ caseworker at the Glen Innes CSC, attended Laila's home to conduct a safety assessment. Ms "NW" observed the house to be infested with mice and in a state of uncleanliness. Laila told Ms "NW" that she had been using marijuana and had a mental health diagnosis, which was untreated at that time. Laila indicated that she had been co-sleeping with ML. A Safety Plan was devised with the family moving to reside with Laila's mother, while the house was fumigated, cleaned and the rubbish removed.
- 29 On 25 October 2018, Ms "NW" left the Glen Innes CSC and Laila's case was reassigned to Ms "JM", an Aboriginal Caseworker. Ms "JM" attempted to arrange various meetings with Laila, however, the meetings were repeatedly rescheduled.
- 30 Further reports were made to the 'Helpline' in December 2018 and early February 2019.
- 31 By late February 2019, Ms "CG", the Manager Client Services (MCS) at Glen Innes and Inverell CSCs raised concerns that the family's safety and well-being were deteriorating. Ms "JM" visited the family on 7 March 2019 and

various matters were discussed, including co-sleeping. A cot and bedding were purchased and provided to Laila, together with some pamphlets on safe sleeping arrangements.

32 From late March until late April 2019, Ms “JM” was on leave, and it is unclear whether Laila’s file was reallocated in the interim. After her return from leave, another ‘Helpline’ report was received and Ms “JM” arranged a home visit where a further Safety Plan was devised, including safer sleeping arrangements.

33 In early June 2019, Laila, ■ and ^{ML} spent some time in Queensland visiting family, whilst ■ stayed in the care of her grandmother. In mid-June, shortly before Mike’s release on parole, Laila made an application to vary the ADVO, permitting Mike to visit the children.

34 On 13 June 2019, Laila filed an application to vary the ADVO by removing the condition that Mike was not permitted to go into any premises where Laila lived or worked.

35 On 16 June 2019, Mike was released from gaol and was paroled to live at his aunt’s home in Walgett. Shortly afterwards, it appears that Laila, ■ and ^{ML} visited Mike in Walgett. Mike’s aunt refused to allow them to stay in breach of the parole orders and it is believed that they then all travelled to Moree.

36 On 26 June 2019, Police made an application to vary the ADVO. The variation sought included the addition of Domestic Violence Electronic Monitoring and a non-contact condition pertaining to ■ ■ and ^{ML}. Mike was directed to remain in Moree and was not to travel to Tenterfield. He commenced living with his cousin in Moree.

37 At this time, Laila’s whereabouts were unknown by both the Police and DCJ. Ms “JM” had concerns that Laila and her children were with Mike. Another report was received by the DCJ ‘Helpline’ and further discussions were held between DCJ caseworkers and Corrective Services NSW (CSNSW) Community Corrections officers.

38 On 2 July 2019, the DCJ ‘Helpline’ received a report that ■ had attempted to self-harm and had been taken to hospital under Mental Health legislation. The assigned psychologist was unable to contact Laila.

39 DCJ shared their concerns with Police that Laila and Mike were living together in breach of the ADVO and his parole conditions. Over the next few days, Police conducted numerous ADVO compliance checks with no breaches being detected.

- 40 On 29 July 2019, Moree East Public School confirmed with Ms “JM” that ■ had been enrolled at the school since 3 July 2019.
- 41 On 31 July 2019, a Community Corrections Officer conducted a home visit at Mike’s cousin’s home. The officer noted that there was a woman and children also present within the home. The woman denied that she was Laila.
- 42 Also on 31 July 2019, the DCJ ‘Helpline’ received a report which claimed that ■ had said “sometimes Dad hits Mum; well, a lot actually and it’s really bad. So we run away and hide at Meg’s (a neighbour) house and she gives us lollies.”
- 43 In early August 2019, after DCJ had received confirmation that ■ was enrolled at Moree Secondary College, meaning that it was likely that all the children were now living in Moree, a request was made to transfer the files from Glen Innes/Inverell CSC to Moree CSC. Around this time, it became apparent that Mike’s cousin was the partner of Laila’s sister.
- 44 On 14 August 2019, the DCJ ‘Helpline’ received a report indicating that Laila was hitting ■ and that ■ had kicked the family dog to death.
- 45 On 21 August 2019, there was a transfer meeting held to discuss and formalise the transfer of the files from Inverell CSC to Moree CSC.
- 46 On 29 August 2019, ■’s file was transferred to Moree CSC, however, ^{ML} and ■’s files remained in Inverell.
- 47 On 5 September 2019, the DCJ ‘Helpline’ received a report that Laila had pushed ■’s forehead into the bathroom door. The report was allocated to Inverell CSC for ^{ML} and ■ and to Moree CSC for ■
- 48 A Weekly Allocation Meeting (WAM) was held at the Moree CSC to discuss the report made on 5 September 2019. A decision was made by the Manager Case Work (MCW) to “close the report” citing “no capacity to allocate” the matter. ■ and ^{ML}’s report remained open in Inverell until 16 September 2019 until their cases were transferred to Moree.
- 49 On 26 September 2019, both applications to vary the ADVO made by Laila and Police were determined at Tenterfield Local Court. A final ADVO was made for a period of 2 years, with the conditions that Mike not contact Laila or the children, nor go within 50 metres of any premises where Laila lived or worked.
- 50 On 14 October 2019, Ms Rachel Colvin from Community Corrections advised Mike’s Initial Transitional Support (ITS) worker, Mr Gerry Turner, that

Mike could no longer reside with his cousin and Laila's sister, as two of Laila's children were residing there in breach of the new ADVO.

51 Mr Turner urgently made enquiries with Byamee Homeless Support service to arrange accommodation for Mike. On 21 October 2019, Mike was advised that a one-bedroom unit had been arranged for him to lease for three months. The property was approved by Community Corrections and Mike received the keys to the property on 7 November 2019.

52 Laila had been residing with Mike and the children at her sister's home. Laila had an argument with her sister and left her sister's home, moving herself and the two children (■ and ^{ML}) into the one-bedroom unit which had just been approved as Mike's new residence. Mike later stated that the unit had no hot water and no functional stove or fridge. The family began co-sleeping on an air mattress in the lounge room of the unit. It was unclear whether ■ was also residing at the unit.

53 On 8 November 2019, Ms Colvin from Community Corrections received a phone call stating that Laila and the children were residing with Mike at the new unit. Ms Colvin contacted Moree Police and spoke with the Domestic Violence Liaison Officer, Senior Constable (SC) Jenna Aslin who arranged for an urgent compliance check to be undertaken by Police. Police attended the unit; however, no person answered the door.

54 On 9 November 2019, ■ took ^{ML} for a walk in the stroller to the local bakery and purchased hot chips and gravy for the family. Laila and Mike saw ^{ML} vomiting two to three times after consuming the chips. After she had finished vomiting, Laila said that "she was the same as she always was."

55 Later that afternoon the family went down to the river where they met up with Mike's cousin, who was fishing. They returned home and Laila changed ^{ML}'s nappy and noticed that she had diarrhoea. She put two nappies on ^{ML} and put her down to sleep sometime between 6:30 – 7:00pm.

56 At 9:00pm, Laila and Mike smoked a joint of marijuana and laid down on the mattress in the lounge room and watched a movie. Laila had ^{ML} in her arms. Mike was on Laila's right-hand side, ^{ML} was on her left-hand side and ■ was also on her left hand side. At some point, Laila put ^{ML} on the pillows next to her.

57 Sometime during the night, Laila was woken by ^{ML} saying "mum" and changed her nappy. She gave ^{ML} a bottle of cordial and went back to sleep.

- 58 At around 5:00am on 10 November 2019, Laila woke and went to the bathroom. When she returned, she noticed that ML was lying across the pillows on her back. Her eyes were open, and she appeared to be staring into space and was unresponsive.
- 59 Laila immediately contacted triple zero and was advised to commence CPR. Police arrived shortly afterwards and commenced CPR. Police noted that ML's jaw was clenched shut and she appeared to have some dried blood around her right nostril. Paramedics arrived and attached a defibrillator. ML was transported by ambulance to Moree Base Hospital. Regrettably, she was unable to be revived.

List of issues considered during the inquest

- 60 The following list of issues was prepared before the proceedings commenced and were considered and provided focus during the inquest, namely:
- i. The medical cause of ML's death.
 - ii. The manner of ML's death in the context of family interaction with the Department of Communities and Justice (DCJ) from 1 July 2017 until 10 November 2019.
 - iii. The general management of ML's case by DCJ, including:
 - a. The level of support provided and the adequacy of the DCJ response to the reports made about ML and her family, after the birth of ML and in particular between May and November 2019;
 - b. DCJ's failure to implement a safety plan and/or engage in other consultation processes regarding the care of ML; and
 - c. The nature and adequacy of the response by DCJ to ML's family as First Nation Persons.
 - iv. The circumstance that led to ML's residence at [REDACTED], Moree NSW, in the days prior to her death.
 - v. Whether any recommendations are necessary or desirable pursuant to section 82 of the *Coroners Act 2009*.

Cause of ML 's death

- 61 ML 's parents have maintained that she appeared well on 9 November 2019, apart from the episode of vomiting after consuming the hot chips and some diarrhoea before she was put to bed. Laila stated that she had given her some cordial to keep her fluids up, because of the diarrhoea. Mike confirmed that she had been given cordial.
- 62 Dr Isabella Brouwer, forensic pathologist, conducted an autopsy on ML on 14 November 2019. Dr Brouwer confirmed that there were no signs of recent injury and no skeletal fractures. The post-mortem CT scans demonstrated no significant abnormalities. Dr Brouwer noted that ML displayed evidence of dehydration with deep set eyes and a 'prune belly', although "biochemistry could not confirm systemic electrolyte due to decomposition changes affecting the outcome of the analysis. Kidney function (urea and creatinine) appeared to be normal."
- 63 Dr Brouwer summarised the main histological findings as the "thymus demonstrating reactive changes, with acute bronchiolitis, suggestive of Respiratory Syncytial Virus (RSV) and Microvesicular steatosis".
- 64 Dr Brouwer noted that "RSV RNA was detected in the nasopharyngeal and tracheal swabs, with the lungs showing widespread bronchiolitis with microscopic changes suggestive of a viral (RSV) infection".
- 65 Dr Brouwer commented that "RSV is a major cause of bronchiolitis in young children resulting in airway obstruction and may cause death if left untreated."
- 66 Dr Brouwer also noted that the "Clinical history of diarrhoea [was] confirmed at examination (green stools in nappy, similar contents in bowels and absence of formed stools in large bowel). No infective source for diarrhoea identified. RSV infection does not usually cause diarrhoea."
- 67 Expert opinions were sought from Dr Scott Dunlop, consultant paediatrician, and Professor Peter Ellis, forensic pathologist. They both provided expert reports which have been tendered in these proceedings, and they were called to give their evidence concurrently at the inquest.
- 68 Dr Dunlop stated, given a finding of RSV at autopsy, he would expect the "child to have respiratory symptoms of cough, rhinorrhoea, coryza, potentially a fever, moving on to increasing work in breathing, respiratory distress which could present as tachypnoea or fast heart rate, expiratory

grunt, tracheal tug, increased use of intercostal muscles, all indicating increased effort in breathing.”

69 Dr Dunlop opined that he would have expected ML’s symptoms to have been evident for a number of days with very obvious signs that she was unwell. In his oral evidence, he said, “I would expect for bronchiolitis to be a significant contributor to a cause of death; that eventually there would be an element of respiratory fatigue and increasing respiratory failure, which may present as cyanosis, lethargy, reduced level of consciousness... On assessment, I’d expect that child to look extremely unwell. I’d expect the child to have reduced energy levels, reduced activity, reduced interactions. And I note that there were findings of a prune belly. That would be a sign of severe dehydration”.

70 Dr Dunlop attributed the appearance of ‘prune belly’ and sunken eyes to severe dehydration which can occur for two reasons. The first reason could occur “acutely from a significant illness with obvious symptoms, significant vomiting, significant diarrhoea, reduced fluid intake, reduced urine output, they might be pale, they might be lethargic, they may eventually be drowsy and generally disinterested.” The second reason he suggested was a situation where dehydration could have been a chronic process over a much longer period of time, where fluid intake is inadequate over that time and accumulates to a point where the child might be severely dehydrated. He stated that he would expect to see some signs of the child becoming increasingly unwell over that period of time.

71 Mr Turner, Mike’s ITS caseworker, recalled driving Mike, Laila, ■ and ML to the unit on 8 November 2019 and describing ML as having a “severe croupy cough”. He also recalled hearing the cough earlier when he had spoken to Mike on the telephone.

72 Dr Dunlop questioned whether ML had a rare metabolic disorder that might have played a role in advancing ML towards a life-threateningly position more quickly. He commented, “One of the unexplained potentials is whether ML did have an undiagnosed inborn error of metabolism, which is a possibility. In that if you have a metabolic disorder, your threshold for tolerating normal insults of, for instance, viral infections, RSV or gastroenteritis, is much lower, and those kids can get into trouble much more quickly.”

73 Professor Ellis thought that Dr Brouwer’s diagnosis was not unreasonable. He agreed that bronchiolitis played a role in ML’s death. He also agreed that there were symptoms of dehydration in ML Professor Ellis

concluded that the cause of ML's death was principally related to RSV bronchiolitis.

74 Dr Dunlop was troubled by the available evidence relating to ML's presentation, which he opined was inconsistent with the slow decline in her health that he would have expected from RSV. He concluded that her cause of death was therefore unexplained.

75 It is possible, for whatever reason, that either Laila and Mike did not realise the true state of ML's health or were understating her symptoms in the day or days prior to her collapse.

76 On the balance of probabilities, there is evidence which allows the court to be satisfied that ML died from complications of acute bronchiolitis arising from RSV.

Department of Communities and Justice, New England Region

77 Ms "NW" was allocated the family's case after a DCJ 'Helpline' report on 2 August 2018, which was assessed as a ROSH report requiring a response within 72 hours. The ROSH was discussed at the Glen Innes CSC WAM on 14 August 2018. WAMs were held on a weekly basis. Ms "NW" was allocated the report and was tasked with undertaking a field assessment.

78 Ms "NW" reported that during her time at Glen Innes and Inverell CSCs, she had a very high case load of 19 files regarding children at risk serious of harm.

79 On 17 August 2018, a Pre-Assessment Consultation (PAC) was convened, and attempts were made to meet with Laila over the next couple of weeks. Due to illness, the meeting did not take place. On 18 September 2018, a home visit was conducted. On 21 September 2018, a Safety Plan was devised.

80 On 24 September 2018, Ms "NW" met with Laila and two support workers from the Armajun Aboriginal Health Service (Armajun) and a Tenterfield Social Development Committee (TSDC) member, who provided suggestions for a Safety Plan on behalf of Laila. On 27 September 2018, a further Safety Assessment was conducted and Ms "NW" indicated that Laila was engaging with the discussions and action plans.

81 On 29 September 2018, a "Helpline" report was received indicating that Laila was injecting 'ice' in front of the children and yelling at them when she was

coming down from the effects. The report was screened as a ROSH report with a required follow up in 72 hours.

82 On 4 October 2018, a Risk Assessment was conducted and the children were assessed as being at “very high” risk of future harm.

83 On 5 October 2018, a Family Action Plan (FAP) meeting was undertaken involving Laila, Armajun and DCJ. A caseworker from DCJ, Ms “LD”, and Ms “NW” took different views on the engagement process with Laila and there was clearly some disharmony exhibited between them.

84 Laila was later reported to have indicated:

“They should have let me have my say at the meeting of what did I want, what was best for us, my family. I was just sort of like - I was sort of cornered into a space where they had everything sort of planned out, what they wanted done, but not what I actually wanted done for my children and myself.”

85 On 9 October 2018, a Group Supervision Session was convened to discuss the transfer of the family’s case to Ms “JM”. It is unclear from the meeting note whether Ms “JM” was present at the meeting.

86 On 25 October 2018, Ms “NW” transferred to a new role at a different DCJ office. The following day, Police advised DCJ that the ADVO has been varied to specifically include Laila’s children as persons in need of protection.

87 Laila’s family’s file was formally reassigned to Ms “JM” on 6 November 2018. There does not appear to have been any formal handover process between Ms “NW” and Ms “JM”, prior to Ms “NW” transferring to her new employment, although there appears to have been some discussion via email, between the two caseworkers from 15 – 18 October 2018.

88 At this time, there was no permanent MCW at Glen Innes CSC. It is customary that the MCW would oversee the handover between caseworkers. Where no MCW is available, the MCS would facilitate the handover between the caseworkers.

89 During this period of time, the MCW responsibilities were being managed by Ms “CG”, MCS. In her oral evidence, MCS “CG” said of the handover between the case workers, Ms “NW” and Ms “JM”, “we have a process. I would say in this instance it was inadequate, and it didn’t happen effectively.”

90 On 6 November 2018, Ms “JM” became the new caseworker for the family.

91 On 7 November 2018, a report was received by the “Helpline” but was not assessed until 19 November 2018. The reporter stated that ■ had

changed from being an “outgoing and chatty girl to being quiet, withdrawn and a loner.” The report included a comment from ■ that the family were moving to Orange to be closed to Mike when he was released from custody.

92 On 13 November 2018, Ms “JM” conducted her first home visit with the family. Ms “JM” was able to confirm with other support agencies that Laila and the children were being supported.

93 On 10 December 2018, Ms “JM” met with Ms “KM” from TSDC to discuss the FAP. Ms “JM”’s intention was to complete the FAP during December and January, however, Laila and the children were frequently not in Tenterfield and the plan remained incomplete.

94 Ms “CG” added that the FAP should not have taken the length of time it took for finalisation.

95 On 21 December 2018, a report was received by the “Helpline” reporting that Laila was out drinking 3 to 4 times per week and leaving ■ and ■ to look after ML . A home visit had been scheduled for the same day; however, it became apparent that Laila was in Warwick, Queensland, and the visit was rescheduled to 27 December 2018.

96 On 12 February 2019, a report was made to the DCJ “Helpline” regarding ■’s non-attendance at school. The report also contained information concerning domestic violence and the use of drugs and alcohol within the home. This was screened as a ROSH report and allocated.

97 On 13 February 2019, Ms “JM” and another caseworker made a home visit and confirmed that ■ and ■ had returned to school. Laila told the caseworkers that she had been estranged from her family over the Christmas period and indicated that she had not consumed any drugs since September 2018. They discussed ■’s self-harm and Laila confirmed that she was in regular telephone contact with Mike from custody and they were planning on getting back together on his release from gaol. Home visit dates were agreed to occur on 22 February and every Friday in March 2019.

98 A Safety Assessment was completed by Ms “JM”, with the children being assessed as “safe” in the care of Laila.

99 Ms “JM” was on leave from 19 February until 4 March 2019.

100 In March 2019, two reports were received on the DCJ “Helpline”.

101 The first of those reports was received on 3 March 2019, and referred to ■’s low attendance at school. This was in the context of ■ referring

on two occasions to wanting to kill herself. It was noted that ■ was engaged with a counsellor and other services.

102 On 7 March 2019, Ms “JM” visited ■’s school and spoke with staff about her low attendance. She also spoke with ■ and later spoke with Laila.

103 On 11 March 2019, Ms “JM” brought a cot and bedding to Laila, together with information about the dangers of co-sleeping. Later that day, the second report was received, and referred to ■ being questioned about stealing a phone and indicating “I want to end it I can’t go on living like this.” Police called an ambulance, and ■ was taken to Tenterfield Hospital and admitted overnight. ■ went to stay with her grandmother when she was discharged the following day.

104 The following day, caseworkers met with Laila at the TSDC, and they discussed the mobile phone incident and the impact the violence has on the children, particularly ■’s recent indication of self-harm. The importance of both girls receiving support was discussed. The FAP was raised as was the need to make progress with the FAP, including the possibility of including Mike in the plan. Later that day the caseworkers visited Laila’s home and discussed the plan for ■ to move to her Aunty’s home in Narrabri. Her Aunty was an authorised kinship carer and Laila agreed to this proposal. ■ moved to Narrabri and enrolled in school. She was given a mobile phone and remained in contact with the caseworkers over the next few weeks.

105 On 14 March 2019, the “Helpline” received a report indicating that ■ was residing with the children’s grandmother.

106 On 26 March 2019, Ms “JM” commenced unexpected personal leave until 23 April 2019.

107 On 3 May 2019, a report was received by DCJ “Helpline” concerning ■’s physical presentation, including having skin sores and complaining that the bath water was cold, and she was getting up during the night to get ^{ML} her bottle. This report was screened as a ROSH with a 10 day follow up.

108 Caseworkers visited Laila’s home on 13 May 2019 and described the house to be in disarray. The washing machine was not working and the drain in the bathroom was blocked, and the bath was half full of water. Heating was reduced to a bar heater as there was no wood for the fire. The family were all co-sleeping on mattresses on the floor. A Safety Plan was agreed to with a follow up visit arranged for 16 May 2019.

- 109 During the home visit on 16 May 2019, the house had been cleaned by Laila and her mother and the plumber was due to arrive later that day to clear the drains. The caseworkers had arranged for a new washing machine, the installation of a fire guard and the delivery of firewood. A Safety Assessment determined that the family were 'safe with a plan'.
- 110 On 23 May 2019, another home visit was conducted, with Laila indicating that she and Mike were planning on reuniting upon his release from custody. There was ongoing discussion as to who Laila would like to be present at the next FAP meeting. Laila indicated that ■ was homesick and wanted to come home. ■ returned to Tenterfield at the end of May 2019, although it remained unclear as to whether she was homesick or had been told to return home.
- 111 The caseworker had maintained contact with ■ when she was living in Narrabri. ■ had come to the notice of Police and had been directed to attend a Youth Justice Conference (YJC) on 30 May 2019. At the YJC, ■ was directed to attend school and have counselling until November 2019.
- 112 On 10 June 2019, ■ was taken to hospital by Police after threatening self-harm. ■ was referred to the Children and Adolescent Mental Health Service (CAMHS).
- 113 On 13 June 2019, caseworkers attended Laila's home for a home visit. No-one was home, and they made enquiries with Tenterfield High School and were informed that ■ was not attending school and was currently living with her grandmother. They attended the grandmother's home and were told that Laila, ■ and ^{ML} were in Brisbane, visiting a sick uncle. The caseworker made the enquiry with Laila's mother as to whether Laila was on her way to Walgett to meet Mike, who was due to be released from custody on 16 June 2019, and no further information was forthcoming.
- 114 On 26 June 2019, the DCJ "Helpline" received a report about the care of the children. CSC caseworkers also received a phone call from Community Corrections at Coonamble informing them that Mike was no longer permitted to remain at his aunty's home, which was a condition of parole. The reason given, was that Laila and the children had arrived at the aunty's home and were asked to leave.
- 115 Community Corrections made contact with Mike and believed that they had all travelled to Moree after leaving the aunty's home in Walgett.
- 116 The CSC caseworker and her manager expressed significant concern about ^{ML} and ■ residing with Mike and requested Community Corrections

provide the details of Mike's address to enable Moree CSC to undertake a welfare check, with a view to assess whether the children needed to be removed if Laila wanted to stay with Mike. At first, an incomplete address was provided. By 9 August 2019, the correct address was received.

- 117 Community Corrections approached Laila's mother, who was currently caring for ■ to enquire whether Mike could be paroled to her address. She declined the request. Mike was then paroled to his cousin's home, which his cousin shared with Laila's sister.
- 118 On 27 June 2019, the DCJ "Helpline" received a report indicating that ■ had attempted to self-harm. Police and ambulance were called, and ■ was taken to hospital. ■ was referred to mental health and other services, however, there were issues contacting Laila to arrange appointments.
- 119 On 29 July 2019, a further report was received by the "Helpline" relating to ■'s disclosure of domestic violence in the home and her having to seek refuge at the neighbour's home.
- 120 On 14 August 2019, a report was received by the "Helpline" stating that ■ had indicated that she was being hit by Laila and ■ was being cruel to her. The report also noted that ■ had killed the family dog by kicking it to death.
- 121 A Risk Assessment was completed on 22 August 2019, with a "very high" risk being assessed. There had been no contact with Laila since June 2019 and the information from this assessment was gleaned from information available prior to June 2019 and the more recent "Helpline" reports.
- 122 ■'s file was transferred to Moree CSC at the end of August 2019, but ■ and ML's files remained with the Inverell CSC. No transfer notes have been located.
- 123 On 5 September 2019, a report was received by the "Helpline" reporting that ■ had said that Laila had pushed her head against the bathroom door and that her mum was not 'ok' as ML was keeping her up at night. This report was screened as a ROSH report with a 24-hour response required. A DCJ crime report was prepared and forwarded to the Moree CSC for ■ and also to the Inverell CSC regarding ■ and ML. The report was closed due to "no capacity to allocate" at Moree and no action appears to have been taken at Inverell.
- 124 On 19 September 2019, ■ and ML's files were forwarded to the Moree CSC.

- 125 On 8 November 2019, a report was received stating that Mike had been living with Laila and the children since he arrived in Moree in June 2019. Community Corrections contacted Police, requesting and ADVO compliance check be undertaken. Community Corrections also contacted Moree CSC and the caseworker asked that she be provided with an update. It would appear that neither Police nor Moree CSC followed up on this report until after ML's death.
- 126 On 11 November 2019, Mike's ITS caseworker picked Mike up, together with a woman that he identified as being his cousin and a baby about 15 months of age who had a severe 'croupy' cough.

Staffing and caseworker skill sets at the various CSCs during 2018-2019

- 127 Caseworker Ms "NW" indicated that in 2018 she had a very high case load of 19 children when she was working at the Glen Innes CSC.
- 128 The management structure in DCJ at the relevant CSCs involves a Manager Client Services (MCS) overseeing Manager Case Workers (MCW), who in turn oversee Caseworkers (CW).
- 129 As noted above, at this time, there was no permanent MCW at Glen Innes, the MCW responsibilities were being managed by Ms "CG", MCS and the handover between the caseworkers, Ms "NW" and Ms "JM", "didn't happen effectively."
- 130 It was also explained that there could be a significant lag time between a new report from the DCJ "Helpline" and a response being completed by caseworkers. For example, on 2 August 2018 a report was received in relation to the children with a response required within 72 hours, however, it was transferred to the Glen Innes CSC on 3 August and was discussed at the WAM on 14 August 2018, and by 10 September 2018, an initial response (the 72-hour response) had not been completed.
- 131 As also noted above, Ms "JM" had graduated from the DCJ Casework Development Program in June 2018.
- 132 Ms "JM" gave evidence to the effect that the members of her team were all "pretty inexperienced", with generally one or two years' experience. She stated that there were no senior caseworkers, even though the office was funded for three MCW, plus one MCS. This meant that MSC "CG" was often covering two positions, being the MCS and MCW roles. In addition, the

casework specialist was shared between two CSC offices and had a heavy focus on home care accreditation.

133 Ms “JM” gave evidence that her experience at that time made her feel that junior caseworkers were not receiving the guidance that they required to perform their roles effectively. She stated that she was often directed to the written practice kits for guidance. These kits were contained voluminous documentation, which were difficult to navigate.

134 Ms “JM” recalled feeling under significant pressure to perform her role with limited or no support, such as the difficulty in co-ordinating secondary caseworkers to attend family meetings.

135 Ms “JM” stated;

“... even when there was an acting manager of casework, they didn’t necessarily have child protection experience or recent child protection experience. You know, some of them had never worked in the field as caseworkers or, you know, they had or that it was only in out-of-home-care or sort of – the support when it was there wasn’t timely for whatever reason or it didn’t, you know, people only have this much time, you know, like, just, there was no one to refer to, there was no one to support the family. There was nowhere to go with it.”

136 Ms “CG” added that the FAP commenced in September 2018 should not have taken the length of time it took for finalisation as “the family action plan should be telling us where we’re going, moving forward. So it’s kind of a little bit different to just being open for a long time, not completed.”

137 Ms “CG” explained that in 2018-19, there was no capacity to backfill positions and there was no process in place to allow the timely transfer of information

Support Resources in the New England area

138 Caseworkers gave evidence that there are scarce resources available in the New England area to assist and support client families.

139 Caseworkers indicated that it would be ideal if they were able to refer families to various programs and services.

140 Ms “JM” gave evidence about a service called the “Shark Tank” which is aimed at equipping woman who have been the victims of domestic violence,

with greater skills with which to protect themselves and their families. She confirmed that Laila had been offered this service, however, the referral was subsequently withdrawn as Laila was assessed as being “too high a risk”.

141 Ms “JM” stated that Laila;

“... was unable to access [it] because she was too high of a risk, basically. So, it was left in this space of us educating and trying and helping, and it was – yeah, so you were the – you were assessing safety and risk and educating and trying to – and raising the worries with no support services that you could refer to , to outsource that information, to corroborate your information about your worries, to understand if the family was, you know, progressing or not progressing. There was no other set of eyes, so to speak. There was no one to go to.”

142 Ms “CG”, the MCS, agreed that there was a scarcity of resources in the region, particularly services for family referrals. She commented that “the type of service that Tenterfield Social Development Committee provided – it’s a family support service, not a service funded to work with high or very high-risk families.”

143 Ms “CG” informed the inquest that the referral process in Glen Innes has since changed, whereby high-risk families can now be referred to The Benevolent Society, although no further detail was available.

144 Ms “CG” also advised that there had been an increase in Aboriginal service providers in the Inverell area in recent times.

145 Professor Jude Irwin, who provided an expert report in relation to the DCJ response to ^{ML} , noted that much of the work being done at the CSCs is;

“Crisis-driven and it’s stretched, and particularly in areas like New England where there’s not a strong service system around, you know, agencies that work with men who use violence for instance. But we get into this way of thinking that if you just take the man who uses violence out of the picture everything’s going to be safe, and the evidence is that’s often not the case; that years of living as the victims of violence can erode women’s capacity to parent.”

146 Professor Irwin observed that there is some “really good case work going on” but what she sees “is the big gap is the capacity issue, and when you don’t have capacity, you move to the things that are most important.”

Culturally Appropriate Support

- 147 Professor Irwin perceived that engagement with the local Aboriginal communities was vitally important in building local indigenous-specific child protection response services, as this promotes community governance and self-determination.
- 148 Ms “NW”, CW, said that the only culturally appropriate service in Tenterfield during the time she was engaged with this family was Armajun. At least two representatives from Armajun were involved in supporting Laila during this period of time.
- 149 Ms “JM”, CW, herself identifying as a First Nations person, said her experience of Aboriginal consultation was that “at the time... while I was working with this family it wasn’t available. The whole time that I worked in DCJ was – it wasn’t available.”
- 150 Ms “CG”, MCS, stated:
“I think it’s a process that we haven’t done well, but also one where we can engage other Aboriginal colleagues throughout the district, colleagues within the CSC. A consultation can occur within a PAC. A consultation can occur with a family who guide us in the work that we do, and how we should do that work with their family we consult more with family, when we’re taking with family, to bring supports around a family. Probably not with our Aboriginal services, in a formal consultation. That’s a process that wasn’t in place. But certainly, we’ve always had Aboriginal staff within our organisation that we could consult with.”
- 151 Ms “MA”, the MCS at Moree, indicated that the practice for First Nations consultations were:
“So for Aboriginal consults we will first refer to our peers within the CSC who have local knowledge. We will seek guidance from them around the best way to support families within the community. If Aboriginal caseworkers or managers casework aren’t available, then we will seek support from further Aboriginal staff within the district, to ensure that we have appropriately responded in a culturally and respectful way.”
- 152 The evidence suggests that an Aboriginal consultation panel was difficult to coordinate. The situation has changed and there now exists a team of caseworkers based in Tamworth called the “Cultural Connections” team which provides consultation and support, especially for CSC offices that do not have First Nations caseworkers. This team was established in 2023 and

is managed by Ms “MA” and provides an additional perspective towards the community, including views on the most appropriate supports or individuals who can be relied upon to benefit the families.

Laila’s Perception of DCJ during 2018-2019

- 153 Laila had experienced government intervention with her family as a child.
- 154 Laila gave evidence about her perception of caseworkers and what impact they may have on her family. She indicated that she was reluctant to meet with the caseworker, Ms “NW”, in 2018 as she thought that DCJ wanted to remove her children, and she did not trust them. Laila stated in evidence, “I was scared of them removing my kids because I’ve had family members had their kids removed and not give them back to them, and I thought that was going to happen to me and I’ll never see my kids again.”
- 155 Laila gave an example of a close friend of hers being taken into care until she turned 18 years of age and that she was worried her children might be sexually assaulted if they were taken into care.
- 156 Laila stated in her evidence that no one had ever explained to her in what circumstances her children might be removed from her care, and she didn’t understand the process like she does currently. She indicated that it would have been beneficial to have had that explained and that she could have been consulted about appropriate “out-of-home” placements if the children had been removed. Laila stated “Absolutely yes. That would have given me that reassurance as their mother that they was [sic] going to somebody that I fully trusted, you know.”
- 157 Laila gave evidence that she found it quite difficult to talk with her caseworkers about domestic violence. She felt that it may have been easier to discuss domestic violence if she had a family member with her.
- 158 Ms Kate Alexander, Senior Practitioner within the Office of the Senior Practitioner (OSP) at DCJ, acknowledged in evidence;
- “But on top of that the additional factor for a lot of families we work with, but most particularly Aboriginal families, is a recognition about the response they may have received from government systems in the past. So, if you’re an Aboriginal parent who has experiences of trauma that may not have been well received or well supported or well met by government systems, if you were removed from your family or your parents were

removed of stories of stolen generations that run deep through Aboriginal communities and then we'll turn up to knock on the door, it's really hard. It's really hard and a lot of Aboriginal people will be frightened of us for good reason because of that history."

Mike and DCJ during his incarceration in 2018-2019

- 159 During late 2018 and early 2019, the caseworker, Ms "JM", CW, attempted to engage with Laila and Mike to prepare a FAP, as well as various Safety Assessments and Plans.
- 160 Ms "JM" was aware from speaking with Laila during the home visits that she was in contact with Mike via telephone with the prison and that it was their intention to continue their relationship when he was released from custody. It is unclear whether caseworkers spoke with ■ and ■ as to their views about Mike returning to the family home.
- 161 Caseworkers were hampered by Mike's refusal to engage with them. On 14 March 2019, Ms "JM" told Laila that she would like to speak with Mike while he was in custody.
- 162 At the end of April 2019, Mike applied to have visits with the three children while he was in custody. Corrective Services contacted Ms "JM" however, the details of the conversation are unclear.
- 163 Ms "JM" had arranged to speak by telephone with Mike on 2 and 15 May 2019, to discuss his plans following his release from custody, however, Mike declined to accept either call. Ms "JM" attempted to arrange further telephone meetings, without success. Ms "JM" commented that the process of trying to get access to Mike in custody was difficult, onerous and time consuming. Ms "JM" gave evidence that Mike "was just a hard person to open up to. He didn't, like, really express his feelings or – or anything like that, I think maybe because of his upbringing."
- 164 Professor Irwin noted:
- "Mike participated in other programs while he was in prison and on parole, however his attendance was intermittent, and he does not complete programs. He has been described as a 'watcher' as he would only participate in group discussions when asked. This information does not appear to have been shared with FACS [DCJ] but had it been shared it may

have led to a better understanding of why it was difficult to engage Mike and why he struggled to be accountable for his behaviour.”

- 165 Whilst in custody, Mike was noted to have completed 18 out of 20 sessions of the EQUIPS Foundation programme, according to CSNSW records. This program uses cognitive behaviour therapy to address offending and re-offending factors.
- 166 On his release from custody, Mike was to attend weekly supervision sessions with his Community Corrections officer and comply with home visits and case plan reviews. He was also referred to the Aboriginal Client Services Officer (ACSO) to assist him in finding culturally appropriate services to facilitate his reintegration into society.
- 167 Mike’s case management targeted the risk factors of domestic violence, alcohol and drugs, aggression, and mental health. Parole conditions included a prohibition on attending Laila’s address or contacting her in any way. He was referred to a domestic violence program and attended a men’s group at Moree Sports Health Arts and Education (SHAE) Academy. Community Corrections reported that he was compliant with all conditions, except for the suspected contact with Laila.
- 168 Ms Alexander reviewed the case notes and made the following assessments:
- i. “Mike's decision not to engage with caseworkers while incarcerated should have been considered in the context of his past experience of authorities, including Police and caseworkers;
 - ii. Mike's request to see ^{ML} and her sisters while incarcerated should have prompted caseworkers to have a conversation with him about what it was like to be a father, what his experience of being parented was like, what was important to him in his role as a father and what was getting in the way of being the father he wanted to be;
 - iii. Mike should have been involved in assessments and interventions. For example; Mike should have been consulted in respect of the FAP that was finalised in 2019. This could have been done in collaboration with CSNSW to seek to ensure that Mike received counselling to address issues such as his underlying trauma and the destructive ways in which it was displaying itself; ...”

Family circumstances after Mike's release

- 169 Laila and Mike had been in an intimate relationship for approximately 7 years at the time of ML's death. This relationship was marred by physically violent, and psychologically serious domestic violence, resulting in a period of incarceration. Laila referred to the violence as being "nothing really violent", which bears the hallmarks of ingrained abuse on a victim. Laila had been present when Mike had threatened to kill himself and burn the house down with the children present.
- 170 Drug use was an issue for Laila in 2018-19, including the time following Mike's release from custody. Laila indicated that she was not in the right head space to be accepting or understanding the need for counselling in relation to domestic violence.
- 171 In her oral evidence, Laila candidly conceded that she had moved in with Mike shortly after his release from custody in June 2019. She stated that she wanted ML to have her father in her life because her other two daughters did not have their father in their lives.
- 172 Laila said that after Mike had gone into custody, she did think about how her domestic violence was affecting her ability to parent, she did not appreciate the extent to which it might have had an impact on her three children. She stated that since ML's death, she has become abstinent and met other mothers who have experienced domestic violence and drug use.
- 173 Ms Rachel Colvin commenced working as Mike's Community Corrections Officer (CCO) on 5 August 2019. She had regular contact with Mike throughout the supervision period and built a healthy working relationship with him. During this period, Mike had no engagement with DCJ caseworkers and Ms Colvin gave evidence that she was not sure if it would be deemed to be a "reasonable direction" to direct Mike to commence such an engagement.
- 174 On 5 August 2019, Police advised DCJ that the children were enrolled in school and were living with Mike in Moree.
- 175 On 6 August 2019, Ms Colvin spoke to Mike and reminded Mike of his parole conditions that he was not to have any contact with Laila unless it was through a lawyer and Mike acknowledged the direction from Ms Colvin.
- 176 On 7 August 2019, Ms Colvin spoke to the Domestic Violence Liaison Officer at Armidale Police station about her concerns that Mike was living with Laila

and the children. Over the ensuing weeks, Mike consistently denied that he knew where Laila was residing.

Transfer of the children's files from Glen Innes CSC to Moree CSC

- 177 Between 7 – 9 August 2019, caseworker Ms “JM”, CW, exchanged emails with Ms “CG”, MCS, updating her about the family and the possible transfer of the DCJ file to Moree CSC.
- 178 Family case files are often transferred if a family moves between locations, or there has been a change in DCJ caseworkers. Cases can be transferred internally within a CSC or between CSCs.
- 179 On 9 August 2019, Ms Colvin told Ms “JM” that Mike was at Laila’s sister’s home (also Mike’s cousin’s home) at Moree, and ■ and ■ were also residing at that home.
- 180 On 15 August 2019, Ms “CG”, MCS at Glen Innes CSC, asked Ms “AF”, MCW, and Ms “JM”, CW, to liaise with Ms “BC”, MCW at Moree CSC, to transfer the case to Moree CSC.
- 181 Ms “MA”, MCS at Moree and Narrabri CSCs, gave evidence that she would expect there to have been a conversation between the outgoing MCW and the incoming MCW and a case management transfer meeting if there was to be a transfer of a case between CSCs.
- 182 Ms “MA” explained the importance of triaging a case on referral from another CSC. Ms “MA” stated;
- “Triage ensures that we keep track of reports that come in. The caseworker can focus on that work so that we don’t miss reports that come in. The triage caseworker will access what’s there and speak to the manager casework around new reports that have come in for families that we haven’t worked with before, or that another report has come in for a family that we’re currently working with.”
- 183 There appeared to have been some uncertainty associated with incomplete triages and whether they needed to be completed before a transfer could be affected.
- 184 A transfer meeting was scheduled for 21 August 2019. Reference was made to a telephone meeting that day, however no records of the meeting exist.

185 Ms “JM” completed a Risk Assessment for the three children on 22 August 2019, scoring them as a “very high risk for neglect and abuse.” This report was submitted to Ms “AF” at Glen Innes for review and was subsequently amended and finalised. Ms “JM” gave evidence that at the time of the transfer;

“There was outstanding, you know, sort of ROSH reports that have come in that hadn’t been responded to. But they’d been outstanding for a long time because I couldn’t do it – I just couldn’t do it. Because I had too much work and by the time I had corroborating information it was June, and I had a clear picture. Well, June, July, and then – you know, and then Mum was gone.”

186 On 29 August 2019, ██████’s case was transferred to Moree CSC, but ██████ and ML’s cases remained at the Inverell/Glen Innes CSC. Ms “JM” requested assistance from her MCW and MCS to finalise the transfer of the two other files.

187 Ms “BC”, MCW at Moree, requested a transfer meeting when the files pertaining to the family were going to be transferred from Glen Innes CSC to Moree CSC. Ms “BC” gave evidence that a transfer meeting was important to her, in addition to the records held on “ChildStory”, because “sometimes some of the information the caseworker still might hold that has not made its way to “Childstory”. Some of the information might be held with the manager as well.” Ms “BC” agreed that even though these meetings are best practice, resources sometimes do not allow for a transfer meeting to take place.

188 On 4 September 2019, Ms “BC” indicated that the transfer could not be finalised until all the forms had been completed and a transfer meeting had taken place.

189 On 9 September 2019, Ms “AF”, MCW at Glen Innes, forwarded an email to Ms “BC”, MCW at Moree. The email contained a reference to a meeting having taken place over the telephone. Ms “AF” understood that the phone call was the transfer meeting, however, Ms “BC” did not share that understanding and was waiting for a transfer meeting.

190 Although Ms “BC” gave evidence she was not aware that the ██████’s file had been transferred to Moree CSC, she indicated that in her view the triage caseworker at Moree would be aware that ██████’s case had been electronically transferred to Moree CSC, because when the transfer is received from another CSC, it comes in on a “transferred in” list. She said the case would sit on the “transferred in” list until the transfer had been

acknowledged and then it would move to an “incomplete triage” list, and it could be sitting in that list for a number of reasons.

191 On 11 September 2019, the WAM at Moree CSC discussed the ROSH report received on 5 September 2019 regarding ██████’s report that Laila had pushed her head into the bathroom door and assessed with a response time of 24 hours. A decision was made to “close the report”, citing “no capacity to allocate”. ██████’s case remained open. Ms “BC” said that it was unusual for a 24-hour response report to go for six days without being discussed at a WAM.

192 Ms “BC” gave evidence;

“That’s not generally our practice for that to happen. When we have a less than 24 report come in, it needs to be peer-reviewed by the managers and also the MCS for a decision for that to then either have a response at that time of it could go to WAM. We might be gathering some additional information. I believe with this case, because we thought that, well, we were aware that Glen Innes had an open case, that this report wouldn’t have come through to us. When we closed the report, so I know we’ve got there that we’ve closed it with no capacity, we actually only have four areas that we can select to close the report, and we would write to why we’ve closed that.”

193 Ms “BC”, continued;

“The triage worker will provide a copy to everyone that’s present at WAM, and we will sit there and talk through the reports. We will have a look at the response times. We’ll have a look to see if the family are known to us. Have a look at how many reports we’ve received on the family. But we also have to take into consideration what capacity we have to allocate. So I think sometimes we could have, you know, between 10 and 20 reports come to WAM, but due to staffing, we might not be able to allocate anything, or we might be able to allocate one.”

194 On 19 September 2019, ML and ██████’s cases were transferred to Moree CSC. Caseworker Ms “JM” had no more involvement with the family after the transfers.

195 Ms “MA”, MCS at Moree and Narrabri CSCs, was unable to recall what the process was for the allocation of the files and the discussions associated with the transfer. There are no records available to establish that there was any contact with the family after the matters were transferred in September 2019, until after ML’s death.

- 196 At around this time, Ms “BC” said that she spoke with caseworker Mr “CR” and informed him that the family’s files were going to be allocated to him. Ms “BC” then went on leave and she is unsure if the files were actually allocated to him. If the files hadn’t been formally allocated to Mr “CR” he would not have received emails informing him that he was the new caseworker.
- 197 On 25 September 2019, a WAM took place at Moree CSC. The report shows that the case was allocated to Mr “CR” for review. The documented WAM outcome was to close the report as “information from Corrective Services that mum and children not residing the same household as Mike.” The decision was confirmed at the WAM on 6 November 2019.
- 198 No casework was undertaken with the family from 25 September 2019 until 10 November 2019.
- 199 File notes made after ^{ML} ’s death by Ms “MA” on 11 November 2019, indicate that the family were last seen at a home visit on 13 June 2019, prior to the case being transferred to Moree CSC.
- 200 Professor Irwin commented that, “the person who was most worried about these children was the caseworker Ms “JM” and she was the person that, to me, her insights and her worries were essential to feature in a handover.”
- 201 Professor Irwin also noted that handovers should be done in person, given that;
- “... it’s not just the documents. It’s the introduction of the person that’s previously been seeing and supporting the person to introduce the new worker. It’s like a warm, what do they call it, a warm meeting. So the worker isn’t going in cold, and the person, it it’s [Laila], has some introductory process. That’s about respect for me. So I think that’s as important as are the transfer notes.”

Interagency Issues

- 202 In the New England region of NSW there are a number of established interagency groups. They include Safety Action Meetings (SAMs), Complex Case Coordination Meeting (CCCM), Youth Action Meetings (YAMs) and the Local Coordinated Multiagency (LCM) program.
- 203 Safety Action Meetings (SAMs) are held every two to four weeks and are coordinated by the Police and the Women’s Domestic Violence Court Advocacy Service (WDVCAS). After the report of violence against a woman,

both Police and the WDVCS prepare a Domestic Violence Safety Assessment Tool (DVSAT) with the victim, which assesses the perceived level of risk. If the level of risk is assessed as being at the level of “serious threat” the victim’s matter is referred to a SAM.

204 Participants at SAMs include Police, DCJ, NSW Health, CSNSW, The Benevolent Society, Homes North and WDVCS. Each referred case is discussed, with each government agency or NGO providing additional services and support to the victim or ongoing monitoring of their matter. The information provided to DCJ during a SAM assists with case management relating to their client families.

205 A CCCM is a government initiative funded by the NSW Department of Education (NSW Education) and includes DCJ and NSW Health. NSW Education makes the majority of referrals to a CCCM and provides additional supports and information gathering for children and families.

206 The funding for CCCMs ceased in around 2019. The CCCMs were child-focused due to the funding being received from NSW Education and the referrals were predominantly received from schools.

207 On 27 August 2019, Mike was offered to participate in the LCM program by Community Corrections, for additional, multi-agency support, however he declined the referral.

208 Mr Rodney Chenhall, Director Northern District, CSNSW Community Corrections, provided a statement and gave oral evidence during these proceedings.

209 In relation to the LCM, Mr Chenhall stated the;

“LCM is a program that brings together key agencies to co-ordinate a multi-disciplinary case management model to nominated clients. The partner agencies work together to help reduce a participant's risk of re-offending through information sharing and the development of joint case planning.”

210 He continued:

“There’s a management group, and the management group’s remit is to ensure governance of the process, and then there’s a practitioner’s group. The coordinator is a Corrective Services employee that basically provides that conduit between the two groups, so it’s partnered with DCJ, Health, and Police. The idea is that we go beyond our own individual remits and expand into other portfolios and coordinate information, collaborate, and I’d like to think be quite responsive to how we provide services.”

211 Mr Chenhall commented on the importance of interagency collaboration attempted by the LCM program:

“I think collaboration is critical in any service delivered by government. It just – it allows us to think across our portfolios and it allows us to get to an understanding of the different levers of other agencies and allows us to work together and cooperate. My experience in collaboration is, with Corrective Services, the issue of what we do and when we do it is critical when you’re dealing with families, so we work obviously with offenders but offenders exist within a family and within a community, so we need to be mindful of that when we’re working with an offender.”

212 Mr Chenhall said there is a move towards a more family-based approach to managing offenders on the LCM program. He said, “..we’re sort of moving our context away from just the individual to include the family and to include all the social supports.”

213 Mr Chenhall continued to comment;

“I think there’s a real prospect in one case plan that sits across multiple service providers so that we are connecting and cooperating. I think the relationships is what creates the cooperation, so if we’re working in silos then you don’t have the relationships and people don’t want to work for each other. I also think there needs to be a better understanding of the pressures and the levers that pull different departments in different ways, so that we’re not making judgments on performance or non-performance.”

214 The evidence suggested that CSNSW are taking a more comprehensive view of offenders in the community, their risk factors upon release and how the risk factors can be managed in the local community. CSNSW have proposed, “transitioning into a more connected and responsive service delivery model” that will see “support going beyond the inmate to include support for their family as they transition back into the community with a focus on employment and housing.”

215 Mr Chenhall suggested that CSNSW is also taking a more holistic view on how they manage offenders in the community. This includes looking at culturally appropriate services. Mr Chenhall said;

“We’re looking at targeting identity, belonging culture, so not just talking about criminogenic risk and compliance but moving into what kind of pathways we can connect people into, to look at reducing reoffending. So to me, I think employment and education’s really important, and it’s a live

conversation so we're currently mapping services with the idea of, I hope, change".

216 Mr Chenhall indicated Community Corrections are redesigning the service delivery model to work with clients withing their families and social structures. They concede that this will involve a "renewed focus on community relationships and having more meaningful engagement with the local Aboriginal communities."

217 Mr Chenhall impressed as a lateral thinker who perceived the immense benefits of a collaborative approach to overwhelming community issues. A Strategic Partnership Guideline is currently being drafted, and it is hoped it will facilitate improved family and community options.

218 Ms Alexander, OSP, DCJ, was only vaguely aware of the LCM program. Ms "CG", MCS at Glen Innes and Inverell CSCs, was not aware of the LCM program. Managers Client Services at Moree had had no engagement with the LCM program since 2019.

219 Senior Constable (SC) Paul Caldwell is the domestic violence liaison officer at Armidale Police station. He indicated that he had heard of the LCM program, but had a limited knowledge of the program, other than "it is chaired by ... Correctives and other organisations who I'm not familiar with."

220 In relation to SAMs, SC Caldwell commented that "the purpose of the meeting is to, you know, try to identify any potential risks of trauma, harm to victims and children." He perceived that the participants at the SAM were motivated to assist and share information, although at times the information could be somewhat dated.

221 Professor Irwin stated that building interagency collaboration is "critical for good child protection practice". She thought the absence of interagency collaboration in this case limited the work of DCJ and other agencies with the family because caseworkers were working with either partial or no information, limiting what they could do. For example, closer work between CSNSW and DCJ might have allowed caseworkers to locate Laila and the children sooner in late 2019. In Professor Irwin's view, "regular, collaboration between the multiple agencies that are working with children, young people and families, needs to be written into child protection policies and practice."

222 In relation to November 2019, Professor Irwin commented;

"if there'd been communication between them, that might have worked out, that they knew where she was I guess, and then they moved into an inappropriate accommodation at the end, and I think if there'd been that

connection with Community Corrections then, in fact, that might have been different.”

- 223 Evidence emerged after the inquest of the establishment of a DCJ initiative on the Central Coast of NSW called the Multiagency Response Centre (CCMARC). The CCMARC is an initiative of DCJ where DCJ are the lead agency. The centre has DCJ “helpline” staff, triage workers and interagency staff from both NSW Education and NSW Health. A further evaluation of this service is expected to be completed by 30 June 2025.
- 224 In 2014, another model, the Macarthur Intake and Referral System (MIRS) was launched by DCJ. This service was described as a satellite “Helpline” in South Western Sydney. After a review in 2018, the model was discontinued citing difficulties with implementation and sustaining practice.
- 225 Another model known as the Helpline Advanced Screening Program (HASP) was trialled in 2018. It was intended as a dedicated “Helpline” team created to work collaboratively with DCJ’s Northern NSW District, NSW Education and NSW Health Child Wellbeing Units (CWUs) to achieve better outcomes for children. It involved broadening the “Helpline’s intake to include an information gathering and referral function.” In 2021, a review by the OSP, found there were problems with the accuracy of the decision-making process resulting in large numbers of cases being screened out, instead of being screened in, and it did not therefore mitigate the safety concerns of children at the risk of serious harm.

Liaison between DCJ, Community Corrections and Police after Mike’s release from custody

- 226 On 26 September 2019, a final ADVO was made in the mandatory terms, together with conditions preventing contact between Mike and Laila and preventing him from going within 50 metres of her home or work. The conditions were for a 2-year period and applied to the three children.
- 227 Community Corrections Officer Ms Colvin, spoke to Mike about the Orders on 30 September 2019, and he responded that he was “shattered” by the outcome. The Police also effected service of the ADVO on Mike on 30 September 2019. The evidence suggests that Laila was also aware of the nature of the current ADVO.
- 228 On 26 September 2019, an email was forwarded from the DCJ Quality Assurance Team to the Triage Caseworker at Moree CSC, Ms “SS”, to the

effect that Mike was residing with Laila and the children, contrary to the current ADVO.

229 On 1 October 2019, Ms “SS” contacted Ms Colvin and advised her that DCJ were concerned that Laila and the children were in Moree and their whereabouts were unknown and that the DCJ staff did not know what Laila looked like. Ms Colvin responded that neither she nor the local Police knew what Laila looked like. Ms Colvin recalled, however, that at the time, “the [Community Corrections] manager was a long-term resident of Moree and a long-term employee of the department. She basically knew everyone that walked through the door and was very familiar with many, many families.”

230 There did not appear to have been a successful liaison between the agencies to identify Laila during this time. This may have confirmed that Laila was indeed residing with Mike. This appeared to have been a lost opportunity.

231 On 11 October 2019, Laila’s sister, contacted Ms Colvin and told her that ■ and ■ were staying with her and she didn’t know where Laila was residing, although it would appear that Laila was residing at her sister’s home with Mike.

232 Ms Colvin passed this information on to Police, who indicated that they would attend the premises to conduct compliance checks over the coming days. Ms Colvin also contacted an ITS caseworker, raising her concerns about the need for him to secure independent accommodation for Mike. It does not appear that she contacted DCJ at this time.

233 On 8 November 2019, Laila’s sister again spoke with Ms Colvin and confirmed that she had been lying for Mike and that Laila and the children had been residing at her house and that they had now moved to Mike’s new accommodation in the ■ apartment.

234 Ms Colvin again contacted Police who conducted an ADVO compliance check at the ■ apartment, but no-one appeared to be home at that time.

235 Ms Colvin also contacted DCJ and left two messages for Ms “SS”. Ms “SS” called her back and noted that Laila’s sister had not attempted to contact DCJ with the same information. No caseworker attended the premises to conduct a home visit.

236 Information sharing during the period from late September until early November 2019, was crucial in terms of the protection of these children. Professor Irwin noted:

“Collaborative interagency connections between [DCJ] and Community Corrections could have helped to clarify this...A little more curiosity or more collaborative connections between organisations may have clarified this.”

The [REDACTED] Unit

- 237 Mike accepted a referral to Initial Transitional Support (ITS) for accommodation support. This service is funded through Community Corrections. One of the support agencies associated with ITS was Housing Plus. Mr Turner, was employed by Housing Plus and assisted Mike to find the accommodation on [REDACTED], Moree.
- 238 On 21 October 2019, the unit in [REDACTED] was identified as being appropriate accommodation for Mike, although he needed assistance with obtaining furniture.
- 239 On 23 October 2019, Mike made an application for ‘Rentstart’. He entered into a rental agreement on 6 November 2019 until 5 February 2020. He received the keys to the [REDACTED] property on 7 November 2019.
- 240 On 31 October 2019, the bond for the rental property was approved.
- 241 Ms Colvin confirmed that there had been a shortage of accommodation for many years in Moree. There was no requirement or obligation on Community Corrections or Housing Plus ITS to physically inspect accommodation to ensure the habitability of the accommodation. The unit was inspected by Mike, but it is unclear as to whether he was accompanied by anyone at this time.
- 242 On 6 November 2019, Laila argued with her sister.
- 243 By 7 or 8 November 2019, Laila and the children were living with Mike in the unit at [REDACTED].

Internal Review by DCJ

- 244 Ms Alexander reviewed some DCJ records which noted:
- i. Assessments were completed in isolation and there was a lack of appreciation of risk and urgency. The assessments did not recognise the

effects that Mike's use of violence and Laila's drug use and depression we're having on Laila's parenting, nor the cumulative impact of neglect on the children. The response by practitioners did not consider the cultural context of this Aboriginal family and the experience of statutory agencies in their lives. Aboriginal consultations with family and community were not recorded.

- ii. Mike was not included in the assessments and intervention, which resulted in Mike avoiding accountability for his violence on Laila and the children. Practitioners placed the burden of Mike's violence with Laila.
- iii. Early interagency collaboration could have influenced a better case plan for the family. While Mike was in prison, practitioners could have initiated contact with CSNSW to discuss whether Mike had participated in any programmes specifically related to drug and alcohol use and violent behaviour and if not, supported Mike to do so. Involving CSNSW would have removed the onus on Layla to manage Mike's violence and put the responsibility back onto Mike.
- iv. ■ ■ and ML's cases had been transferred on two occasions. The first time in 2018 when the family was relocated to a new caseworker at Glen Innes CSC for ongoing intervention. The second, in 2019 when the family was transferred from Glen Innes to Moree CSC. On both occasions, a case transfer meeting did not occur. When a case transfers to another CSC, there is a risk that important information is not passed on which could be central to understanding the risks to a child and poor decisions can be made as a result. A transfer meeting between Glen Innes and Moree CSC was required to discuss the escalating concerns and ensure that the children were supported and safe.

245 Ms Alexander noted the lack of record keeping in respect of transfers and WAMs was concerning and not consistent with proper practice. She observed that these deficits made it difficult to understand what actions were taken and why some actions were taken, particularly at the time of case transfer from Glen Innes CSC to Moree CSC.

246 One of the issues facing the practitioners in the New England region was workload and a shortage of staff. There are some district-led initiatives being utilised by DCJ in the district to fill this significant and long term vacancies.

Expert Opinion on DCJ involvement with the family

- 247 Professor Irwin provided an expert report for these proceedings, dated 14 July 2023. Professor Irwin gave evidence concurrently with Ms Alexander, OSP, DCJ, on 6 August 2024.
- 248 Professor Irwin firstly considered the reports made to the DCJ “Helpline” during the periods prior to 2014 and also the period from 2014-2017.
- 249 Professor Irwin noted a report was dated 15 July 2010, which referred to a suspected sexual assault on [REDACTED]. [REDACTED] was offered support for about three weeks and then the report was closed as there was no evidence that the children were affected. Laila had recently given birth to [REDACTED] and was described in one of the DCJ reports as being “fragile”, however, no attempt appears to have been made or actioned to refer the family to support services in Inverell, or to the local Aboriginal community support services.
- 250 During the period 2014-17, Professor Irwin perceived that there was an escalation in ‘Helpline’ reports, often in relation to the two girls, [REDACTED] and [REDACTED]. Many of these notifications were closed due to inadequate resources or competing priorities, prior to being adequately assessed.
- 251 Professor Irwin noted that there was an escalation in “Helpline” reports towards the end of the period 2014-17, often about the wellbeing of [REDACTED] and [REDACTED]. Professor Irwin remarked on the number of occasions the decisions were made by DCJ to close cases and not assess the majority of ROSH reports during that period of time.
- 252 During this period, Professor Irwin noted “no consideration [was] given to the cumulative impact that living with domestic violence had on [REDACTED] and [REDACTED], or on Laila's history of drug use and how this might affect her caring of the children.”
- 253 Professor Irwin summarised the interactions between the family and DCJ in the first part of her report. She specifically commented on the occasions that risk of harm reports did not adequately consider the impact of domestic violence on the children. She noted;
- “Despite the history of numerous help line reports about [REDACTED] and [REDACTED]’s wellbeing, the crime report and indications that Mike was with the family, the decision was made at CSC Moree to close the report as there was no capacity to allocate... There appears to have been no action by CSC Inverell in relation to this report. [REDACTED] and ML’s cases were transferred to Moree in September but again there are no transfer notes.”

254 Professor Irwin observed;

“Engaging Laila posed numerous challenges including her decision to continue her relationship with Mike, irrespective of the risks is posed to her and her children, and her struggle to understand the impact the violence on her and her children.”

255 Professor Irwin made the following comments on the response by DCJ and other agencies to the numerous reports of harm received in relation to the family in 2018-19;

- i. “... there should have been more consideration given to the cumulative impact that living with domestic violence had on children.
- ii. There was delay by the “Helpline” in responding to reports, especially ‘E-Reports’.
- iii. There were no transfer notes when a new case worker was allocated in November 2018, when ██████’s case was transferred to CSC Moree in August 2019 or when ██████ and ML’s cases were transferred later in the year. Recording and sharing information updates the new case worker with important material and is critical to good practice.
- iv. There was a long delay in the assessment related to the “Helpline” report of 2 August 2018.
- v. While there was some limited contact with Community Corrections and with teachers and principals of the schools attended by ██████, there does not appear to be attempts by CSC workers to set up collaborative meetings with either government or community services/agencies that were engaged with Laila and her children, such as health services, schools, child care, Community Corrections, Police or the counselling and support services that ██████ and ██████ we’re using. Nor did there appear to be any attempts to engage with the broader Aboriginal community or elders. This was a lost opportunity to develop the collaborative approach between services and the community to engage with Laila and the children to work towards increasing the safety of the family.
- vi. The “Helpline” report on 27 June 2019 was linked to an incident in early June when ██████ attempted to hang herself...It appears the Police did not report this event to the “Helpline”.
- vii. It is likely that ██████ and ML were at home yet there does not appear to be helpline reports directly related to two domestic violence incidents in this period [August/September 2018] other than the report on 17 September.

- viii. After ██████'s attempt to hang herself in June 2019 she was referred to mental health practitioners and counsellors... There is no evidence that this was followed up by CSC caseworkers or that ██████ was saying by the mental health and support services.
- ix. In September 2019, there was a "Helpline" report about ██████'s wellbeing.... Despite the long history of the impact of domestic violence, the decision was made to close the report as there was no capacity to allocate... While the context for this decision is not in the expert brief documentation, in my view, the child protection history of the previous few years should have indicated the high risk for Laila and the children.
- x. In 2018-19 were five safety assessments undertaken and safety plans agreed... All assessments were either 'safe' or 'safe with plan' but despite Mike being in prison when they were all undertaken, the "Helpline" reports kept coming in, with many of them reporting on various forms of neglect (medical, educational, inadequate basic care and inadequate supervision), and concerns about ██████ and ██████'s wellbeing. Child neglect occurs when the basic needs of children are not met including health, education, emotional development, nutrition, shelter and safe living conditions of children... Despite this change in the nature of the reports there was little or no change with Safety Assessments and plans. It appears that the Safety Plans were not constantly monitored. Had this been done, it may have provided a clearer way to work with the family.
- xi. There were three risk assessments completed over 2018-19 ... other Risk Assessments were undertaken in August 2019 and December 2019. In my view both were limited... The Risk Assessment completed after ML's death was based on insufficient information and... There was minimal reference to neglect. Laila, Mike, ██████ or ██████ were not interviewed and details around the context of her death were not included.
- xii. Availability of [Aboriginal] consultations is crucial for culturally relevant and respectful practice.
- xiii. There was no unpacking of the impact of intergenerational trauma and its link to family violence that may have contributed to the resistance of Laila and Mike in working with FACS."

Intergenerational Trauma

256 Professor Irwin commented in her report that First Nations people carry the trauma of colonisation in many forms including the forced removal of children from their families, country and culture. She noted;

“the cumulative effect of this historical trauma has contributed to the ongoing struggles that confront Aboriginal and Torres Strait Islander peoples to fully participate in their lives and communities, leading to widespread poverty, disadvantage, and the breakdown of healthy patterns of individual, family and community life (HREO 1997, SNAICC, 2016). The removal of the children, racist assimilation policies, systemic racism, loss of land and culture fractured the deep spiritual connections First Nations peoples had with the land, sea and community and has led to intergenerational trauma, impacting the lives and wellbeing of Aboriginal and Torres Strait Islander peoples.”

257 Professor Irwin and noted the responses by DCJ to the family’s domestic violence issues, commenting;

“there was little acknowledgement that an underlying influence of the violence may have been the traumatic events in the childhood of Laila and Mike and/or intergenerational trauma that effects the lives of many First Nations people. The experiences of violence were reported and assessed as individual incidents with little or no recognition of the cumulative impact that ongoing domestic violence had on Laila and the children or the ways in which intergenerational trauma may have contributed to the nature and extent of the violence”.

258 Professor Irwin commented on the cumulative impact of domestic violence on Laila and the children and noted that DCJ did not seem to adequately consider the effects of that accumulation in some of the Safety and Risk Assessments. She stated;

“The trauma of domestic violence is pernicious. It plays havoc as it creeps into all aspects of the lives of people who live with it. Laila's drug taking and alcohol use and her struggles caring for her children were exacerbated by this violence. The children became very fearful and felt unsafe and this was played out in the concerning changes in their behaviour. Practitioners who work in this area need to have a thorough understanding of the ways violence can play out in people's lives. Employers have the responsibility of ensuring that staff have this knowledge.”

259 Professor Irwin noted;

“Women who live with the trauma of violence are more likely to experience depression, are at greater risk of misusing alcohol and other drugs and may be unable to act on their own choices because of fear of further violence, often focusing on their partners needs and demands. This can result in struggling to attend to their own and their children's needs and wellbeing. They can live in isolation from their extended family possibly because of their shame, stress, anxiety, alcohol and drug use and/or the fear of further violence. Children are highly likely to be affected by their mother’s struggles to adequately parent them”. Laila experienced many of these symptoms, she had depression, she was physically exhausted (her house was often in disarray and her older children had to care for ML), she isolated herself from the family from time to time, and she denied using drugs although many of the Helpline reports referred to her drug use. All this contributed to the challenges she had in parenting the children. Often this played out in various forms of neglect.”

260 The likely impact on ML was summarised as follows;

“ ML was exposed to the impacts of the violence for her short life of 17 months. She was three months old and in the arms of her mother, when Mike had severely assaulted Laila. During ML’s life the helpline received twelve ROSH reports and five non-ROSH reports related to the three girls. Other than co-sleeping CSC caseworkers appeared to focus minimally on the risk and safety issues of ML. ■■■ and ■■■ were in the ‘public eye’, at school, at sport and the “Helpline” reports were frequently about them and related to educational and medical neglect, inadequate basic care, severe discipline, emotional abuse, parental alcohol and drug use and the impact these had on the care of the children. Just as ■■■ and ■■■ were affected by the violence and its consequences, ML was too. She was not yet verbal, but she too would have experienced her mother’s screaming when she was coming down from using drugs and the various forms of abuse and neglect.”

261 After Mike’s incarceration in 2018, there were three “Helpline” reports that were assessed as non-ROSH relating to ■■■ and/or ■■■’s lack of attendance at school, their behavioural changes, educational and medical neglect, inadequate basic care an inadequate supervision. Most were related to the consequences of living with fear in an unsafe house.

262 Professor Irwin opined;

“... these reports were assessed in isolation, not in the context of the numerous other reports received over the previous years. The assessments did not consider the possible role that intergenerational trauma may have played to the cumulative impact that living with domestic violence had on the children and Laila. Mike was not involved in any of the assessments and refused to engage with the CSC caseworkers when he was in prison and avoided involvement at other times. The consequence of this was that he was not held accountable for the violence and the responsibility became Laila’s. It is critical that practitioners working in child protection have regular training to refresh and update their knowledge of how intergenerational trauma can contribute to experiences of domestic violence in the lives of women and their children and how to include perpetrators of the violence in the healing process.”

263 In her oral evidence, Professor Irwin noted the cumulative impact of domestic violence on children as:

“It's really evident now that children are impacted by this, and you can see this in ██████’s and ██████’s behaviour, changes of behaviour. ML was not verbal, so she would have been affected too. Her communication is with her mother, and so any tension and fear around that.”

264 Professor Irwin noted that the system requires transformative change, and a re-imagining of ways to work with Aboriginal communities and elders;

“... seeking their views of how intergenerational trauma and family violence can be responded to in THEIR communities, developing culturally responsive practise, the inclusion of indigenous communities in the decision-making processes, could contribute to the strengthening of communities, the provision of responsive services for women and children who need support, perpetrators being held accountable and communities becoming safer and free from violence. Critical to strong and resilient indigenous families and communities is social connectedness and a sense of belonging, connection to land, culture, spirituality and ancestry; living on only or near or connectedness with traditional lands; self-determination strong Community governance and the passing on of cultural practices.”

265 In November 2019, after ML’s death MCW Ms “BC” consulted with an expert in intergenerational and relational trauma and healing or recovery for Aboriginal clients with a view to offering support to Laila. At that time, Laila declined the offer and she felt that she was being adequately supported. This was a support not previously offered by either CSC.

Considerations

- 266 A number of personal and systemic issues failed ML .
- 267 ML was born into a family dynamic which was already mired in domestic violence and drug and alcohol misuse. It is accepted neither Laila nor Mike could have contemplated the outcome based on their choices. Indeed, ML 's death was a tragedy for all involved.
- 268 Given their own personal circumstances and experiences with government departments as children, it is unsurprising that Laila and Mike were vary of engaging with DCJ. Laila expressed her fear that her children would be removed from her care, which appeared to be based on personal experience. Mike simply refused to engage with DCJ at any time. It is noted, however, that Mike did comply with most directions from his Community Corrections officer, except the direction that he comply with the ADVO restricting his contact with Laila and the children.
- 269 Both Laila and Mike appeared to lack the insight that their personal choices were harming their children.
- 270 Mike has chosen not to participate in these proceedings.
- 271 The caseworker, Ms "JM", attempted to support and educate Laila regarding her need to provide a safe environment for her three children while Mike was in custody. Ms "JM" was dealing with a number of obstacles, including Laila's reluctance to participate in counselling and support, Mike's refusal to participate, excessive caseloads and lack of support and training within the CSC.
- 272 Both Ms "JM" and her colleagues were chronically overworked and overwhelmed by their caseloads. They appeared to be dedicated and hardworking individuals who were not receiving support from senior management in DCJ.
- 273 It is easy with hindsight to conclude that criticisms of individual staff explain the shortcomings of DCJ in ML 's case. The reality is that DCJ's shortcomings involving other clients, are unfortunately neither isolated nor unusual. Historically, DCJ has failed to effectively support employees in terms of staffing, education and skills development, which can impact directly on the children and families they are tasked with assisting.

- 274 Multiagency collaboration with other departments clearly affords the opportunity for information sharing, which will result in greater support and understanding of the shortcomings of individuals and families. DCJ needs to adopt a far more proactive approach to multiagency cooperation throughout NSW, and particularly in rural and regional areas.
- 275 It is of concern that DCJ appears to trial interagency programs and programs which are more tailored to client needs, only to close or abandon these programs. Clearly more needs to be done in this area of service provision.
- 276 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 ^{ML} will have experienced extreme regret and trauma.
- 277 Broad systemic changes are required by DCJ. These clearly include filling excessive staff vacancies, providing improved systems and training to staff and improving staff resourcing and policies. Continuing with the same processes and practices will result in further poor outcomes for families and staff.

Conclusions

- 278 A combination of factors led to ^{ML}'s death, including unsuitable accommodation and the effects of ongoing domestic violence. ^{ML}'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.
- 279 Laila has successfully engaged with a wraparound service which is an Aboriginal Child and Family service. Participants in the service include women who have struggled with domestic violence and drug and alcohol issues, and Laila has derived support and assistance from them. Her attitude appeared to be positive and buoyant when she gave evidence in these proceedings.
- 280 Laila told the Court that she wants to;
- “help other mums and dads and show them they have a voice and to use it. I was too afraid back then to speak up. I want to do some courses and help me get qualified to become that and to be that motivation for other people”.

281 Laila said:

“I want to do this in the spirit of ML . I want to start my own organisation. The river is my people’s place so I want to try and set up that organisation in memory of ML and call it ML ’s Dreaming – even if it is just a place for mums, dads and bubs as a walk along the river so they have someone to always talk to free from judgment. That little walk in life can go a long way and give people a chance to talk.”

282 Laila has honoured the memory of ML with the significant efforts she has made to address her issues. Laila should be encouraged to continue with her efforts to support herself and her children.

Closing Observations

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

284 I would also like to acknowledge and thank the Officers in Charge of this investigation, Detective Senior Constable Matthew Roberts for his assistance and commitment.

285 Finally, I would like to again record my most sincere condolences to ML ’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 ML .

Date of Death

ML died between 9 and 10 of November 2019.

Place of Death

ML died at [REDACTED], Moree.

Cause of death

The cause of ML 's death complications of acute bronchiolitis arising from Respiratory Syncytial Virus (RSV).

Manner of Death

Natural Causes.

I now close this inquest.

Magistrate Joan Baptie

Deputy State Coroner

4 March 2025