CORONERS ACT, 2003

SOUTH  *AUSTRALIA*

FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 3rd, 11th, 12th, 13th, 14th, 17th, 18th, 19th, 20th, 21st, 24th, 25th, 26th and 28th days of August 2015 the 1st, 2nd and 4th of September 2015 and the 28th day of January 2016, by the Coroner's Court of the said State, constituted of Anthony Ernest Schapel, Deputy State Coroner, into the death of Ebony Simone Napier.

The said Court finds that Ebony Simone Napier aged 4 months, late of Brooklyn Park, South Australia died at Brooklyn Park, South Australia on or about the 8th day of November 2011 as a result of blunt head trauma. The said Court finds that the circumstances of her death were as follows:

1. Introduction

1.1. Ebony Simone Napier died on or about 8 November 2011. She was born by caesarean section at the Women's and Children's Hospital (WCH) on 4 July 2011. She was thus only 4 months of age at the time of her death.

1.2. Ebony's parents were C[1], who at the time of Ebony's death was a girl of 17 years of age, and Bradley Napier-Tucker, who was 19 years of age. On the afternoon of 15 November 2011 Ebony's parents attended at the Families SA office at Woodville where they informed staff that Ebony had been lying dead at their home for about a week. Ambulance personnel then attended at premises at a home unit at Brooklyn Park which was the home of Ebony and her parents. There they discovered Ebony deceased in her cot. There was evidence of decomposition that was consistent with her parents'

[1] Ebony Napier's mother was under the age of 18 years at the time of these events. Following Ebony Napier's death the mother would be sentenced for an offence in the Supreme Court. The outcome of those proceedings will be referred to in this finding. To the extent that pursuant to section 63C of the Young Offenders Act 1993 the mother's identity may not be reported in connection with the Supreme Court proceedings, she will be referred to in this finding as C.

assertions that Ebony had been dead for some time. Naturally police attended at this location and an investigation ensued. Ebony's parents would tell police that the reason they had not reported Ebony's death prior to presenting at the Families SA office at Woodville on 15 November 2011 was that they were scared and did not know what to do[2].

2. Cause of death

2.1. A post-mortem examination that included a full autopsy as well as a full post-mortem skeletal survey and CT scan were performed in respect of Ebony's remains. It is no exaggeration to say that the post mortem examination revealed that Ebony had been mercilessly and serially brutalised. The autopsy was performed by Dr Karen Heath who is a forensic pathologist at Forensic Science South Australia. Dr Heath's post-mortem report was tendered to the Inquest[3]. Dr Heath determined that the cause of Ebony's death was blunt head trauma. I find that to have been the cause of Ebony's death.

2.2. Dr Heath's post-mortem report contains a description of a number of head injuries. There were multiple, bilateral skull fractures resulting in bilateral subdural haemorrhages, intraventricular haemorrhage and haemorrhage and necrosis of the underlying brain. In Dr Heath's opinion there was clear evidence of both previous and recent injury. This included recent subarachnoid haemorrhage and recent intraventricular haemorrhage, together with recent and old intracranial subdural haemorrhage and spinal subdural haemorrhage. There were subdural haemorrhages of varying ages, the oldest of which was at least several weeks duration. This could be regarded as evidence of previous head injury. Amyloid precursor protein detected at post-mortem was consistent with a period of survival post injury before death. Alternatively, it could have resulted from raised intracranial pressure from previous head injury. The bony injuries included fractures in the left frontal bone, left temporal bone and in the right and left parietal bones of the skull. In this case there were three distinct areas of subcutaneous bruising in the scalp consistent with at least three separate blows to the head. The fracture of the left parietal / temporal bones was a depressed fracture, meaning that fragments of broken bones were displaced inwards. Such a depressed fracture results from blunt force trauma. Depressed fractures most

[2] C Interview, Exhibit C73e, Answer 53; Napier-Tucker Interview, Exhibit C45f, Answers 291, 292
[3] Exhibit C2a

commonly occur either from the person being struck on the head with an implement or from the striking of the head against a hard object or surface.

2.3. Dr Heath reports that acute subdural haemorrhages usually develop after high speed acceleration / deceleration injuries and can result in death by causing an increase in intracranial pressure which in turn can cause compression and damage to underlying brain tissue. In this case the mechanism of the lethal injury would have been the combined effects of direct trauma to the brain from blunt force impact resulting in multiple skull fractures with a depressed skull fracture in addition to severe acceleration / deceleration injuries due to impact of the head with a hard object resulting in bilateral subdural haemorrhages which would have caused death through raised intracranial pressure. I accept all of that evidence and find that Ebony's blunt head trauma resulted from multiple blows to the head by, or against, a hard object or surface.

2.4. In addition to the head injuries, there were multiple additional bony injuries to other parts of Ebony's skeleton including the spine, rib cage and upper and lower limbs. These injuries were revealed either from the anatomical findings at autopsy or from the skeletal survey and full body CT scan, or all of those modalities. The number of bony injuries was extraordinary. There were forty-eight old healing rib fractures alone. There were four recent rib fractures. There were two possible crush fractures to thoracic vertebrae. There were bony injuries to the upper limbs as well as to the feet. The fractures were of differing ages. Post-mortem radiological appearances suggested the presence of more recent fractures occurring through older fractures. In particular many of the rib fractures, as well as a fracture to the right clavical and fracture of the right humerus, showed changes suggestive of new fractures occurring through sites of healing older fractures.

2.5. There was evidence of a healing fracture through the midshaft of the left femur (left thigh bone) which I will return to in a moment.

2.6. As to the mechanism of the fractures, Dr Heath's report suggests that the rib fractures were consistent with a compressive or squeezing force such as that provided by encirclement by hands. Finger and toe fractures were consistent with squeezing or stomping on the hands or feet. In this case the fractures observed are described by Dr Heath as being highly specific for inflicted injury, that is to say, deliberately inflicted injury and distinct from the accidental.

2.7. I have accepted Dr Heath's evidence in its entirety.

2.8. In her post mortem report Dr Heath expresses the view that given the large number and distribution of the fractures, Ebony would undoubtedly have been symptomatic with pain and impaired function at the time of injury and for some time afterwards, particularly with movement such as would occur with being picked up, bathed and dressed. I also accept that view without hesitation.

2.9. I have referred to the healing fracture to the midshaft of the left femur. This fracture had been diagnosed in Ebony on 10 August 2011 when she was approximately 5 weeks of age. Her parents had presented Ebony to The Queen Elizabeth Hospital (QEH) on that date. The thigh injury was diagnosed at the QEH by X-ray. Ebony had then been transferred to the WCH where she remained until discharge into her parents' custody on 22 August 2011. I will discuss the circumstances of the infliction of that injury in due course but it is worth noting here that on 12 August 2011 a skeletal survey that was conducted that day at the WCH revealed that the only bony injury that Ebony had at that point in time was the thigh fracture. Thus, consistent with Dr Heath's observations, the other injuries that I have described above must have occurred in the period between Ebony's discharge from the WCH on 22 August 2011 and 8 November 2011 which was the approximate date of her death. With the exception of the thigh injury, her skeletal injuries occurred at different times during that period, although many of them were determined to have been recently inflicted prior to death.

2.10. Putting aside the left thigh fracture for the moment, I accept and I find that the injuries identified at post-mortem had been deliberately inflicted by a person or persons.

2.11. I have referred to the possible timeframe over which these injuries were inflicted. As will be seen later in these findings there is no evidence that any person other than the child's parents had actually sighted Ebony after 16 October 2011 on which date Ebony and her parents had a chance meeting with some acquaintances. From the observation of the acquaintances there was no reason to suppose that Ebony was injured or unwell on that occasion. By that date health services that had earlier been in place in respect of Ebony's care had either been withdrawn or resisted by this family. Ebony had last been sighted by services on 23 September 2011. The failure of Ebony to be sighted by any person with influence or in authority for some weeks prior to her death in early November 2011 is an astonishing fact in and of itself, as will be revealed when the narrative of Ebony's short life and brutal death is described.

3. The source of Ebony's injuries

3.1. There is no evidence that during the period prior to Ebony's death any person other than her parents had access to her that might have facilitated an opportunity to inflict the injuries that she had sustained prior to her death. Neither during her life nor after her death was a complaint ever voiced by either of her parents that any person extraneous to this family had assaulted Ebony or caused her any injury. Aside from the earlier thigh injury in August 2011, the first revelation that Ebony had sustained physical injury occurred when her parents attended at the Woodville Families SA office on 15 November 2011, by which time Ebony had been dead for approximately a week. Leaving aside the thigh injury for the moment, which I deal with in a discrete section of these findings, to my mind the possibility that she sustained her injuries accidentally can be put to one side. The inference is overwhelming that Ebony's injuries, fatal or otherwise, had occurred at the hands of one or both of her parents.

3.2. Subsequent to Ebony's death both of her parents were arrested and charged with Ebony's murder. In the event the murder charge was not proceeded with in the Courts. Ultimately both of Ebony's parents pleaded guilty to a charge pursuant to section 14 of the Criminal Law Consolidation Act 1935, namely criminal neglect. This charge against both parents was resolved in the Supreme Court of South Australia in March 2014. Bradley Napier-Tucker and C both pleaded guilty to the charge. Napier-Tucker was sentenced to a term of imprisonment of 9 years with a non-parole period of 7 years and 3 months which was backdated to the time he had been taken into custody on 16 November 2011 which was the day after he and C had presented at the Woodville office of Families SA. C, who was below the age of 18 at the time of the commission of the offence to which she pleaded guilty, was released on a bond to be of good behaviour for a period of 2 years. In arriving at this sentence the Supreme Court took into consideration a period of 10 months that C had spent in a youth detention centre following her arrest as well as a period of approximately 18 months that she had been detained on strict home detention bail.

3.3. The pleas of guilty tendered by both of Ebony's parents in respect of the charge of criminal neglect meant that there had been no need for a trial to take place in the Supreme Court. However, the factual basis upon which the Court dealt with each of Ebony's parents upon their pleas of guilty was determined following a disputed facts hearing in which both C and Bradley Napier-Tucker gave oral evidence. Following

that disputed facts hearing the Supreme Court, as constituted by Justice Stanley, delivered reasons for decision in which His Honour identified the factual basis upon which he would ultimately sentence both of Ebony's parents.

3.4. In considering this Court's findings in respect of the circumstances in which Ebony suffered her injuries, including her fatal injuries, the Court has not found it necessary to hear from either C or Bradley Napier-Tucker. Neither person was represented during the course of this Inquest. Rather, this Court has adopted the findings of fact that were made by Justice Stanley following the disputed facts hearing to which I have referred. This Court has received into evidence the transcript of the evidence given by both of Ebony's parents on the disputed facts hearing and the various statements that both parents made following the events with which this Inquest is concerned. I have also taken into account all of the other evidence that was taken at this Inquest. To my mind this Court is permitted to adopt the findings of the Supreme Court pursuant to section 24 of the Coroners Act 2003 which stipulates that in holding an Inquest the Court is not bound by the rules of evidence and may inform itself on any matter as it thinks fit and must act according to equity, good conscience and the substantial merits of the case without regard to technicalities and legal forms. I would add that as far as natural justice and procedural fairness is concerned, such was accorded to both C and Bradley Napier-Tucker in the Supreme Court in connection with the proceedings that took place there, and I would regard it as an inappropriate and pointless exercise, and one that would not be in the public interest, to repeat the process in this Court. In my opinion natural justice and procedural fairness have been accorded to C and Bradley Napier-Tucker at all material times.

3.5. The factual dispute underlying the hearing before Justice Stanley involved the issue as to the identity of the person or persons who had assaulted Ebony and caused her injury. It appears to have been common ground between the prosecuting authorities on the one hand and C and Bradley Napier-Tucker on the other that no person other than the parents could have been responsible for any of Ebony's injuries, fatal or otherwise. However, in dealing with the disputed issue His Honour made it clear that the essential elements of the charge of criminal neglect, as distinct from those that constituted the withdrawn charge of murder, meant that it was not appropriate for the Supreme Court to make specific findings that either or both parents had inflicted the fatal injuries.

3.6. Included within the elements of the offence of criminal neglect to which the two accused parents had pleaded guilty were that Ebony had suffered serious harm as a result of unlawful acts, namely assault and lack of medical attention, that the two accused were or ought to have been aware that there was an appreciable risk that serious harm would be caused to Ebony by those unlawful acts, that they failed to take steps that they could reasonably have been expected to have taken to protect Ebony from harm and that their failure to do so was, in the circumstances, so serious that a criminal penalty was warranted. His Honour Justice Stanley was of the view that the Supreme Court was required to identify the unlawful act or acts upon which the contravention of section 14 of the Criminal Law Consolidation Act 1935 depended. If the unlawful act had been committed by one or both of the accused, this would be a relevant circumstance of aggravation.

3.7. Accordingly, His Honour was satisfied that assaults had been committed. His Honour found specifically that the assaults on Ebony had been committed solely by Bradley Napier-Tucker. In His Honour's sentencing remarks[4], His Honour rejected Bradley Napier-Tucker's evidence that his assaults upon Ebony had been confined to his having squeezed and shaken her between seven and ten occasions over a period of possibly a month and a half. Implicit in His Honour's finding was an acceptance of C's evidence that she did not assault Ebony. Further, His Honour found that both accused had been aware of the fact that the assaults committed on Ebony had been committed by Bradley Napier-Tucker. His Honour made further findings to the overall effect that no person other than Napier-Tucker could have been responsible for Ebony's injuries looked at in their totality.

3.8. Although, as seen above, His Honour held that he was precluded from making any specific finding that Bradley Napier-Tucker had inflicted the fatal injuries, it is implicit in His Honour's findings that Napier-Tucker must have inflicted the fatal injuries. In any event there is no such restriction in respect of the task facing this Court. The finding of this Court, which is consistent with the findings made by the Supreme Court, is that the injuries discovered at post-mortem, including the fatal head injuries, had all been inflicted by Bradley Napier-Tucker. I further find that the injuries had been inflicted

[4] Exhibit C111

on occasions subsequent to 16 October 2011. I put to one side for the time being Ebony's earlier thigh injury.

3.9. Other relevant findings made by the Supreme Court which I adopt include that neither parent sought medical assistance for Ebony despite the fact that it would have been abundantly clear to both of them that Ebony was extremely unwell. Her behaviour had changed dramatically. She had been described as having been in a 'vegetative state' by her parents. She had stopped feeding and had stopped crying. She would either stare blankly or her eyes would roll to the back of her head. She barely moved. His Honour also sentenced Bradley Napier-Tucker specifically on the basis that he had obstructed C from obtaining treatment for Ebony and that his own failure to obtain assistance for Ebony, and failure to notify the authorities of her death sooner, was out of fear that any such attention would disclose the assaults that he had inflicted upon Ebony. In respect of C, His Honour sentenced her on the basis that she could have done more to protect her baby from the risk that her father had posed to her. This Court adopts those findings.

3.10. The only other matters arising from the Supreme Court criminal proceedings that are of relevance to this Court's inquiry are the fact that the report of Dr Craig Raeside[5], forensic psychiatrist, which was compiled for the purposes of those proceedings, revealed a matter of importance in respect of Bradley Napier-Tucker's character. The report states that Bradley Napier-Tucker had a history of poor anger management and of acting out when frustrated. The report also identified Napier-Tucker's resorting to cannabis use to regulate his emotions, with the acknowledgment on his part that he had been smoking a significant amount of cannabis on a daily basis around the time of Ebony's death, upwards of 20 to 30 cones a day. In His Honour's sentencing remarks Justice Stanley obliquely referred to that fact and in my view correctly observed that Napier-Tucker's cannabis use did not mitigate his conduct in any way. The references in Dr Raeside's report to Napier-Tucker's cannabis use had included the observation that in Napier-Tucker's oral testimony in the Supreme Court he had stated that he was 'stoned' all the time, had lost motivation and basically had not wanted to do anything other than to stay at home. In addition, the report contained reference to the observation that had been made by others within the custodial system that Napier-Tucker's offending behaviour appeared to have revolved around his cognitive distortion and drug use, that his significant cannabis dependence and abuse had been problematic, had

[5] Exhibit C112

appeared to have escalated both before and after Ebony's birth and that this would have further aggravated his frustration, aggression and even paranoia. Dr Raeside further opined that Bradley Napier-Tucker's cannabis use was a significant factor affecting the relationship that he had with his partner C, but which was almost likely related to his anger management. As well, Dr Raeside refers to the detriment to the family's finances that Napier-Tucker's cannabis use was contributing. The pre-sentence report compiled by the Department of Correctional Services[6] for the purposes of the Supreme Court proceedings revealed an acknowledgement by Napier-Tucker that at the time of Ebony's death he had been smoking up to ½ an ounce of marijuana every two or three days and that he had been smoking marijuana since he was 15 years of age.

3.11. As will be seen, the question of Bradley Napier-Tucker's cannabis use is an important feature within the circumstances leading to Ebony's death. It was a circumstance that relevant authorities connected with child protection had been aware of. There had been subjective evidence that Napier-Tucker's cannabis usage was a matter that adversely impacted upon his capacity to properly and safely exercise parental responsibilities with respect to his daughter Ebony. More of that later.

4. Background

4.1. Ebony's mother C was born in 1993 in New South Wales. She had an extensive involvement with the New South Wales child protection authorities, at that time known as the Department of Community Services (DoCS)[7]. C had been declared to be under the parental responsibility of the relevant Minister in New South Wales. That status was imposed upon her on 19 December 2002. At the time of Ebony's death, Ebony was the only child of C.

4.2. Ebony's father, Bradley Napier-Tucker, was born on 7 February 1992. He too had an involvement with the child protection authorities in New South Wales, both in his own right and also in connection with C as well as with two other children whom I will discuss in another section of these findings.

4.3. It appears that C and Bradley Napier-Tucker met sometime in late 2010 and started cohabiting within a very short time thereafter. This occurred at a time when C was still

[6] Exhibit C113
[7] The entity is now known as the Department of Family & Community Services, but it will be referred to herein as DoCS

under the parental responsibility of the Minister in New South Wales. She would remain so until her eighteenth birthday in December 2011.

4.4. Very soon after their relationship commenced C became pregnant with Ebony to Bradley Napier-Tucker. In January 2011 C and Bradley Napier-Tucker decided to come to South Australia from Goulburn in New South Wales. C's movement from New South Wales to South Australia would have been in contravention of the limits imposed upon her as a consequence of her Ministerial parental responsibility status in New South Wales. In other words, she absconded from New South Wales. There was no such restriction in respect of Bradley Napier-Tucker who was over the age of 18 years in any event.

4.5. The regime of supervision that was involved in C being under the parental responsibility of the Minister in New South Wales did not carry over into South Australia. The relationship between C and the New South Wales Minister existed purely by virtue of New South Wales State domestic child protection legislation. It was not as if the South Australian Minister who had responsibility for child protection would automatically assume guardianship of a person in C's circumstances once in South Australia. The New South Wales child protection authorities in Goulburn eventually became aware of the fact that C had left New South Wales to go to South Australia, but having regard to the proximity of her attainment of adulthood, indicated that they would take no action in relation to C's presence in South Australia, or more correctly, her absence from New South Wales. There was some occasional communication between the South Australian authorities and their NSW counterparts through the South Australian interstate liaison officer about C's circumstances and what might occur to advance her welfare in this State, but it came to nothing and did not in any way serve to protect Ebony. What did transpire as between South Australia and New South Wales in that regard in essence amounted to further missed opportunities to identify significant risk factors that existed in Ebony's environment, and I refer here to her father's alleged propensities towards small children which were at no stage made known to the South Australian authorities.

4.6. When C and Bradley Napier-Tucker came to South Australia on 13 January 2011, they resided at premises in Magill in the first instance. C was 13 weeks into her pregnancy. In due course C met a Mrs Ann Grenci through a TAFE course and it was through Mrs Grenci and her husband Bruno that Bradley Napier-Tucker secured a brief period

of employment in Mr Grenci's café in the city. Mr Grenci was also instrumental in securing for C and Bradley Napier-Tucker the accommodation at the Brooklyn Park residence that I have already mentioned.

4.7. After their arrival in South Australia C and Bradley Napier-Tucker had some interaction with an entity known as Streetlink which is a primary health service for young people between the ages of 12 and 25 who are at risk of homelessness. Streetlink's first contact with C and Bradley Napier-Tucker occurred on 19 January 2011 after they had presented to the service for support with C's pregnancy. Streetlink had occasional contact with the couple in the period prior to Ebony's birth in July 2011. After Ebony's birth Streetlink organised a grant for C and Bradley Napier-Tucker to purchase some items connected with the baby.

4.8. Ebony was born by caesarean section at the WCH on 4 July 2011. Following her birth, the midwives caring for C referred her for a social work review. This was at least in part due to an admission by C that she had suffered from depression in the past. A WCH social worker, Ms Kelly Koufalas, spoke with C and Bradley Napier-Tucker at length. Numerous topics were covered, including the question of C's parental responsibility status in New South Wales. Following Ms Koufalas' conversation she contacted the New South Wales authorities about C. It was Ms Koufalas who made the first high risk infant notification to Families SA's Child Abuse Report Line (CARL). Ms Koufalas was particularly concerned about C's age, lack of support systems and her involvement with the child protection system in New South Wales. Later in these findings I will refer in more detail to this Families SA intake. In the days following Ebony's birth there would be contact between Families SA personnel and personnel from New South Wales DoCS in their Goulburn office, for the most part concerning C's history in New South Wales. Concerning information about C would be imparted to Families SA, but very little about Bradley Napier-Tucker was imparted other than the bare fact that he was the father of another child in New South Wales who was '1½' years of age and who had been removed from the mother's care.

4.9. Following Ebony's birth two entities concerned with the provision of health services to families would become involved with Ebony and her parents, namely Children, Youth and Women's Health Service (CYWHS) and Child and Family Health Services (CAFHS), both arms of SA Health. However, the engagement of this family with those services would become inconsistent to the point where on two occasions during

Ebony's life the family to all intents and purposes became disengaged from those services. It will be understood that neither of these two entities had any direct statutory or other legal responsibility in relation to the protection of children. That said, the community in general does have moral responsibility for the welfare of children and staff of entities such as these are mandated notifiers under the relevant South Australian child protection legislation.

4.10. The responsibility for child protection in South Australia at that time lay, and still lies, by virtue of the Children's Protection Act 1993, upon Families SA. The stated objects of the Act include to ensure that all children are safe from harm[8] and the Act also makes reference to ensuring that risks to a child's wellbeing are quickly identified and that any necessary support, protection or care is promptly provided[9]. Responsibility for the carrying out of the functions under the Act was and is that of the relevant Minister and the Chief Executive of the relevant Department. The entity Families SA was in effect the government entity that was charged with the responsibility of carrying out the objects and functions of the Children's Protection Act 1993.

4.11. The Act provides for the mandatory notification of the abuse or neglect of a child where such is reasonably suspected, the statutory obligation being to notify the Department of that suspicion. There are a number of mandated notifiers under the relevant provision[10].

4.12. The Act enables the removal of children in danger from a family [11].

4.13. Investigations and assessments may be undertaken pursuant to the Act where, inter alia, there is reasonable suspicion that a child is at risk and where the matters causing the child to be at risk are not being adequately addressed[12]. There is a mandatory obligation upon the Chief Executive to carry out such an investigation. Police possess certain powers for the purposes of assisting an investigation including the power to enter premises[13]. In certain circumstances a family care meeting may be held. Depending on the outcomes of investigations the Youth Court is empowered to make certain orders that include orders in relation to the directing of assessments for parental drug abuse and for the capacity to care and protect a child. Other orders include care and protection

[8] Section 3(a)
[9] Section 3(c)
[10] Section 11
[11] Section 16
[12] Section 19, Section 20
[13] Section 19(3)

orders[14] as well as custodial orders in favour of guardians or the Minister. An order may place a child under the Guardianship of the Minister until the child attains the age of 18 years.

4.14. There has been for some time now, including at the time with which this Inquest is concerned, specific mandatory obligations upon the Chief Executive and the Minister where a child is suspected on reasonable grounds to be at risk by virtue of the drug abuse of a parent[15]. I deal with these obligations in a dedicated section of these findings.

4.15. There is nothing in the Children's Protection Act 1993 that would enable the obligations for child protection contained within it to be delegated to or devolved upon any other government or non-government entity. However, police have certain powers under the Act. These powers include powers to remove children from dangerous situations[16].

5. Bradley Napier-Tucker's child protection history

5.1. Bradley Napier-Tucker is said to be the father of a male child, M, date of birth 7 November 2008. It will be noted that as of the date of M's birth Bradley Napier-Tucker was 16 years of age. The mother of M (not C) is said to have been approximately 23 at the time M was born. There is an extensive New South Wales DoCS file consisting of some 18 volumes in relation to M. That file was tendered to this Court[17]. Extracts from some of those 18 volumes were drawn to the attention of a number of witnesses in this case in order to demonstrate that there was a body of information in the hands of the New South Wales child protection authorities to suggest that Bradley Napier-Tucker had a propensity towards ill treatment of young children including M, and possibly in respect of another child with whom he allegedly had some contact in 2009. That child was identified during the course of the Inquest. I shall refer to the child as P. As will be seen, the reactions of the various witnesses in respect of this information were revealing.

5.2. None of the information relating to Napier-Tucker's propensities was made available to Families SA notwithstanding that Families SA were placed in possession of information by the New South Wales authorities that Bradley Napier-Tucker was the father of M and that the child had been placed within the parental responsibility of the

[14] Section 37
[15] Section 20(2), Section 37
[16] Section 16
[17] Exhibit C86

relevant New South Wales Minister[18]. It was also plainly evident to the South Australian authorities that Bradley Napier-Tucker, for whatever reason, had nothing or little to do with the child M in 2011 notwithstanding that he was the father of M. The information about Napier-Tucker was important, and not merely in hindsight. It could have made all the difference in respect of Ebony's safety. Families SA never sought the information. This was an egregious oversight, the incompetence being all the more culpable having regard to the relative ease with which it could have been obtained and the fact that the neglect in failing to obtain the information persisted over several months.

5.3. I here set out by way of summary the information that the New South Wales authorities possessed in respect of Bradley Napier-Tucker as contained in the files relating to M, and to a lesser extent, the child P.

5.4. Matters that gave rise to concern and which were well documented in the New South Wales DoCS files relating to M arose very early in the piece following M's birth. It is recorded that Bradley Napier-Tucker, described as the father of M, came to the hospital where M and his mother were then confined and that the father had come into the hospital to remove the baby[19]. As a result of this incident the police were contacted and attended the hospital. This had given rise to a departmental notification in which it was also recorded that there were concerns for the physical safety and psychological and emotional wellbeing of the newborn M. In particular it was recorded that both the mother and father had extensive child protection history with DoCS[20].

5.5. Then it is recorded that the child's mother, who was recorded as making inconsistent claims about whether Bradley Napier-Tucker was the father, assured hospital staff that Bradley Napier-Tucker was not going to come to the house following discharge because he had been violent in the past and had hit her[21]. It was recorded that at the hospital the mother and Bradley Napier-Tucker had been arguing about money and drug issues. A further departmental contact from January 2009 recorded that the mother and M had been at the house in which Bradley Napier-Tucker was then residing and that he and the mother smoked bongs in the presence of M. A further report in this documentation recorded that Bradley Napier-Tucker's mother had seen the bongs and had destroyed

[18] Parental Responsibility of the Minister in New South Wales is a similar state to Guardianship of the Minister in SA
[19] Exhibit C86, Volume 1, page 115
[20] Exhibit C86, Volume 1, page 114
[21] Exhibit C86, Volume 1, page 121

some of them and that this apparently had made Bradley Napier-Tucker '*very irate*'[22]. Then, later in 2009 further DoCS documentation in respect of M records the mother and Bradley Napier-Tucker being verbally aggressive at the Goulburn Community Services Centre in respect of court proceedings[23].

5.6. Correspondence apparently generated in February 2009 and which is contained within DoCS files states that Bradley Napier-Tucker had juvenile court appearances in respect of common assault and maliciously destroying property for which he was placed on a good behaviour bond in May 2008. There is also reference to the offence of breaking and entering for which he was placed on another bond in January 2009[24]. Within another volume of the New South Wales material relating to M there is reference to the activity that allegedly underlay the court appearances for assault and damaging property and that is that the assault was in respect of Bradley Napier-Tucker's mother, Leane Napier, and the damage was of a motor vehicle and/or a wall of a premises[25].

5.7. Then there is an assessment record from March 2009 that records the gathering of information from M's paternal grandmother, who is Bradley Napier-Tucker's mother Leane Napier, outlining the risks of exposure to domestic violence between M's mother and father, the risk of physical injury and the rough handling of M and drug use, and exposure to drug affected adults[26]. It is clear that on 4 March 2009 Ms Leane Napier candidly provided information to DoCS about her son. A reportedly emotional Ms Napier stated that she should have provided this information earlier. Ms Napier is reported as having informed DoCS workers that M had been taken to hospital because he was hot. Medical staff had noted scratches on his foot, leg and his head and suggested that M had a head injury. Ms Napier also reported that in the previous week there had been a '*punch up*' between Bradley Napier-Tucker and M's mother. At that time Ms Napier had been nursing M. In addition Ms Napier reported that further concern had been generated during the previous week when she had left M with Bradley Napier-Tucker. When she next saw M he had a mark on his nose and a swollen lip. There was a graze under his nose. It appeared to her as if a person had shoved a bottle too hard into the child's mouth, or had pushed a dummy into the mouth area really hard. There had been no such injuries to his face earlier that morning. She said that the child

[22] Exhibit C86, Volume 1, page 152
[23] Exhibit C86, Volume 1, page 216
[24] Exhibit C86, Volume 2, page 11
[25] Exhibit C86, Volume 7, page 84
[26] Exhibit C86, Volume 2, page 54

had been with her son, Bradley Napier-Tucker, the entire time since she had last seen the child. She also reported that Bradley Napier-Tucker had once squeezed the child's arm leaving a mark like a love bite. She also reported that M continuously cried as if he was frightened. She stated that when M was about two months old a neighbour had heard Bradley Napier-Tucker scream at M using words such as '*shut up, fuck ya*'. Ms Napier reported that M appeared fearful, anxious and would flinch when he was held. She believed that scratches recently noted on the child were due to Bradley Napier-Tucker. She also reported that the fight of the previous week had resulted in damage to a window and door at the relevant premises[27]. The Court appreciates that a witness statement taken from Ms Napier in August 2015 during the currency of the Inquest[28] presents as a somewhat less dramatic account of the events that she had described to DoCS in 2009, but it also has to be borne in mind that in 2011 after Ebony was born Ms Napier, who with her daughter stayed in South Australia for a brief period after the birth, attempted to impart negative information about her son to a CYWHS worker specifically in order to draw her attention to his potential for aggression. Ms Napier was never spoken to by Families SA. More of that later. I infer that in 2011 Ms Napier while in South Australia would have been a fecund source of important knowledge about the propensities of her son Bradley, had she been probed in any detail about that subject. Even in her 2015 witness statement Ms Napier confirms that marijuana made Bradley's behaviour worse and that he was more likely to become aggressive after smoking marijuana, was prone to violent outbursts and could just snap. As it was, Ms Napier and her daughter who had been in Adelaide following Ebony's birth in order to provide familial support to C and Bradley, ultimately left after Bradley had become increasingly angry and had told them to '*Fuck off home*'. They obliged. Thereafter, neither C nor Napier-Tucker, at the respective ages of 17 and 19 and with a baby, had any meaningful family support or oversight.

5.8. There is also reference in the New South Wales DoCS material to a phone call on or about 4 March 2009 with a Dr Gerard, a paediatrician at the Goulburn Hospital, in which Dr Gerard advised that there was sufficient reason to keep M in the hospital due to concern at the possibility that he had been shaken[29].

[27] Exhibit C86, Volume 2, page 66-60
[28] Exhibit C21b
[29] Exhibit C86, Volume 2, page 67a

5.9. Then there is reference to an argument having occurred between Bradley Napier-Tucker and his sister, albeit in 2005, in which either or both of them may have produced a knife or scissors[30].

5.10. Bradley Napier-Tucker also had his own child protection file with New South Wales DoCS[31]. There are a number of records of observations made in relation to Bradley Napier-Tucker's relationship with his parents, in particular his father's aggressive and violent nature and his physical abuse of Bradley Napier-Tucker, and in respect of alleged drug use on the part of his mother and sister as well as general neglect. Loitering and truancy appear to have been intrinsic aspects of his behaviour. Trouble with the police is also suggested, as is a history of violent and aggressive behaviour, specifically towards his mother and younger sister.

5.11. I have mentioned a matter in relation to another child, P, who in December 2009 was aged 3 years. It is recorded within DoCS records for both M and P that information was received by an unidentified caller who claimed that he or she had witnessed Bradley Napier-Tucker abusing P on many occasions. The caller reported that two days previously Bradley Napier-Tucker and P were together and that Bradley Napier-Tucker slapped P across the face with an open hand, as a result of which a red mark was noticeable on the child's face. The child was very distressed and crying. The caller asserted that this happened all the time and that Bradley Napier-Tucker normally hit the child all over the child's body. The caller also reported that two weeks previously the caller saw Bradley Napier-Tucker pulling the child by the arm and dragging the child along the road. The caller asserted that Bradley Napier-Tucker was a cannabis user and was '*very cranky*'. The caller also asserted that the caller had witnessed the child's mother (not C) and Bradley Napier-Tucker conducting an argument in front of P in which Bradley Napier-Tucker called the mother a whore and a slut. The New South Wales DoCS file in relation to P[32] records that an assessment was made that these allegations concerning Bradley Napier-Tucker were '*vindictive*', the suggestion being that they had been made with an ulterior motive in respect of Bradley Napier-Tucker's association with M. Naturally it is beyond the scope of this Inquest to assess the veracity of that suggestion.

[30] Exhibit C86, Volume 7, page 82
[31] Exhibit C89
[32] Exhibit C88

5.12. The point of all of this information is that it had the potential to contribute greatly to the risk that Bradley Napier-Tucker posed to Ebony Napier. The risk was all the more acute having regard to the fact that a substantial part of the information that had been imparted to the New South Wales authorities about Bradley Napier-Tucker had emanated from his own mother and for that reason could be given added credence.

5.13. As will be seen, Families SA were advised in July 2011, just after Ebony's birth, that Bradley Napier-Tucker was the father of M. Further, Families SA had even agreed to act as a conduit for the transmission of Family Court documentation between the New South Wales authorities and Bradley Napier-Tucker in relation to M. Neither in the context of the initial intake received by Families SA at the time of Ebony's birth, nor at the time of a subsequent intake received when her broken femur was identified, was any detail sought by Families SA about Bradley Napier-Tucker's background when at all material times both his and C's parenting abilities were open to question and Bradley Napier-Tucker's possible involvement in the infliction of the broken thigh, an event that ought to have been regarded with the utmost concern, was a matter that required thorough investigation and appropriate evaluation. It is astonishing that no person's curiosity about Bradley Napier-Tucker's background in New South Wales was at any time piqued. This is all the more perplexing when it is considered that when the first intake was received at Families SA it was reported, and duly recorded by Families SA, that C had a history of involvement in domestically violent relationships. One would therefore ask why it would not be of considerable interest for the South Australian authorities to know whether or not C was currently in such a relationship.

5.14. It is also worthwhile observing that in the most recent contact records for C which were in the possession of New South Wales DoCS there is both direct and indirect identification of Bradley Napier-Tucker as a person who had a recent association with C[33]. One report dated 17 November 2010 recorded C's transience and lack of engagement with services, and in addition it asserted that she was in a current relationship with an 18 year old male who had a child in care and a history of domestic violence. That male person is not identified by name, but it certainly fits the description of Bradley Napier-Tucker, especially when the report goes on to say that C might be pregnant and that she was trying to have a baby with her boyfriend[34]. Then there is

[33] Exhibit C85b, pages 33-40
[34] Exhibit C85b, page 33

specific reference to Bradley Napier-Tucker in a contact record in relation to events of 3 November 2010 in which Bradley Napier-Tucker is identified as C's current boyfriend. Thus it is that an interrogation of C's New South Wales records, and in particular her most recent records dating from when approximately she had last been in New South Wales, would have identified Bradley Napier-Tucker as the person who allegedly had a history of domestic violence and who was the father, and currently in loco parentis, of Ebony Napier. This source of information was also never tapped.

6. The failure to gather information regarding the history of Bradley Napier-Tucker and its impact

6.1. Mr Ryan Barna was the Families SA worker who took the original notification from the WCH social worker at the time of Ebony's birth. Mr Barna gave oral evidence before the Court. I say at the outset that no criticism is directed towards Mr Barna.

6.2. Mr Barna told the Court that he received a notification about Ebony from a social worker at the Women's and Children's Hospital where Ebony had been born on 4 July 2011.

6.3. Mr Barna told the Court that on 6 July 2011 he made contact with the New South Wales authorities. To try to cut what arguably became an unnecessarily complicated story relatively short, Mr Barna that day sought information from the New South Wales DoCS office in Goulburn about C's interaction with them. The reply from a Ms Christie Ralston who was an acting manager at the Goulburn office, and who also gave oral evidence, was that C was under the parental responsibility of the Minister in New South Wales until she attained the age of 18 years. New South Wales had not been able to locate her since September 2010 at which time she was said to have '*absconded*'. An email reply from Ms Ralston advised Mr Barna of a number of relevant matters concerning the risks that might be posed to the newborn Ebony from C's background, including significant alcohol and drug use, mistrust of services and a lack of engagement with them and her history of involvement in domestically violent relationships. There was also reference to suicidal ideation and other health issues. There was also reference to '*extreme risk taking behaviours*', poor impulse control and an ability to become aggressive when challenged. The same email stated that DoCS did not have records relating to '*Bradley Napier Tucker*', an erroneous assertion, and that as a result DoCS did not know what his parenting capacity might be. The email

advised that DoCS would be happy to provide any support but that they were unable to force C to return to New South Wales.

6.4. Ms Ralston gave oral evidence by way of video link from New South Wales. In her evidence Ms Ralston told the Court that at the time Mr Barna's request for information was received she had conducted an electronic search of DoCS files for any record relating to Bradley Napier-Tucker but that this may have been frustrated, among other things, by the hyphenation of the man's surname. I accepted Ms Ralston's evidence in that regard. However, in a subsequent conversation with a colleague, Ms Ralston by pure chance established that Bradley Napier-Tucker had an association with a young child we now know to be M. As a result of Ms Ralston coming into that information she made contact with Families SA on 7 July 2011. As it also happened, DoCS in New South Wales needed to serve Family Court proceedings documentation on Bradley Napier-Tucker and so I infer that this was at least part of the reason why Ms Ralston contacted Families SA on 7 July 2011. On this occasion the call was received by a Mr Ryan Balkwill who was at that time a supervisor of one of the teams at the Woodville office of Families SA. He was in the same position relative to his team that Ms Loretta Parenta, who would become the supervisor of the team that would assume responsibility for Ebony, was to her team at the same office.

6.5. Mr Ryan Balkwill of Families SA gave oral evidence to the Inquest about his being provided with this information from New South Wales. It appears that he took Ms Ralston's call possibly in the mistaken belief on the part of the New South Wales authorities that he was Ryan Barna who had been in contact with New South Wales the day before. What is clear is that Mr Balkwill was told by Ms Ralston that Ms Ralston wanted to see what had happened since the birth of the baby. For some reason Mr Balkwill told Ms Ralston that there was uncertainty as to whether the matter would be allocated within Families SA. In any event Ms Ralston of DoCS informed Mr Balkwill that New South Wales would like to arrange discharge of care concerning C and that they wanted her to contact one of the other workers at Goulburn by phone. In the course of this telephone conversation Ms Ralston, who by that time had been told by her colleague of the existence of the young child who had an association with Bradley Napier-Tucker, told Mr Balkwill that Bradley Napier-Tucker had a '1½' year old child who had been removed from the mother's care in New South Wales. This was in fact a reference to the child M. It does not appear that Ms Ralston mentioned

the name of the child as M, but it does not matter. Ms Ralston informed Mr Balkwill that DoCS were required to serve on Napier-Tucker certain court documents in connection with the child. It was obvious from this conversation that DoCS knew something about Bradley Napier-Tucker after all, and in particular knew something of a relationship between him and a small child who had been removed into care. As seen earlier, there were files relating to both Bradley Napier-Tucker and to the child M in the possession of New South Wales authorities at that time. There was also reference to Bradley Napier-Tucker within C's New South Wales documentation.

6.6. In any event the information imparted on 7 July 2011 to Mr Balkwill about Bradley Napier-Tucker having a 1½ year old child was more than enough information upon which the South Australian child protection authorities could have made further inquiry of New South Wales to see exactly what information they had in relation to him. I pause here to say that I have rejected any suggestion that there was some obligation upon the New South Wales authorities to furnish each and every piece of information about Bradley Napier-Tucker when it was not solicited from them.

6.7. Ms Ralston told the Court that after she provided the initial information on 7 July 2011 to the South Australian authorities, in the normal course of events she would have expected to receive a formal request for further information from South Australia[35]. She told the Court of the processes by which such a request could have been actioned. Because of the large number of files relating to the child M in particular, it may have taken some time for the information to have been collated. However, depending on the type of information that was required, an approach could have been made to the South Australian authorities to ask them if they wanted to narrow down the amount of information that they wanted so that New South Wales could provide a more targeted response[36]. Ms Ralston explained to the Court that typically in such a situation they could deal on a caseworker to caseworker basis without necessarily going through interstate liaison officers[37]. Asked as to what she would have done if on 7 July 2011 Mr Balkwill of Families SA had asked her for further information about what was known about Bradley Napier-Tucker at DoCS, and whether she could have another look to see what there was about him on their system, she said that she would have conducted another search and have spoken to the allocated caseworker in more detail about what

[35] Transcript, page 1394
[36] Transcript, pages 1396-1397
[37] Transcript, page 1397

was known about him[38]. Ms Ralston explained to the Court that a search on their system could be narrowed down simply to look for contact records and initial assessments. In the case of the child M there were in excess of twenty such records, which would require staff to go through them individually in order to find Bradley Napier-Tucker's name. But she was asked this question by counsel assisting, Ms Kereru:

> 'Q. If you'd explained that difficulty to Mr Balkwill or to anybody else who might have inquired about Bradley Napier-Tucker and the difficulty had been appreciated by the South Australia authorities but nevertheless they were keen for you to do that exercise, would you have done it.
>
> A. Absolutely.' [39]

6.8. When it was put to Ms Ralston that it had been suggested by Families SA staff that having gone to the trouble of contacting Families SA to notify them of the existence of the 1½ year old child who had an association with Bradley Napier-Tucker that she had some kind of onus to notify Families SA of further concerns that they knew of in respect of the father, she said:

> ' Look, I could have provided them with additional information but I guess I was waiting for a formal request to come through because I'd provided the initial information, I then followed up with a telephone call and that say, any further information needed to really come through a formal request.' [40]

6.9. I accepted that evidence. There is no criticism to be levelled at the New South Wales authorities or any of their staff. The initial inquiry from Mr Barna related to C for the most part and the information that was imparted by New South Wales about her was adequate in the circumstances. In the time available, even if Ms Ralston had successfully completed a search in relation to Bradley Napier-Tucker, it would not have been reasonable to expect her or any of her colleagues to have extracted all of the relevant information in relation to Bradley Napier-Tucker from files in which he was either the subject of the file himself or had an association with the subject of the file. There was a clear obligation on Families SA after the first intake, and especially after the second intake relating to Ebony's thigh injury, to initiate all inquiries from any source about Bradley Napier-Tucker's history.

6.10. I have examined the files relating to the child M of which there are 18 in number. Most of the relevant information is contained within the first few volumes. Although it is to

[38] Transcript, page 1421
[39] Transcript, pages 1422-1423
[40] Transcript, page 1423

be acknowledged that the distilling of information from that material concerning Bradley Napier-Tucker may have been a time consuming process, it does not occur to the Court that it would have been a task that would take weeks, or one that was prohibitively time and resource consuming, especially if a targeted inquiry had been made along the lines suggested by Ms Ralston. I do not believe that the question of time is particularly relevant. It was an exercise that clearly needed to be undertaken. It was not undertaken, not because the exercise would have been impossibly onerous, but because the South Australian authorities never asked for it to be undertaken.

6.11. According to Mr Barna the information that the New South Wales authorities possessed in respect of Bradley Napier-Tucker may have altered the assessment due to the increase of risk that it presented to Ebony[41]. It is possible that the Tier rating of the intake, which was assessed as Tier 2, may have been upgraded to a Tier 1 response which would have dictated an immediate response within 24 hours [42]. Mr Barna acknowledged that if he had been aware that Bradley Napier-Tucker had a small child who had been removed from the mother's care in New South Wales he would have made further enquiries of New South Wales DoCS to establish the history of that child[43]. Information about Bradley Napier-Tucker's relationship with the child M would have prompted a request to the New South Wales authorities for further information about his child protection history[44] and it would have increased the risk to Ebony. When asked as to why that would be the case, Mr Barna suggested that the behaviour of smoking drugs around the child would be relevant[45]. As will be seen in a later section, the question of smoking cannabis in the period after Ebony was born was indeed something of an issue. Mr Barna also acknowledged that had the information from Bradley Napier-Tucker's mother that I have set out above been imparted to him, it would have resulted in the intake being regarded as a Tier 1 intake due to his having allegedly previously harmed another child[46]. Mr Barna suggested that the allegations themselves would be enough for this to have occurred. He was asked in his evidence what in his view would have warranted a child being removed and he identified a previous history that a parent has harmed or killed another child in their care as one such trigger[47]. Mr

[41] Transcript, page 325
[42] Transcript, page 326
[43] Transcript, pages 371-372
[44] Transcript, page 328
[45] Transcript, page 328
[46] Transcript, page 337
[47] Transcript, page 303

Barna advised the Court that removal of the child Ebony would have been a question for the supervisor of the office to which the matter was sent.

6.12. Following his communication with New South Wales, Mr Barna had nothing further to do with the matter other than contacting Ms Parenta of the Woodville office. Mr Barna explained that although it was not a Tier 1 intake, which one would normally call through personally, he did so on this occasion in relation to the Tier 2 report regarding Ebony because the matters as revealed to him, he believed, were very concerning in and of themselves and he wanted to bring the matter to her attention[48]. I infer that if a Tier 1 rating had been assigned having regard to the more detailed information relating to Napier-Tucker's history that ought to have been made available, any communication with Ms Parenta would have been even more emphatic. Whether it would have made any difference to her performance is another matter.

6.13. It would seem that there was in possession of the New South Wales authorities information which suggested that Bradley Napier-Tucker had a previous history of harming a child in his care, or at least there was information suggesting that there were allegations along those lines. This information ought to have prompted immediate consideration as to whether Ebony should have been removed. In the event Mr Barna was not made aware of any information regarding Bradley Napier-Tucker as the original information that came to him from New South Wales was that, in effect, they knew nothing about him. I accepted Mr Barna's evidence. I found Mr Barna to be an ingenuous and straightforward witness. I was impressed by the fact that as soon as he received the intake he acted promptly. I have no reason to doubt that had he come into possession of information about Napier-Tucker having had an association with another child he would have made or at least instigated the necessary enquiries of the New South Wales authorities. I have no reason to doubt that the New South Wales authorities would duly have provided that information, perhaps not immediately, but in due course and at a time when it could and should have made a difference to the quality of Ebony's protection.

6.14. There is no criticism to be levelled at Mr Barna. He did everything that he could to secure information about the risks posed to Ebony. His request, perhaps, could have been targeted more specifically at Bradley Napier-Tucker's history, but in any event he

[48] Transcript, page 350

was told by Ms Ralston that there was no history in respect of Bradley Napier-Tucker at New South Wales DoCS. He was entitled to act on that basis. Unfortunately, what basic information that ultimately did come from New South Wales about Napier-Tucker did not come to him. It went to the other Ryan, that is Mr Ryan Balkwill.

6.15. Mr Ryan Balkwill was the Families SA supervisor at the Woodville office who took the call from Ms Ralston on 7 July 2011 and who was advised of the existence of the 1½ year old child of Bradley Napier-Tucker who had been removed from the mother's care. Mr Balkwill gave oral evidence at the Inquest. Mr Balkwill made no further inquiry of New South Wales as to the detail of Bradley Napier-Tucker's involvement with a 1½ year old child. It appears that he did not discuss the matter at all with any of his colleagues in the Woodville office. He merely made a note of the information[49] which was placed upon the C3MS system. Mr Balkwill said that he had read the original intake, or at least the information that had originally been imparted by Ms Ralston to Mr Barna regarding Ebony, and so it is clear that he must have had an appreciation of the negative information about Ebony's mother's history and circumstances. Mr Balkwill acknowledged that the most significant concerns were C's alcohol and drug use, lack of engagement with services, her transience, her history of domestically violent relationships and the reported lack of insight. As to his recorded comment to Ms Ralston as to whether the matter would be allocated, Mr Balkwill seemed to recall some uncertainty on Ms Parenta's part about that. Asked as to what his own view about allocation would have been, he said:

> 'It clearly indicates an infant at risk and I don't know a supervisor in the department that wouldn't have allocated it if they possibly could have. It's often not a question of if you like to allocate but if your team has the capacity to.' [50]

As to Mr Balkwill's own lack of reaction to the information imparted, he countered by saying that he had no official role in the matter. He said he was not the responsible supervisor involved in the case. As to whether it had occurred to him to ask about the child protection history of the 1½ year old child he said it did not occur to him and that it was not his place to embark upon investigative work on the matter. The matter was not within his team, it was not within his own personal role and it was not the '*correct channel*'. To him the 'correct' avenue to request such information would have been via

[49] Exhibit C81, page 283
[50] Transcript, page 388

the interstate liaison office[51]. At one point Mr Balkwill suggested that he would have liked to have thought that if he had been the responsible supervisor and had been made aware of an interstate history, that he would have sought further information[52]. He acknowledged that the bare information about the existence of the child was relevant. But on a number of occasions in his evidence Mr Balkwill eschewed the suggestion that he personally could have taken the initiative to request more information or at least could have drawn specific attention to the existence of the 1½ year old boy to those within his office who had responsibility for the matter. The following passage of evidence was given in response to questions from Ms Kereru, counsel assisting, regarding Mr Balkwill's agreement to facilitate service of documents but his reluctance to become involved in any further inquiry:

'Q. And so did you envisage that Ms Sharpe would serve the documents on Mr Napier-Tucker and have him sign a proof of service.

A. Yes.

Q. So you agreed to one of your staff members at your office taking Family Court documents from New South Wales to Mr Napier-Tucker but you didn't ask for further information regarding the circumstances surrounding that child's removal.

A. That's correct.

Q. Do you see any difficulty with that.

A. I can understand how that looks, but for me I was really performing a administrative task in passing on that to the appropriate team. And, again, it wasn't my case, or my assessment to be seeking that sort of information.

Q. Would Ms Parenta be upset with you if you had sought information about the circumstances surrounding the removal of this child.

A. I'm not sure about that.

Q. You don't know whether she'd be upset or not.

A. It just wouldn't have been appropriate for me to have been carrying out that sort of a task for - under those circumstances.' [53]

Further:

'Q. Would there have been some benefit in the three of you, that's you, Emma Sharpe, and Loretta Parenta, having a verbal discussion in your office, and might that have then resulted in identifying a need to go further behind the information that you had about Bradley Napier-Tucker and his one and a half year-old boy.

A. It's not really how it works. I had no formal role in the case. If Loretta had a situation with a case and wanted to see what my thoughts are about it she would ask me, and I would do the same, and that sort of dialogue happened a lot, but it wasn't a routine

[51] Transcript, page 395
[52] Transcript, page 398
[53] Transcript, page 400

> formal mechanism as such. If a supervisor would like to consult regarding case directions there are various consultants within our own department that they can approach for that view as well.' [54]

Mr Balkwill disagreed with Ms Kereru that he himself should have taken the step to enquire about the circumstances of the removal of the 1½ year old child. He suggested that it would not have been '*an appropriate role*' for him[55]. Mr Balkwill stated that he had '*identified a line of inquiry for the other team*' and that that was something for them to follow.

6.16. I have carefully considered Mr Balkwill's evidence. Regardless of whose responsibility within his office the matter was as of 7 July 2011, he was the supervisor who received the important information about the existence of another child relative to Bradley Napier-Tucker. He received that information in a personal telephone call from a New South Wales counterpart. In my view it is nonsense to suggest that there would have been anything '*inappropriate*' about Mr Balkwill making a further inquiry of Ms Ralston at the time that would have at least set in motion the provision of further information about the 1½ year old child. He could also have mentioned the importance of this revelation to either Ms Parenta or to Ms Emma Sharpe, a social worker, who was in Ms Parenta's team. Mr Balkwill was all too willing to assist the New South Wales authorities in relation to service of documents, but did not have a keen enough eye to realise that the very existence of the child who was the subject of the court proceedings was a matter that should have been explored in relation to the notification concerning Ebony Napier. Mr Balkwill's failure to even informally suggest to Ms Ralston that further information would be required was one of the more salient missed opportunities for Ebony to have been protected.

6.17. Mr Balkwill's evidence to my mind painted a bleak picture as to morale, camaraderie and rapport between colleagues in the Woodville office of Families SA.

6.18. Ms Emma Sharpe, a social worker in the Woodville office to whom Ebony's matter may or may not have been allocated depending on one's view as to what the term allocated actually means, and whose role I will deal with in more detail in another section, in her oral evidence before the Court agreed with counsel assisting that the bare information that Bradley Napier-Tucker had a 1½ year old child who had been taken

[54] Transcript, page 403
[55] Transcript, page 404

out of the mother's care would amount to a red flag, although she added that the information did not actually suggest that the child had been removed from the father. She did say that it would be concerning information regardless and that if further information about that matter had not been received with the court documents that were ultimately sent through, there would be a request for that information. There was no such request in this case. When asked as to whether at the time of the provision of the documents for service on Bradley Napier-Tucker that she should have made such enquiries, she said:

> 'Quite possibly, yes. I didn't actually take the call from New South Wales to serve these documents, that was received by Ryan Balkwill, the other supervisor, who arranged - made those arrangements with New South Wales.' [56]

When asked as to whether or not it was incumbent upon Mr Balkwill to have done so, she said that that was not necessarily so, but that certainly she could have made those enquiries herself[57]. Further, Ms Sharpe agreed that she should also have enquired as to whether or not Bradley Napier-Tucker himself had any child protection history[58]. In this respect she suggested that Bradley Napier-Tucker's own history that had involved abandonment by his mother at a young age, physical abuse by this father, domestic violence of his mother and sister, criminal behaviour and truancy and drug use combined with C's own history meant that '*with that information in mind*' there would have been very high concerns held for Ebony's care and protection whilst in the care of her parents. It is hard to disagree with that acknowledgment.

6.19. During the course of Ms Sharpe's testimony Ms Kereru of counsel assisting took Ms Sharpe through the entirety of Bradley Napier-Tucker's history in respect of the child M. Ms Sharpe's reaction was firm. She suggested it would be a major red flag for Ebony to remain in her parents' care and that the information would have involved instant removal, even with the first intake[59]. She agreed in questioning by me that the monitoring or management of a case such as Ebony's in the absence of the information about Bradley Napier-Tucker's interaction with the child M meant that it was

[56] Transcript, page 886
[57] Transcript, page 886
[58] Transcript, page 945
[59] Transcript, page 952

fundamentally flawed from the outset[60]. She agreed with that by saying '*yes, absolutely*'[61]. To my mind this was a concession that was well made.

6.20. Ms Loretta Parenta, Ms Sharpe's team supervisor, was asked about the failure of her office to make any inquiry about Bradley Napier-Tucker's history. She told the Court that she, as Ms Sharpe's supervisor, did not ask Ms Sharpe to investigate the father's child protection history at the time the child was in hospital following her birth. Asked as to why that was the case, she said that she had no indication that Bradley Napier-Tucker had a child protection history. She had been told that New South Wales had no history on the father. That of course was the original information from Ms Ralston to Mr Barna, but there was further information given to Ms Parenta's colleague, Mr Balkwill, the following day. Asked as to whether at that early stage an inquiry needed to be made about Bradley Napier-Tucker's history, Ms Parenta said that it was an inquiry that '*could have been made*'[62]. Asked as to whether it should have been made Ms Parenta seemed prepared only to give qualified assent to that proposition when she said '*in retrospect, without a doubt*'[63]. If that answer was meant to be interpreted that, having regard to the outcome of Ebony's death, only in hindsight could one now suggest that the inquiry should have been made, I reject that contention. It was an obvious inquiry that should have been made and it ought to have been obvious at the time.

6.21. Ms Parenta told the Court that she could not recall when it was that she had seen reference to the existence of a 1½ year old child. Even then she did not ask Ms Sharpe to enquire as to the circumstances of the removal of that child. She pointed out that the information was that the baby had been removed from the mother[64], not from Napier-Tucker himself.

6.22. Then followed during the course of Ms Parenta's evidence a number of instances on her part where she attempted to lay responsibility on the New South Wales authorities for the lack of information about Bradley Napier-Tucker. Whilst conceding that it would have been appropriate for South Australia to have made enquiries of New South Wales as to the circumstances surrounding the removal of the 1½ year old child, she said that if New South Wales had entertained serious concerns about the father, in

[60] Transcript, page 954
[61] Transcript, page 954
[62] Transcript, page 1195
[63] Transcript, page 1195
[64] Transcript, page 1197

particular if he had been violent, she would have expected the New South Wales worker to have provided that information at the time. She said that she would have expected that to have been passed on. She repeated this disclaimer on a number of occasions during the course of her evidence[65].

6.23. Insofar as Ms Parenta attempted to cast blame upon the New South Wales authorities, I would reject that. Ms Ralston did not know of the detail of Napier-Tucker's involvement with M. I accept her evidence that if she had been asked, she would have seen to it that further searches were conducted. The fact of the matter was that Families SA had a responsibility in respect of the protection of Ebony Napier. Concomitant with that responsibility was the need for South Australian authorities to obtain as much information as was available. It must have been known to Ms Parenta that there was such information available. Even if she had not seen reference to the 1½ year old child, which I would regard as impossible to believe, there was a conspicuous lack of curiosity on her part about the history and background of the father. There was also the question of her knowledge of Family Court proceedings in relation to a child with whom he had a connection. None of this had been enough to pique her curiosity at the time except by way of an acknowledgement on her part that '*in retrospect, it could have been explored further*'[66].

6.24. Again Ms Kereru, as with other witnesses, took Ms Parenta through the New South Wales history in relation to Bradley Napier-Tucker's involvement with the child M, as well as the information regarding the child P. Ms Parenta stated that if she had been provided with that information the baby would have been removed from the hospital and from the parents' care because of the allegations of violence in respect of Bradley Napier-Tucker. She said that Ebony would have been removed from the outset under an investigation and assessment order. I was relieved that Ms Parenta would concede that much. Asked as to whether in reality she had, as supervisor of the intake and assessment team that had conduct of this file, given it the appropriate attention that it needed, she said:

> 'I accept some responsibility around that but I am also saying that I was totally overloaded. I had the responsibility for half of another team, but I do accept some responsibility, yes.' [67]

[65] Transcript, page 1284. Transcript, page 1291
[66] Transcript, page 1461
[67] Transcript, page 1285

Asked by Mr English of counsel for the New South Wales authorities as to what difference in effect the information about P would have made and whether she would have taken into consideration the possibility that this had been a vindictive complaint, Ms Parenta suggested that might possibly have been taken into account. The observation again needs to be made that even if this had been considered to be vindictive, the report still added to the risk.

6.25. There is no doubt in the mind of the Court that the information concerning Bradley Napier-Tucker's association with the child M was essential information for Families SA to have been in possession of. There is equally no doubt that it was the obligation upon Families SA staff to seek out that information once it was known that the child existed. This was of course especially so after Ebony had been presented to hospital with a broken leg. There is also no question in the mind of the Court that even at a very early stage, as acknowledged by Ms Parenta, the information would have formed a proper basis for an appropriate removal of a child from the care of C and Bradley Napier-Tucker such that they would have been prevented from removing her from the hospital.

6.26. The information should also have been taken into account in conjunction with what would prove to be a questionable explanation for Ebony's serious leg injury in the following weeks.

6.27. I agree with Mr English that there was nothing within the 'Protocol for the Transfer of Care and Protection Orders and Proceedings and Interstate Assistance'[68] that would have precluded NSW DoCS from imparting all relevant information about C and Bradley Napier-Tucker to Families SA. On the contrary, the document contains plenty of encouragement for that to happen. Nor was there anything in the NSW domestic child protection legislation that would have precluded such sharing of information. Again, the contrary would be the case having regard to section 231V of the Children and Young Persons (Care and Protection) Act 1998 (NSW) that specifically enables the disclosure of information to interstate child protection authorities.

6.28. I also agree with Mr English that there were multiple opportunities for a formal request for further information to have been made prior to Ebony's death especially taking into account a number of communications that had taken place as between the South

[68] Exhibit C91

Australian interstate liaison officer (ILO) and NSW DoCS officers regarding C's status and other matters affecting her but not directly related to Ebony.

6.29. Aside from a verbal request, a request for information from SA to NSW could also more formally have been effected by way of the completion of a straightforward form specifically designed for the very purpose[69].

6.30. The failure of the South Australian authorities to inform itself about Bradley Napier-Tucker's history was a serious oversight and I have little doubt that proper inquiry in respect of this topic could have been enough to have prevented Ebony's death. It could and should have altered what ultimately became a casual approach to her protection on the part of Families SA.

7. Events following the first notification to Families SA

7.1. In this section I will discuss events during the period from Ebony's discharge from hospital following her birth until her hospitalisation on 10 August 2011. During that period Ebony was the subject of the notification that had been made to Families SA by the WCH social worker on 6 July 2011.

7.2. Ebony was discharged from the WCH on 8 July 2011 following her birth on 4 July 2011. She was discharged into the care of her parents. The family resided in the unit at Brooklyn Park to which I have already referred.

7.3. Although Ebony was the subject of the notification to Families SA, she would not actually be sighted by a Families SA employee until 1 August 2011. Even then, there is good reason to believe that the home visit that was conducted by the Families SA employee only took place as the result of further concerns raised by staff employed by the CAFHS.

7.4. Any detailed analysis of what transpired between 8 July 2011 and 10 August 2011, as with all other aspects of this matter, has to be examined against the premise that any engagement between Ebony's parents and any service provider, including Families SA, was fundamentally flawed as a result of the fact that none of these services knew of the background or history of Bradley Napier-Tucker. This is no criticism of service providers such as CAFHS because no-one from that entity was in a position to have

[69] Exhibit C106a

obtained the information about Bradley Napier-Tucker that needed to be obtained. This was a matter that was principally, if not exclusively, within the province of Families SA. Nevertheless, it is worthwhile noting the salient features of what transpired between the child's discharge on 8 July 2011 and her readmission to the WCH on 10 August 2011. The period in question, as well as the period following Ebony's discharge from that readmission, would be characterised by an increasing level of concern entertained by service providers such as CAFHS, a worrying disinclination on the part of Ebony's parents to engage with those services and a perplexing and ongoing level of insouciance to the whole affair within certain quarters of Families SA.

7.5. In the period immediately following Ebony's discharge following her birth a domiciliary midwife from the WCH visited the Brooklyn Park premises in which Ebony was housed. This person was Ms Penelope York, a registered nurse and midwife with CYWHS, which is a service under the umbrella of SA Health, more specifically the WCH. Ms York provided a statement to the Inquest[70] and gave oral evidence. Ms York visited the premises on 9 July 2011, which was the day after Ebony's discharge from the hospital, and also on 10 July 2011 and 13 July 2011. On each of those occasions Bradley Napier-Tucker's mother and sister, who had been visiting from New South Wales and were also staying at that premises, were present. In her evidence before the Court Ms York described the services that she and her organisation provided. She described it as an extension of the post-natal care that is offered to women who deliver in the WCH. The domiciliary midwife goes into the home of the child post discharge and performs post-natal observations that include conducting observations of the wellbeing of the mother, checking sutures and lactation. There is also an assessment made in respect of the baby's wellbeing that will include weighing the baby. Advice is provided as to feeding. General education in the providing of care for the child is also imparted. The domiciliary midwife also assesses the home environment and in particular whether it is suitable for a baby and also whether the appropriate equipment is in place. Sleeping environments are checked and assessed for safety.

7.6. Ms York told the Court that on the first occasion she visited the home Bradley Napier-Tucker would answer questions that had been directed to C. She felt that his behaviour was '*very, very in my face*'[71].

[70] Exhibit C96
[71] Transcript, page 541

7.7. On the second visit which occurred the following day Bradley Napier-Tucker made it very plain that he was not happy about the notion of C breastfeeding. Ms York described him as being '*obviously upset*'[72]. Ms York describes behaviour on his part that was quite agitated if not downright churlish in respect of that issue. Some of Bradley Napier-Tucker's anger was also directed towards his mother. Bradley Napier-Tucker did not articulate what his objection to breastfeeding was and Ms York told the Court that her impression was that his attitude was based purely on the need to control. Given the absence of any verbalised rational objection to breastfeeding, one can readily see that Ms York's assessment of Napier-Tucker's attitude was most likely accurate.

7.8. When Ms York returned on 13 July 2011 Bradley Napier-Tucker's mother intercepted her on the way into the unit. She told Ms York of Bradley Napier-Tucker's overbearing behaviour and of the existence of conflict within the premises. Napier-Tucker's mother suggested that he needed to return to work to allow C to get on with the task of looking after the baby. The mother went so far as to say that her son required anger management. His mother told Ms York that within the next day or so she and her daughter were leaving Adelaide to return to New South Wales and so it was that Ms York formed the impression that '*she was obviously trying to warn me that there were problems that she was worried about*'[73]. When Ms York entered the premises there was an air of tension within. Bradley Napier-Tucker remained outside and it is obvious from what Ms York observed that he was smoking marijuana.

7.9. Following this third visit by Ms York she entertained an understandable general concern about the family. She said that she had entertained concern because she knew something of the history, which I took to mean the history in respect of C for the most part; she could have known nothing of Napier-Tucker's history. Her observations of the family prompted her to complete a document known as a Domiciliary Midwife Visit Summary Following High Risk Infant Notification to Families SA[74]. In that document Ms York highlighted relationship problems and mental illness, referring to C's depression. She also highlighted her young age and the lack of family support from her own family while in South Australia. She also noted that although Bradley Napier-Tucker was conscientious in his care for C and the baby, he was very controlling and verbally aggressive. She highlighted his lack of enthusiasm for C's decision to

[72] Exhibit C96, page 4
[73] Transcript, page 550
[74] Exhibit C79, pages 8-9

breastfeed. No doubt Ms York's concern would have been even greater had she known something of Napier-Tucker's background.

7.10. As for Ms York's observations of Ebony, there does not appear to have been any adverse observation made except that on 13 July 2011 the child had not put on as much weight as may have been expected and she was back on a bottle feeding regime.

7.11. Unfortunately Ms York did not note in any document Bradley Napier-Tucker's marijuana smoking. It also does not appear to have occurred to Ms York that if he was smoking marijuana the mother may also have been smoking marijuana.

7.12. I pause here to make the observation that had the authorities in South Australia known of Bradley Napier-Tucker's history at that point, and in particular what had been disclosed to the New South Wales authorities about him by his own mother, what his mother said about him to Ms York would have taken on additional and powerful significance. Further, any reasonable person who knew of the NSW information and of what Ms Leane Napier had said to Ms York could not have failed to identify the need for Ms Napier, while she was still in South Australia, to have been spoken to at length about her son's propensities.

7.13. For similar reasons if Bradley Napier-Tucker's prior history had been known, his marijuana consumption may also have been a matter of greater concern than it apparently was to Ms York. Ms York was one of a number of witnesses who suggested that marijuana consumption is common in this scenario and poses only a minor risk, say, compared to other substances such as alcohol[75].

7.14. Asked by counsel assisting, Ms Kereru, as to what Ms York's approach may have been if she had known of Bradley Napier-Tucker's own child protection history as well as that of the child M, she acknowledged that she would have undertaken her visits differently. She said that she would have been much more concerned '*about what was being exhibited in the home*'[76]. Her overall impression that Bradley Napier-Tucker's behaviour was possibly the result of new parenthood and its accompanying anxieties may have been seen in a different light, and in particular the information that his mother imparted to her would have been much more concerning[77]. Armed with a different

[75] Transcript, page 568
[76] Transcript, page 577
[77] Transcript, page 577

impression, Ms York said that she would have contacted the WCH social worker about the matter and would have considered making another high risk notification to Families SA[78].

7.15. Ms York had the expectation that the document that she completed following her visit on 13 July 2011 would make its way to Families SA[79]. There is no evidence that it did. As to the reaction that it ought to have generated, Ms Kelly Koufalas, who was the WCH social worker who had raised the first Families SA CARL notification, told the Court that although Ms York's document would have made its way onto the WCH file, unfortunately her involvement in the case had ceased by the time it was created and she did not see it. However, she told the Court that in her opinion the contents of the document ought to have given rise to a further CARL notification. In fact, if she had seen the document she would have encouraged Ms York to have made a notification. In the event, not only was there no notification, but it appears that Families SA may never have received Ms York's document. It would be easy to conclude that Ms Koufalas was merely speaking with the keen eye of hindsight if it were not for the fact that it was she who had made the original CARL notification about this family in the first instance. I accepted her evidence that the document contained matters of importance that ought to have been acted upon had the document made its way to the right quarters.

7.16. On 16 July 2011 a further visit was made by a different WCH domiciliary midwife. Nothing of significance was reported in respect of that visit.

7.17. A scheduled visit for 19 July 2011 did not take place. This was apparently rescheduled for the following day, but no-one was home when the domiciliary midwife attended. There were no further visits or attempted visits from this organisation.

7.18. However, in the period between 8 July 2011 and 10 August 2011 a home visit was also attempted by a representative from the Child and Family Health Service. This is a separate entity from the entity that was responsible for Ms York's visits. Like CYWHS it is also under the umbrella of SA Health. The CAFHS attempted visit was by Ms Jennifer Moore who is a family home visiting nurse. Ms Moore gave oral evidence in

[78] Transcript, page 578
[79] Transcript, page 572

the Inquest as did one of her superiors, Ms Rosemary Ranford, who was the clinical practice consultant at CAFHS.

7.19. Ms Moore explained to the Court the function of CAFHS and the purposes of a CAFHS engagement with a family through its home visiting service. Like Ms York's entity, a family's engagement with CAFHS is purely voluntary. This situation is to be distinguished from an engagement with Families SA who have coercive powers under the Children's Protection Act 1993.

7.20. An arrangement was made between Ms Moore and C for a home visit to take place on 19 July 2011. On that day Ms Moore telephoned two numbers in an attempt to remind C of the scheduled visit. She received no response after leaving messages. An attendance was made that day at the actual premises. No response was gained when Ms Moore and her companion knocked on the door several times. However, a baby was heard crying from within. A flashing television screen could also be seen through a window. These events occurred at about 11:30am. A note was left on the front door to contact Ms Moore. There was no response either to that or to later attempts that afternoon to contact C by phone.

7.21. At 2:35pm on the same day Ms Moore telephoned Ms Loretta Parenta of Families SA. Ms Moore noted in the CAFHS file[80] her concerns at the events of that morning. She also noted that the agreed plan with Ms Parenta included an attempt to rebook a visit. Ms Moore also recorded that Ms Parenta advised that Ms Emma Sharpe would manage the case for Families SA. Ms Moore also documented Ms Parenta's advice that a fresh notification to CARL was not required. Ms Moore herself thought that a further notification to CARL would be required for the most part due to poor recent contact with the family, and she was also concerned by the fact that the baby was very small, but was assured by Ms Parenta that the family was in the system and that there was no need for another call. Ms Moore felt that Ms Parenta was discouraging her from making a high risk notification. Ms Moore told the Court that although she had determined to continue to attempt to make contact with the family, she believed and expected that Families SA itself would be '*stepping up and making visits at that stage*'[81].

[80] Exhibit C79, page 15
[81] Transcript, page 441

7.22. As seen earlier a domiciliary midwife had visited the home on 20 July 2011 and the door was not answered on that occasion either. As things would transpire Ebony would not be sighted between 16 July 2011, which was the date of the final domiciliary nurse visit, and 1 August 2011 when Ms Sharpe of Families SA made that organisation's first visit. In the intervening period a letter was written to C by Ms Moore. The letter dated 21 July 2011 outlined C's lack of response thus far and advised that if CAFHS did not hear from C by 27 July 2011 they would assume that she did not wish to have them visit[82]. In addition, on 22 July 2011 Ms Moore spoke to Ms Sharpe of Families SA to inform of their inability to make contact with C and Ebony, as had previously been discussed with Ms Parenta three days previously. Ms Moore noted that she told Ms Sharpe about the letter that had been written to C.

7.23. Ms Moore told the Court that at this juncture she was feeling '*very helpless*' about the situation[83]. Thus on 26 July 2011 Ms Rosemary Ranford, the CAFHS supervisor, was informed of developments. At that time a decision was made within CAFHS that their interest in the matter would be escalated with a determination on Ms Ranford's part that she herself would contact Ms Parenta at Families SA about the matter. I will come to the details of that in a moment.

7.24. In the event Ms Moore was unable to make any contact with Ebony's parents either by telephone or in person, except that on 2 August 2011 when she had attempted to call Bradley Napier-Tucker on a mobile phone number, unsuccessfully at first, she later received a call from a person whom she believed was Bradley Napier-Tucker who, as soon as she identified herself, hung up.

7.25. I have spoken of Ms Moore's frustration. I do not believe that Ms Moore could have done any more for her part. She was dissuaded by Ms Parenta from raising another CARL notification in the belief that it was not necessary as Ebony and her parents were already in the Families SA system. In addition, she had also spoken to Ms Sharpe of Families SA in the not unreasonable hope and expectation that Families SA would assume an active role in the child's protection and in particular take steps to contact and assess the family for themselves. As to the Families SA action that she had in mind,

[82] Exhibit C79, page 55
[83] Transcript, page 447

Ms Moore suggested that she would have expected Families SA to make visits to the home without appointment, which they were empowered to do[84].

7.26. Ms Ranford, the clinical practice consultant at CAFHS, also gave oral evidence. Ms Ranford decided on the case escalation on or about 26 July 2011. Ms Ranford told the Court that the case escalation was due for the most part because CAFHS had not recently sighted Ebony. Ms Ranford said that she was beginning to become worried and that they were probably not receiving '*as big an action from Families SA as what I probably would have liked personally*'[85]. The matters that Ms Ranford identified as risk factors for Ebony at that point in time were, in the Court's view, valid. She explained that it had concerned her that among other things the mother was only 17 years of age and was still under the parental responsibility of the Minister in New South Wales and had been so since the age of 9. She had wanted early discharge in relation to herself and Ebony following the birth and she had refused to be assessed for her mental health history. She was also concerned about the conflicting information about observations that had been made concerning Bradley Napier-Tucker who was described on the one hand as being supportive, but on the other hand as aggressive. He was also young and the couple had come from interstate and had the organisation Streetlink involved in their lives. That said to Ms Ranford that there was a legitimate question mark as to why it was that this couple had moved interstate. That of course was a concern in respect of C in particular because it was obvious that she had moved interstate in contravention of the status that she had in New South Wales vis-à-vis the Minister.

7.27. Ms Ranford took a number of actions that included contact with Ms Parenta at Families SA to raise concerns about the fact that the baby had not been sighted since 16 July 2011. Ms Ranford told the Court that on 26 July 2011 she spoke to Ms Parenta who told her that she would arrange for Ms Sharpe to attempt to visit within the next couple of days. Ms Ranford stated that she did not believe that it was necessary for her to make any further formal notification to CARL because the case was already within Families SA and, in addition, did not want to clog the system with what essentially would amount to no additional relevant information beyond what was already known.

[84] Transcript, page 489
[85] Transcript, page 791

She told the Court that when speaking to Ms Parenta on the phone on 26 July 2011 she was hoping that Families SA would access Ebony as they had a legislative responsibility to do so[86].

7.28. Ms Ranford also made contact with Ms Helen Steffensen-Smith who was the Families SA South Australian interstate liaison officer. This contact was made in relation to possible assistance that Ms Ranford believed might be afforded by New South Wales, having regard to the fact that C was under the parental responsibility of the Minister there. In an email dated 29 July 2011 which was three days after Ms Ranford's telephone conversation with Ms Parenta, she informed Ms Steffensen-Smith that in her conversation of 26 July 2011 Ms Parenta had told Ms Ranford that Ms Ranford was a '*dog with a bone*'[87]. This does not appear in Ms Ranford's note of her conversation with Ms Parenta of 26 July 2011, but Ms Ranford told the Court that Ms Parenta had said that to her in the conversation and that she had taken the comment as criticism that she had been unduly persistent in her desire to ensure that Ebony was actually sighted by Families SA[88]. Much of Ms Ranford's own frustrations and concern about Ebony is reflected in her email correspondence with the interstate liaison officer, Ms Steffensen-Smith, who in response to Ms Ranford's email asked Ms Ranford whether she would like her to escalate the matter through Families SA to which Ms Ranford responded by email later that afternoon saying:

> 'I am very worried and concerned as it is now 13 days.
> Don't want to get Loretta off side but at the same time I just want to know mother and baby have been seen and are okay.' [89]

7.29. That was Friday afternoon the 29 July 2011. I should add that when Ms Parenta gave oral evidence she denied that she had ever referred to Ms Ranford as a dog with a bone, or if she had said that that, it had been said tongue in cheek. There is no question in my mind but that she did say that to Ms Ranford. I think it highly unlikely that Ms Ranford would have invented this simply for the sake of emphasis in her subsequent email exchange with Ms Steffensen-Smith. I have no doubt that Ms Ranford not unreasonably took that as a slight on her endeavours to ensure that Families SA take a more active role in sighting Ebony who, as of the date of the telephone conversation,

[86] Transcript, page 820
[87] Exhibit C79, page 70
[88] Transcript, page 830
[89] Exhibit C79, page 69

had not been sighted by a responsible person for 13 days. Further, it should have been evident to Ms Parenta that at that point Ms Ranford's persistence had been reasonable and that the need for Families SA to sight the child was a matter of priority.

7.30. In the event Ms Emma Sharpe of Families SA did visit the family on Monday 1 August 2011. Ms Sharpe was a social worker in Ms Parenta's team at the Families SA Woodville office. She was stationed at that office from 11 July 2011 to 16 September 2011. The precise role of Ms Sharpe in Ebony's matter was not entirely clear. At one point it was suggested that she was tasked merely to monitor the matter, at other points it was suggested that she had been allocated the matter. I found that dichotomy unhelpful. It is more pertinent to observe what Ms Sharpe actually did or did not do in her time at the Woodville office.

7.31. Ms Sharpe's home visit on 1 August 2011 would the first of only two occasions on which a Families SA representative attended at the Brooklyn Park address. The other occasion occurred after Ebony was released from hospital following her thigh injury. Ms Sharpe made a detailed note of her attendance of 1 August 2011[90]. The tone of Ms Sharpe's note is upbeat in the sense that it describes an '*immaculate*' living environment and an apparently healthy, but very small, baby. Bradley Napier-Tucker is recorded in positive terms about his career path as a chef. Bradley Napier-Tucker is also recorded as saying that a health nurse from the hospital had been visiting, which of course says nothing of the difficulties that both the domiciliary midwife service CYWHS and CAFHS had been experiencing in engaging with the family. When Ms Sharpe had asked about drug consumption Bradley Napier-Tucker reported that since moving to Adelaide in January 2011 neither he nor C had smoked any marijuana as, being newcomers, they did not have the necessary contacts. When Ms Sharpe asked as to what would happen when they did have access to marijuana, Bradley Napier-Tucker is recorded as having laughed and said '*not sure*'. Ms Sharpe asked if any other drugs were part of their lifestyle to which Bradley Napier-Tucker made a denial. The claim that neither of them had smoked any marijuana since moving to Adelaide could have been examined against the observation made by Ms York on 13 July 2011 that Bradley Napier-Tucker was smoking marijuana outside the unit in an agitated state. But Ms York had not recorded that anywhere.

[90] Exhibit C81, page 270-271

7.32. Although this home visit by Families SA had a comparatively positive outcome, it has to be examined against the fact that when Ms Sharpe returned on 4 August 2011 to serve Bradley Napier-Tucker with the New South Wales court documents to which I have already referred, Ms Sharpe could not elicit a response when she knocked on the door notwithstanding the fact that she could see that the television was on and that at one point the channel was apparently changed by some person within the unit. When she tried five minutes later the same lack of response was encountered. On 5 August 2011 she returned to serve the documents and again there was no response to her knocking on the door. All of this prompted Ms Sharpe to write a letter to the parents dated 5 August 2011. The letter raised with Ebony's parents a number of matters including the lack of any response to door knocking by various professionals and Ebony's prematurity with the consequent need for medical checks to be carried out. The letter also contained a warning by Ms Sharpe that if they did not respond to attempts by professionals to contact them, Families SA would continue to receive information of that nature and it was likely that this would involve '*more investigation into your family*'[91]. The letter urged the parents to set up an appointment with her and a number was provided. There is no evidence that Ms Sharpe received any response. The word of warning would, in the event, prove to be hollow because further disengagement that would occur in the period prior to Ebony's death was met with cold indifference by Families SA. Worse, as will be seen, Families SA by closing its file and allowing it to remain closed despite that known disengagement, would divest itself of responsibility for Ebony's protection.

7.33. On 9 August 2011, which was the day before Ebony was brought to the QEH with a broken leg, Ms Sharpe created a document that was entitled '*Social work assessment of risk & protective factors & family strengths & needs*'[92]. Again this amounts to something of an upbeat assessment of Ebony and her parents who are said to be '*managing Ebony very well at this stage*'. In this document Ms Sharpe did not identify any risks, but in her oral evidence before the Court she said with masterful understatement:

[91] Exhibit C81, page 2
[92] Exhibit C81, page 257

> 'In terms of yes what I've actually written, but hindsight's a wonderful thing, isn't it, and, yes, there probably were some risks there in terms of that first intake that was received and the history in relation to C.' [93]

In fact as of the date of the creation of this document, the risks identified in the original July 2011 intake were, if anything, being played out. C was behaving true to form in that the New South Wales information from Ms Ralston imparted on 6 July 2011 about the mother's mistrust of services was already being manifested in inconsistent, if not a lack of, engagement with services and there was also the implicit suggestion by Bradley Napier-Tucker that the question of drug abuse had not been completely ruled out in their household. And the reality was, as Ms York had observed but not documented, that he had not stopped consuming cannabis. Ms Sharpe's document did not say anything about the lack of response to the letter that had been sent by her. As Mr Keane of counsel for the Minister for Education and Child Development that encompasses Families SA points out, the document amounted to an assessment that was at odds with the known facts of disengagement and with the requirement that they engage with services as expressed in her own letter of warning. It is difficult to see how at this stage such a positive document could have been written about this family when a letter, containing the warning that it did, had to be sent by the entity responsible for child protection in order to encourage the family to be more responsive.

7.34. In the event the family's worrying disengagement from services from 1 August 2011 would be overtaken by the 10 August 2011 presentation of Ebony to the QEH with a broken leg. The concerns that had been entertained to that point by CYWHS and CAFHS were to a large extent vindicated.

7.35. A medical opinion would be entertained that the injury could have occurred in early August 2011. This might go some way to explain the disengagement from services between 1 August 2011 and 10 August 2011.

7.36. It is not being wise after the event to suggest that the child's presentation with a serious injury amounted to a valuable lesson that a disengagement from services could involve catastrophic consequences for this family. At the very least, any entity that knew of the contemporaneity between disengagement and Ebony's injury was thereafter on notice that further disengagement would amount to a highly undesirable circumstance.

---

[93] Transcript, page 890

7.37. I should say something at this point about the evidence of Mr Bruno Grenci and Ms Ann Grenci who both provided statements to investigating police[94]. Their evidence provides some insight into what was happening within Ebony's family behind closed doors in the period under discussion and what may have been revealed if Families SA had approached the case with a more enquiring mindset. Mr and Mrs Grenci had met C and Bradley Napier-Tucker early in 2011 at a time before Ebony was born. As I understood the evidence Mrs Grenci and C met through a TAFE course. At one point before Ebony was born, Mr Grenci had provided Bradley Napier-Tucker with employment at a city café. Mr Grenci also arranged for the family's accommodation at the Brooklyn Park address. In her statement Ms Ann Grenci speaks of an occasion at the WCH just before Ebony was born when she met Bradley Napier-Tucker's mother. Mrs Grenci describes Bradley Napier-Tucker's mother as agitated during their conversation. Mrs Grenci states that Napier-Tucker's mother told her that Bradley smoked drugs and had been violent towards her. In another conversation that occurred approximately a week after Ebony was born Bradley Napier-Tucker's mother told Mrs Grenci that Bradley had been violent towards her and C and that he was on drugs. She said that Bradley Napier-Tucker had been calling C '*a fucking bitch*' and '*slut*'. She also said that Bradley Napier-Tucker was not allowing C to hold the baby or breast feed the baby or to bond with her. It is to be noted that this attitude was more or less confirmed through Ms York, the CYWHS worker. In her statement Mrs Grenci asserts that in a subsequent conversation with C, C herself confirmed Bradley Napier-Tucker's negative attitude towards her and confirmed the names he called her. Both Mr and Mrs Grenci speak of Bradley Napier-Tucker's aggressive reaction to their enquiry as to whether the family was receiving assistance through CAFHS or Families SA. Napier-Tucker had said that he did not want that type of intervention because the authorities had caused his son to be taken away from him, which in hindsight is a clear reference to the child M. Mrs Grenci had to tell him to calm down. All of this evidence tends to confirm that concerns entertained within CYWHS had not been misplaced.

7.38. As events were to transpire, Mr and Mrs Grenci would likely be the last persons to see Ebony alive. This occurred on Sunday 16 October 2011, approximately three weeks before Ebony's death.

[94] Exhibit C74a and Exhibit C75a

7.39. Mr and Mrs Grenci on the one hand and Napier-Tucker and C on the other had been perfect strangers before they met in early 2011. It is apparent from the statements of Mr and Mrs Grenci that there was a strong element of compassion in their interest in Napier-Tucker and C having regard to the strained circumstances in which the young couple had found themselves once in South Australia. Mr and Mrs Grenci endeavoured to provide significant support for this family for which they are to be commended. It is obvious that they took a genuine and compassionate interest in C and Bradley Napier-Tucker, and Ebony after her birth.

8. Ebony is admitted to hospital with a broken femur

8.1. I have already mentioned Ebony's broken femur. It was the sole injury that was indentified during her life. It constituted a circumstance that ought to have seen Ebony removed from her parents. Mr Keane of counsel for the Minister for Education and Child Development, for the Minister for Health, for the Women's and Children's Health Network and for Dr Terrence Donald, the then head of the Women's and Children's Hospital Child Protection Services (CPS), candidly told the Court that his clients accept that the investigation into this injury as carried out by the Child Protection Services miscarried. I agree and so find. In my view the evidence demonstrates that the investigation was a truncated and ill-informed affair that lacked proper cohesion and which wholly failed to protect Ebony. It is also important to note that the investigation was carried out in the absence of any knowledge of Bradley Napier-Tucker's background or propensities and so to that extent it was flawed from the outset. But even allowing for the absence of that information, the manner in which the investigation was carried out meant that it was a flawed investigation regardless.

8.2. At approximately 9:20am on Wednesday 10 August 2011 Ebony's parents brought Ebony to the Emergency Department of the QEH where the triage documentation described her as presenting with a blunt injury to a lower limb. The triage assessment recorded that Ebony had been:

> 'ACCIDENTALLY DROPPED 5 WEEK OLD BABY ONTO THE PRAM ON MONDAY. NOW L LEG SLIGHTLY SWOLLEN. CHILD ASLEEP. O/A'

8.3. Ebony was seen by a medical practitioner shortly after her arrival. It was recorded that Ebony did not appear distressed, was well kept, clean and that her parents appeared very concerned. The account of her parents as recorded by the emergency medical practitioner was that Ebony had been dropped two days previously '*landing on edge of*

pram'. It also reported that the child was dropped from a height of two feet and that this was apparently stated by Bradley Napier-Tucker.

8.4. That morning an X-ray of the affected leg was performed. On the same day the typed X-ray report of Dr Christopher Pozza, who is a radiologist at the QEH, was provided. Dr Pozza reported as follows:

> 'There is a fracture passing obliquely through the mid shaft of the left femur with some foreshortening, bony overlap and varus angulation at the site. In addition, there is periosteal new bone formation seen along the lateral femoral shaft. This latter finding would suggest that the injury is older than the stated history of two days. Non accidental injury should be strongly considered.' [95]

8.5. That afternoon Ebony was transferred to the WCH by ambulance. Before the transfer occurred it was discovered that while at the QEH Ebony had been administered an excessive dose of the analgesic morphine for which a reversal agent had been administered. There is no evidence that Ebony experienced any lasting adverse effect from this overdose.

8.6. Ebony was presented at the WCH just before 1pm that day. She was there seen by Dr Thu Kent. At triage it was recorded that Ebony's father had been holding Ebony and had dropped her with the result that she had fallen and landed with her knee between the dual wheels of a four wheeler pusher. This is recorded within the triage form[96]. It is not recorded whether it was the child's father who imparted that information at that time, but I am prepared to infer that it was Mr Napier-Tucker who had again described what had allegedly happened.

8.7. Dr Kent recorded that the parents believed that Ebony was '*OK*' after the fall, and was '*OK*' yesterday, but that on the current day she had not been feeding as well. In addition, swelling was noticed in respect of the left leg. Dr Kent recorded '*obvious swelling to the left thigh*'.

8.8. The QEH provided the WCH with a discharge summary. The document appears within the WCH casenotes for Ebony [97]. The discharge summary refers in clear terms to the diagnosis of a fractured left femur that is described as having occurred as a result of a fall two days previously that had involved the child landing on the edge of a pram,

[95] Exhibit C76, page 15
[96] Exhibit C78, page 49
[97] Exhibit C78, page 46

resulting in a painful, swollen left leg. The QEH X-ray examination is also referred to and makes clear and specific reference to the X-ray imagery showing evidence of sub periosteal new bone formation. Although I do not see a copy of the QEH radiology report within the WCH casenotes for Ebony, it is clear that the report made its way into the file of CPS that is accommodated within the WCH. The involvement of CPS is a matter that will be discussed presently. Dr Pozza's QEH radiology report referred not only to periosteal new bone formation, but also to its significance insofar as it suggested that the injury was older than the stated history of two days and that a non-accidental injury should be strongly considered.

8.9. Dr Kent gave oral evidence in the Inquest. She told the Court that one of the most common causes of a fractured femur in a baby would be a non-accidental cause. She had naturally been required to give some thought to the question as to whether the injury was accidental, neglectful or inflicted. She said that Ebony's father presented most of the history in respect of the matter and that the history was consistent each time as recorded in her notes of the presentation. However, Dr Kent stated in her evidence that having regard to the nature of the injury in a baby so small, it was routine to refer such a fracture to the CPS so that the question of whether it was a deliberately inflicted injury could be excluded or otherwise. Dr Kent told the Court that in this particular case she was also concerned about the youth of the parents and the fact that on their own version of events they had delayed seeking medical care for two days. Dr Kent said as follows:

> 'I didn't have enough evidence to say that it was inflicted because that wasn't his story and as I said he seemed nice, but I thought that it took some degree of carelessness to drop a newborn baby and then it's not usual to delay seeking medical attention if you've had that kind of an accident.' [98]

Dr Kent added that in her own mind she was unsure of the parents' explanation. She stated that although the parents had provided an account which could be taken at face value, she emphasised that there had been some worrying features associated with the child's presentation, in particular the youth of the parents and the delay in seeking medical attention. Dr Kent added that in her view causes other than those consistent with the parents' explanation had to be ruled out. She told the Court that she did not come to any conclusion about that issue herself because she believed that the task of evaluating the explanation for the injury belonged to the CPS. In particular Dr Kent emphasised that she had not formed the view that the injury was consistent with the

[98] Transcript, page 616

parents' explanation, nor had concluded that there was no suspicion that the injury had been deliberately inflicted. She told the Court that if any contrary suggestion had been made to her at that time she would have disagreed as she had not been in a position to have made such a judgment call. I must say that Dr Kent's evidence in that regard made complete sense. However, when Dr Kent made a notification to Families SA via CARL she would be recorded as having said in effect that Ebony's injury had a benign origin when in fact this was an issue that, on her own compelling evidence, required further detailed and objective investigation. In this respect the investigation into Ebony's injury had an unpromising beginning. And as will be further seen, it had an unsatisfying end, and not merely in hindsight.

8.10. Dr Kent also communicated with the CPS about Ebony's injury. Dr Kent herself does not appear to have made any notes of her conversations either with the CPS or CARL. In giving evidence she was to a large extent reliant on her unaided recollection as to the manner in which she reported Ebony's injury.

8.11. In the first instance Dr Kent spoke to a Mr Luke Watkinson who was a social worker with CPS. Mr Watkinson noted in the CPS file[99] that he had spoken with Dr Kent at about 2:15pm on the afternoon of 10 August 2011. Mr Watkinson noted that Dr Kent had explained to him that she felt somewhat '*unsure*' about the matter and that her concerns related to the parents' delay in seeking hospital treatment and to their youth. If that is the way in which she reported the matter to Mr Watkinson, and in my view it must have been, Dr Kent there gave him no reason to think that she had accepted the parents' explanation, or was advocating its validity. On the other hand, there was a further notation in the CPS records compiled by a Dr Janine Tee that suggested that somebody had informed Dr Tee that the broken femur was '*not suspicious of inflicted injury*'. If this had been based on something said by Dr Kent, it would not and could not have reflected the true state of the investigation thus far and would not have reflected her asserted state of mind. In the event whatever information was imparted to or recorded by Dr Tee, and whatever its source, they were matters that had no material effect on the CPS investigation and for that reason did not require detailed investigation by this Court.

[99] Exhibit C77, page 50

8.12. However, what was recorded by Families SA when Dr Kent that afternoon subsequently reported the matter to CARL did matter. It would set the tone for the organisation's thinly concealed if not overt lack of enthusiasm in respect of the ensuing investigation. It was noted in the Families SA records of Dr Kent's conversation that she had stated that:

> 'The injury sustained by the infant was consistent with the explanation given by the parents and that there was no suspicion of the injury being inflicted.' [100]

This was an unfortunate entry as it did not, and could not, reflect the true position in respect of the investigation at that point in time. It was also inconsistent with what Dr Kent earlier that afternoon had undoubtedly said to Mr Watkinson of CPS. In her oral evidence Dr Kent said that she would not have been in a position to have made a decision about whether the injury was consistent with the explanation given by the parents[101]. She said:

> 'I don't know why I would have said it if I was calling them to notify about being suspicious of the injury.'

Dr Kent told the Court that she did not believe that she had conveyed to the Families SA CARL representative what was recorded in the Families SA documentation as reproduced above, but conceded that she may have said something along the lines that the injury could be explained by the story given by the parents[102], meaning, I think, that the explanation was a theoretical possibility. However, she added that as she had not arrived at a state of mind whereby she entertained no suspicion that the injury had been deliberately inflicted, it was highly unlikely that she would have said any such thing in the terms recorded by Families SA.

8.13. As I say, the manner in which Dr Kent's report to CARL was recorded was most unfortunate, whatever the reason for it being recorded in that manner. At that very early stage of the investigation there was no basis for any person to conclude one way or the other whether the injury sustained by Ebony was consistent with the explanation given by the parents. Moreover, it could not have been legitimately stated that there was no suspicion that the injury had been deliberately inflicted. There was, after all, reasonable cause for such a suspicion simply based upon Dr Pozza's radiological report. Whether the injury had been deliberately inflicted was a matter that was going to require

[100] Exhibit C81, page 130
[101] Transcript, page 610
[102] Transcript, page 619

meticulous and rigorous investigation. It is difficult to understand how a suspicion such as this could be so readily dismissed either by medical personnel or by Families SA personnel as the case may be. Proper objective analysis at that stage could not have generated any conclusion other than that the origin of the injury would remain an open question until such time as the matter was thoroughly investigated. And yet, as will be seen, an attempt was made by Families SA to so dismiss it even at this early stage. The manner in which Dr Kent's report was recorded was perpetuated within the Families SA familial intake report[103] where, again, it is stated that medical staff at WCH had stated that the injury sustained by Ebony was consistent with the explanation given by the parents and that there was no suspicion of the injury having been inflicted.

8.14. I pause here to observe that despite the fact that Ebony was now in hospital, plainly there were reasonable grounds to suspect that Ebony was at risk and that the matters causing her to be at risk were not being adequately addressed. She was not going to remain in hospital forever and at some point the less than palatable prospect of Ebony being released back into her parents' custody would need to be addressed. This meant that the Chief Executive was under a mandatory obligation to conduct a section 19(1) Children's Protection Act assessment or investigation, or to effect an alternative response which would have more appropriately addressed the risk to Ebony. So it was not as if Families SA had a choice as to whether they should participate in an investigation matter of Ebony's injury, unless of course the view was taken that Ebony was not at risk, which it has to be said on the available evidence was an absurd proposition.

8.15. I did not have any reason to believe that Dr Kent, in the giving of her evidence, was being anything other than frank with the Court about her beliefs in respect of the injury. Her stated beliefs made sense. They accorded with what any reasonable person in her position would have believed. The manner in which CARL recorded her report is at odds with what she had told the CPS social worker, Mr Watkinson. My view is that what Dr Kent is recorded as having told Mr Luke Watkinson accurately stated the position, namely that there was a lack of certainty surrounding the parents' explanation and that there was legitimate concern generated by the delay in the parents seeking

[103] Exhibit C81, pages 132-135

hospital treatment and their youth. I am unable to say how the Families SA recorded description of Dr Kent's report came into being.

8.16. Upon receipt of the CARL notification from WCH, a Tier 2 notification was raised at Families SA. This document also contained the misguided reference to the consistency of the injury with the parents' explanation and to the lack of suspicion to which I have already referred. As with the first notification following Ebony's birth, this second notification would be communicated to the Woodville office of Families SA. Ms Loretta Parenta, the Woodville office supervisor, told the Court in her evidence that she read the intake report and specifically noted the reference to the injury being consistent with the parents' explanation. When questioned by counsel assisting, Ms Kereru, Ms Parenta agreed that notwithstanding that reference one would be unable to reach a conclusion about the origin of the injury until all of the relevant information had been gathered[104]. Therefore, to that extent Ms Parenta agreed with the further proposition that the information should not have made any difference to an investigation that would still be required. In fact Ms Parenta said:

> 'Actually, I was quite confused about that and I didn't know where that information had come from, so I had a discussion with, I believe, Dr Donald about it.' [105]

The Dr Donald mentioned in that answer is a forensic paediatrician with the CPS at the WCH. Dr Terrence Donald was the principal medical officer engaged in the CPS investigation that would ensue. Ms Parenta's asserted confusion is not in keeping with the manner in which I have found she approached this matter at the time. I rejected Ms Parenta's evidence that she herself shared the confusion created by the CARL entry and have found that she seized upon it as an opportunity to attempt to discourage, or curtail her participation in, a proper investigation into Ebony's injury. I say so for the reasons that follow.

8.17. Ms Parenta's assertion that she had maintained an open mind in relation to the origin of Ebony's injury was significantly brought into question by the evidence of Mr Watkinson, the CPS social worker, and that of Dr Donald. Ms Parenta spoke to Mr Watkinson in a telephone conversation on the afternoon of 11 August 2011 and then had another telephone conversation with Dr Donald. Ms Parenta did not make any notes on the Families SA file in respect of either telephone conversation. On the other

[104] Transcript, page 1225
[105] Transcript, page 1225

hand, both Mr Watkinson and Dr Donald made contemporaneous notes of their respective conversations with Ms Parenta. I digress slightly here to mention that there is a question raised within the CPS notes as to the order in which these conversations occurred. Mr Watkinson noted the time of his conversation as being 1450 hours that day whereas Dr Donald noted the time of his telephone conversation as having occurred at 1415 hours, when in fact when one looks at the surrounding circumstances it must be the case that Mr Watkinson's telephone conversation with Ms Parenta preceded that of Dr Donald's. I was satisfied that Dr Donald's communication with Ms Parenta actually took place as a result of the content of the conversation that Mr Watkinson had earlier conducted with Ms Parenta. Furthermore, within the note of Mr Watkinson there is reference to a suggestion on his part that Ms Parenta should speak to a CPS doctor and that person was Dr Donald.

8.18. I set out in full Mr Watkinson's note of his conversation with Ms Parenta:

> 'P/C to Loretta Parenta (Woodville FSA supervisor)
> - LNW requested intake
> - Loretta stated that she thinks that hospital have notified that injury is explained and Loretta intends to contact CARL to have rating 'downgraded'
> - LNW explained that further info has been obtained from hospital tests which suggests injury may have occurred earlier than reported
> - LNW suggested Loretta discuss with CPS doctor, Loretta agreed, direct # 8406 ****
>
> CPS will contact Loretta soon' [106]

8.19. Mr Watkinson gave oral evidence in the Inquest. Mr Watkinson explained to the Court that as a CPS social worker and inpatient clinician his role was to support care givers in their engagement with the CPS and to assist the forensic paediatrician in the gathering of psychosocial information in connection with an investigation. In that capacity he became aware of the fact that the Woodville office of Families SA had become involved in the matter. He said that it was taking some time for the intake notification that had been made to Families SA to be provided to the CPS. Mr Watkinson thus telephoned Ms Parenta of the Woodville office to seek out the intake document and to set up a strategy discussion that would involve the relevant authorities including SAPOL and Families SA. Mr Watkinson confirmed the accuracy of his casenote of this telephone conversation. In his oral evidence Mr Watkinson added that when he asked for the Families SA intake, Ms Parenta pointed out to him that the intake document stipulated that the notifier had reported that the injury had actually been

[106] Exhibit C77, page 89 (the last four digits have been deleted from the original entry)

explained and thus it was her intention to contact CARL to have the rating 'downgraded'[107]. I observe that within the note made by Mr Watkinson that he has written the word downgraded within inverted commas. I infer that this was intended to reflect the actual usage of that word by Ms Parenta. Mr Watkinson told the Court that he took from this that Ms Parenta's attitude was that an investigation would not be required[108].

8.20. Mr Watkinson rightly became concerned that Ms Parenta had adopted this attitude without having all of the relevant information that would have enabled a meaningful decision to be made at that point in time. I note that what Mr Watkinson asserts Ms Parenta stated to him is fully reflective of what was originally noted by the CARL member of staff and what is contained within the intake document, namely that medical staff from WCH had stated that the injury sustained by the infant was consistent with the explanation given by the parents, and that there was no suspicion of the injury being inflicted, an observation that at that early point in time was a gross overstatement of the position. The available inference from Mr Watkinson's evidence is that Ms Parenta was parroting the observation recorded in the intake and had elected to run with it because it represented the line of least resistance for Families SA. I return to that in a moment.

8.21. As indicated in Mr Watkinson's note he then explained to Ms Parenta that hospital tests suggested that the injury may have occurred earlier than the parents had reported.

8.22. In accordance with the recorded suggestion that Ms Parenta should discuss the matter with the CPS doctor, Mr Watkinson then spoke to Dr Terrence Donald. Mr Watkinson and Dr Donald together attempted to contact Ms Parenta, unsuccessfully at first. However, Dr Donald managed to contact Ms Parenta later in the afternoon. Mr Watkinson was not present when Dr Donald spoke to Ms Parenta on the telephone.

8.23. In cross-examination by Ms Kereru, counsel assisting, Mr Watkinson confirmed that his concern had arisen from the fact that Ms Parenta's decision to downgrade the intake had been taken despite a lack of appropriate information. He believed that the opinion of a forensic paediatrician was required in order to evaluate the asserted explanation for the injury. Mr Watkinson also referred to earlier difficulties that had been experienced by others in obtaining a copy of the Families SA intake. He said that he had formed an

[107] Transcript, page 975
[108] Transcript, page 976

impression that these difficulties had stemmed from Ms Parenta's desire to downgrade the intake and an intention on her part to talk to CARL before any intake was provided to the CPS[109].

8.24. Dr Terrence Donald also gave oral evidence. He is a forensic paediatrician with CPS. He was the Director of CPS from 1988 until 2010. In 2014 he resigned from the position of consultant paediatrician at WCH and has since been working in a private capacity as a forensic paediatrician reviewing cases on behalf of a number of law enforcement entities. Dr Donald was one of a number of entities and individuals represented by Mr Anthony Keane of counsel.

8.25. Dr Donald gave an account of his interaction with Ms Parenta on the afternoon of 11 August 2011 following Mr Watkinson's telephone conversation with her. It is worthwhile observing that Dr Donald's involvement at that stage was generated by Mr Watkinson's level of concern about Ms Parenta's stated desire to downgrade the intake[110]. In giving evidence Dr Donald referred to his own note of his telephone conversation. I here set that note out in full:

> 'Received the clinical material available with Loretta
> My position (TGD) was that the explanation that was sought and obtained at QEH and WCH was probably not complete.
> In particular, what happened to Ebony's leg when her knee hit the wheels of the pram. The position her body was in after the incident.
> The pram was reported to have 4 sets of double wheels – I would like it established whether or not Ebony's knee could fit between the wheels.
>
> Loretta was concerned that FSA/police involvement would be very stressful for Ebony's mother, particularly as she was still under guardianship. In spite of that Loretta agreed to contact Sturt FVIU (Family Violence Investigation Unit) and then arrange for a strategy discussion tomorrow (12/08/11).'

It will immediately be observed that Dr Donald's last recorded observation concerning the effect of Families SA / police involvement is consistent with a negative attitude on Ms Parenta's part to the conducting of any investigation, the negativity being premised on a wholly irrelevant consideration. The flavour of the note is that Ms Parenta's reticence had to be overcome and that the agreement on her part to a strategy discussion was a begrudging one given '*in spite of*' Ms Parenta's level of negativity.

[109] Transcript, page 1007
[110] Transcript, page 980

8.26. Dr Donald explained to the Court that on the afternoon of 11 August 2011 he became aware that the Woodville office of Families SA had been contacted regarding Ebony's presentation and that the supervisor there had indicated that Families SA were not going to investigate the matter. He told the Court that he had been unhappy with that attitude[111]. His belief was that the matter required investigation and that there was insufficient information at that stage for any conclusion to be drawn about the origin of the child's injury. He therefore then conducted what he described as a '*long discussion*' with the supervisor at Families SA Woodville office, namely Ms Parenta[112].

8.27. I should add here that Dr Donald's own concern about the origin of the injury was at that point, in the main, generated by the QEH radiology report which purported to cast suspicion on the parents' explanation for Ebony's injury. I digress to point out that very early in his evidence Dr Donald stated that he would come to regard the material contained within the QEH radiology report as erroneous and that in his view the assertions in the report had been made by a practitioner who was in essence unqualified to make them. I have rejected Dr Donald's characterisation of the QEH radiological evidence. In my view the radiological report correctly identified a matter of suspicion. Notwithstanding Dr Donald's intransigence in accepting what turned out to be overwhelming evidence supporting the correctness of the QEH radiological report, and despite my rejection of his evidence on that issue, I have accepted his evidence concerning his conversation with Ms Parenta, based as it is for the most part on contemporaneous documentation.

8.28. Before dealing with Dr Donald's interaction with Ms Parenta in respect of Ebony, I should refer to evidence that Dr Donald gave about how he believed Families SA supervisors, in particular Ms Parenta, approached some of their notifications. In the context of the manner in which this particular notification was recorded by Families SA, he suggested that Families SA might place a gloss upon a benign comment made by a medical practitioner as to the origin of an injury. He said:

> 'Some district centre supervisors will take the possibility that it's explained and make that a priority, rather than it's a baby with a broken leg, we'd better look at this.' [113]

Dr Donald surmised that in this case that may well have been the situation and specifically that it may have been a case where a supervisor had opted to choose a '*less*

[111] Transcript, page 647
[112] Transcript, page 647
[113] Transcript, page 649

significant course of action'[114]. In this regard Dr Donald told the Court that it had not been uncommon for Ms Parenta in particular to exhibit the type of reaction that she had exhibited in her conversations with Mr Watkinson and himself, as exemplified by her stated irrelevant concern that Families SA / police involvement would be very stressful for the child's mother. He said '*I mean it's not the first time that we had difficulties*'[115] with Ms Parenta in respect of matters of significant concern to which she had taken an unusual line. He said that his own personal intervention in Ebony's case at that early point in time was a reflection of her attitude '*because there was a very high level of conflict between her and other members of the staff*'[116], meaning his CPS staff. He further explained that the conflict arose out of what he had perceived was a tendency to minimise the possible seriousness of the situation, coupled with difficulty in securing a suitable response on Ms Parenta's part to recommendations that the CPS had endeavoured to make in respect of other matters. He said that her attitude presented '*an ongoing challenge to us all the time*'[117]. He cited as an example a matter in which CPS had experienced difficulty in obtaining a meaningful response from Ms Parenta, when she was working for the Crisis Response Unit, in respect of a baby that had a bruised penis. Ms Parenta in her own evidence, which I will come to in due course, rejected that characterisation of her relationship with the CPS.

8.29. In his oral evidence Dr Donald stated that as of the afternoon of 11 August 2011, while it was his understanding that Families SA were at that point satisfied with the explanation for Ebony's thigh injury, and that that was why Families SA were speaking of downgrading the notification, for his part he was not satisfied with the explanation. He said '*No I was concerned. Yes, absolutely*'[118]. At that point there was only a brief description from the father as far as an explanation was concerned. The explanation had little detail. He did not believe that in the absence of a forensic medical assessment including a skeletal survey any entity could be satisfied with the explanation. That is why he rang the supervisor, Ms Parenta. He said that he did so in the expectation that Families SA would review their current attitude which was not to act. He believed that there was a need to set up a strategy discussion and establish a proper interagency response as opposed to a downgrading, which would involve no response[119]. He agreed

[114] Transcript, page 649
[115] Transcript, page 722
[116] Transcript, page 722
[117] Transcript, page 723
[118] Transcript, page 651
[119] Transcript, page 652

with the proposition that as of the afternoon of 11 August 2011 there had been a rush to judgment by Families SA[120].

8.30. As to Ms Parenta's concern that a Families SA / police involvement would be very stressful for Ebony's mother, particularly as she was still under guardianship, Dr Donald told the Court that he believed that Ms Parenta did not want the matter to be dealt with at a child protection investigation level[121]. He said that in his opinion the concern about such an investigation being stressful for the child's mother could never be a relevant consideration where such an investigation was necessary[122]. He stated that there were other means to ensure that a mother felt supported in the course of an investigation. Nonetheless, Dr Donald said that he did not feel surprised when Ms Parenta had told him of her concern at Families SA / police involvement and the stress that might engender. It was in this context that he referred to the fact that it was not uncommon for Ms Parenta to have that kind of reaction and response in situations where there was nevertheless '*significant concern*'[123]. And it was in this same context that he referred to the very high level of conflict between Ms Parenta and members of CPS staff.

8.31. The Court is in full agreement with the proposition that the potential stress to a parent or parents that might be occasioned by a thorough and appropriate Families SA and police investigation into the unexplained serious injury to a one month old child could never take precedence over the need for such an investigation. The suggestion that an investigation might be forestalled or not be pursued with the necessary vigour because of the stress it might cause to parents is patently absurd, particularly when one has regard to the fact that it may well be the behaviour of the parents that has given rise to the injury. It was not surprising that when Ms Parenta came to give her own evidence she would deny that she had said any such thing in her conversation with Dr Donald. I will come to her evidence in a moment.

8.32. In the event Dr Donald told the Court that a strategy discussion was agreed to in spite of Ms Parenta's reluctance.

---

[120] Transcript, page 653
[121] Transcript, page 721
[122] Transcript, page 722
[123] Transcript, page 722

8.33. I now deal with Ms Parenta's evidence on this issue. I have already referred to the fact that Ms Parenta did not make any note contemporaneous or otherwise in respect of her telephone conversations either with Mr Watkinson or Dr Donald. Thus her accounts of her conversations with those two men had to emanate from her unaided recollection. Before dealing with Ms Parenta's version of those conversations it is necessary to say something about the evidence that she gave in respect of what her attitude would or should have been to an investigation at that time. Firstly, she told the Court that she had been advised of the intake and was aware of information within it that medical staff at WCH had stated that the injury sustained by the infant was consistent with the explanation given by the parents. Ms Parenta agreed with counsel assisting that a conclusion about that observation could not have been made until all of the relevant information had been gathered. She also said that in respect of an investigation into the origin of a broken femur in a baby there would need to be an investigation because of the concern that an injury such as that may not be accidental. In this regard she told the Court that other than the Ebony Napier case she had never encountered a case where a baby had a broken femur[124]. In relation to the statement within the intake about the consistency of the parents' explanation, it will be recalled that Ms Parenta asserted that she had in fact been quite confused about that statement and that she did not know where that information had come from, '*so I had a discussion with, I believe, Dr Donald about it*'[125]. In the event, I have found that these assertions fly in the face of Ms Parenta's attitude at the time as evidenced by what she said to Mr Watkinson and Dr Donald respectively. I reject her assertions in this regard.

8.34. As far as her conversation with Mr Watkinson was concerned, Ms Parenta denied that she had wanted to contact CARL to downgrade the intake. She denied that she had said so in terms to Mr Watkinson. She reiterated that she herself was confused about the manner in which the intake had described the parents' explanation and its asserted consistency. However, she did not deny that she may have had a discussion with Mr Watkinson about the intake statement, but denied that she had said what Mr Watkinson ascribed to her, namely that it was a reason that would enable her to downgrade the intake. Ms Parenta said '*I can't imagine that I would have even been thinking of downgrading it*'[126]. She agreed that a downgrading would mean that the matter would not be investigated[127]. She added that this was a reason why she could say with some

[124] Transcript, pages 1223-1224
[125] Transcript, page 1225
[126] Transcript, page 1227
[127] Transcript, page 1228

certainty that she would not have suggested downgrading or have executed a downgrading.

8.35. Ms Parenta acknowledged that her recollection of her conversation with Mr Watkinson was very vague[128]. It is worthy of note that in his record of this conversation Mr Watkinson has referred to Ms Parenta's intention or desire to contact CARL. In questioning by me, Ms Parenta said that she did not remember whether there had been anything said in the conversation with Mr Watkinson about contacting CARL[129]. However, she said that there would have been no reason for her to contact CARL at that time as they had the necessary information from CARL, and perhaps more significantly, said that she did not believe that there would have been any necessity for her to discuss with Mr Watkinson any need on her part to contact CARL. In other words there would be no reason to bother CARL at that time[130], and it would seem to follow that there would not have been a need to discuss CARL with Mr Watkinson. When further asked if she could think of any reason why she would have told Mr Watkinson that she intended to contact CARL, she said:

> 'It would only possibly have been to clarify information, that it may have been - that may have been the reason.' [131]

The following passage of evidence was given in the course of Ms Parenta's evidence before the Court:

> 'Q. Is it possible that you were all too ready to accept the assertion in the notification that the injury sustained by the infant was consistent with the explanation given by the parents and that there was no suspicion of the injury being inflicted.
>
> A. I was obviously questioning that but the normal procedure would be if the Child Protection Services believed it needed to be investigated further then it would be.
>
> Q. What do you say to the suggestion that as of 11 August you were all too willing to accept that piece of information in the intake and that for that reason you wanted to close the door on the investigation at that very early stage.
>
> A. I don't believe that was the case.
>
> Q. And that you told Mr Watkinson pretty much that.
>
> A. I don't believe I would have done that but I don't recall it.' [132]

[128] Transcript, page 1228
[129] Transcript, page 1229
[130] Transcript, page 1230
[131] Transcript, page 1230
[132] Transcript, page 1230

Ms Parenta denied any rush to judgment about the matter at that time.

8.36. I now deal with Ms Parenta's evidence in respect of her subsequent conversation with Dr Donald. In the course of her evidence counsel assisting invited Ms Parenta to read Dr Donald's note of this telephone conversation. Ms Parenta was asked about the final paragraph of Dr Donald's note that ascribed to her the assertion that she was concerned that Families SA / police involvement would be very stressful for Ebony's mother. Ms Parenta said that she was very surprised at the inclusion of that assertion, saying:

> 'I'm sure it would have been stressful, but that wouldn't have been any reason not to have the investigation.' [133]

Ms Parenta told the Court that she did not believe that she had said any such thing[134]. When the consistency between the attitude expressed in that assertion and what she had allegedly said to Mr Watkinson about an intention to downgrade the intake was pointed out to her, she said '*I don't believe that I said that at all*'[135]. She added:

> 'I don't think that's consistent. I have not said that there. I have said that I - possibly I've said, and I don't remember having said it, that it would be stressful for the family, that's all.' [136]

When she was asked point blank whether she thought an investigation into Ebony's fracture would be stressful for C she said '*I don't remember*'[137]. She agreed with counsel assisting that such an issue was not relevant to a child protection investigation, and indeed agreed that it would be a completely misguided consideration[138]. When asked as to what did occur during this conversation with Dr Donald she said that she could not remember, but said that she certainly could not recall placing any emphasis on the impact of an investigation on the family. When asked by me as to why she would need to mention to Dr Donald the possible stress that would be placed upon Ebony's mother having regard to the fact that she was still under guardianship of the Minister in New South Wales, Ms Parenta could not think of any reason why she would emphasise the connection between potential stress occasioned by an investigation and the fact that the mother was still under guardianship[139], except to say that she may have mentioned the guardianship in passing. I do note, however, that the manner in which Dr Donald

[133] Transcript, page 1232
[134] Transcript, page 1233
[135] Transcript, page 1233
[136] Transcript, page 1233
[137] Transcript, page 1233
[138] Transcript, page 1233
[139] Transcript, page 1234

has recorded Ms Parenta's assertion very much suggests that there was an element of attempted dissuasion on her part in respect of Dr Donald's resolve to investigate the child's injury. Added to this was his notation that Ms Parenta agreed to a strategy discussion involving the police '*in spite of*' her concern about the potential stress occasioned to the mother. Ms Parenta denied that she had to be persuaded to contact the SAPOL Sturt Family Violence Investigation Section (Sturt FVIS) to arrange the strategy discussion.

8.37. Ms Parenta denied that there had existed a level of conflict between herself and members of CPS or that she had a tendency to minimise the seriousness of intakes such as the one under discussion. However, I have accepted Dr Donald's evidence that he and others with the CPS genuinely held this perception of her. Such a perception is highly consistent with Ms Parenta's alleged attitude to the current CPS investigation, is highly consistent with the alleged manner in which she dealt with Ms Ranford of CAFHS at the end of July 2011 and, as will be seen, is highly consistent with the undoubted manner in which she dealt with the issue of Ebony's file closure in October 2011.

8.38. There is one other matter that requires discussion and that is that at 5:13pm that same afternoon Ms Parenta compiled a note for the Families SA file recording that '*the intake*' had been moved to the protective intervention phase in order to provide the family with some services through the New South Wales child protection authority. It was suggested to Ms Parenta that this provided further evidence of her desire to shut down the investigation as of the afternoon of 11 August 2011, or at least to downgrade it. Ms Parenta said this was a reference to the earlier intake from the time of the child's birth. I need say no more about this note except to say that I was not convinced that the note related to the most recent intake involving the child's thigh injury and so for the purposes of this discussion I put it to one side.

8.39. I have given careful consideration to the evidence concerning the discussions that Mr Watkinson and Dr Donald respectively had with Ms Parenta. I have preferred the evidence of both Mr Watkinson and Dr Donald to that of Ms Parenta where there is conflict as to what was or was not said during the course of their respective discussions. Ms Parenta, of course, is at a significant disadvantage insofar as she did not make any record, contemporaneous or otherwise, of her telephone discussion with either gentleman. That of itself does not mean that her evidence is to be rejected where it

conflicts with that of either Mr Watkinson or Dr Donald. Nor does the fact that she made no notes automatically confer credibility on the evidence of either Mr Watkinson or Dr Donald. I have also had regard to the possibility that the evidence of Mr Watkinson and Dr Donald may have been coloured by a pre-existing bias against Ms Parenta having regard to Dr Donald's description of the history between her and his organisation.

8.40. However, I am satisfied that Mr Watkinson was accurate in both his note taking and in his oral evidence about his conversation with Ms Parenta. I find that Ms Parenta said to Mr Watkinson that the hospital had notified that the child's injury was explained and that she intended to notify CARL to have the matter downgraded. I find that Ms Parenta used the word 'downgraded' in her conversation. I find that it was out of concern at this possible development that Mr Watkinson decided to involve Dr Donald in the matter at that stage.

8.41. I have also found that Dr Donald's note accurately reflected his discussion with Ms Parenta and that Ms Parenta did say to him that she was concerned that a Families SA / police involvement would be very stressful for Ebony's mother, particularly as she was still under guardianship. I further find that Ms Parenta begrudgingly agreed to contact the Sturt FVIS to arrange for the strategy discussion. It is highly unlikely in my view that Dr Donald would make such a notation unless Ms Parenta had said the things ascribed to her in his note. In my view Ms Parenta's evidence that she may have said what is ascribed to her about the stress to the mother as a mere passing comment is to be rejected. I do not believe that she merely said this in passing. It is unlikely that a comment about the stress that an investigation might cause to a family would be mentioned in passing. It is unlikely that Dr Donald would have recorded the comment if it had been made merely in passing. It was a wholly irrelevant consideration having regard to Ms Parenta's professional responsibilities. In my view she said this with the intention of dissuading Dr Donald from proceeding with an investigation. An impartial professional person in Ms Parenta's position should have entertained no such concern, nor expressed it.

8.42. The evidence of both Mr Watkinson and Dr Donald is highly consistent as between one and the other and is reflective of a desire on Ms Parenta's part not to have to participate in an investigation into Ebony's injury. I find that Ms Parenta seized upon the notation within the CARL intake to the effect that the hospital had notified that the child's injury

was explained. I find that it was the impetus of that notation that caused Ms Parenta to say to Mr Watkinson that she intended to contact CARL to have the rating of the intake downgraded so that no meaningful participation by Families SA in an investigation would then have to ensue. I can think of no legitimate reason for Ms Parenta to say to Mr Watkinson that she intended to contact CARL other than in the context of her stated desire to downgrade the intake. I take into account Ms Parenta's evidence that she would not have had any reason to notify CARL and there would have been an element of futility in trying to contact them to affect the status of the intake. But I do note in this regard that the Families SA Infants at Risk Policy, Procedures and Practice Standard[140] stipulates that strategy discussions must be held in Tier 2 cases, which this was, between the relevant authorities including Families SA except in those cases where there is no role for police or the CPS. A downgrading would have meant that there would have been no such strategy discussion, or at least one that involved a Families SA Supervisor. Whatever the actual position may have been as far as the niceties that were involved in downgrading a Tier rating were concerned, I am satisfied that in spite of her denials in the witness box[141], Ms Parenta told Mr Watkinson that she had a desire, if not an actual intention, to do whatever it was that was required to curtail her participation in an investigation, regardless of whether that would be achieved by way of notifying CARL or by way of some other measure. As I have said, I am satisfied that it was she who used the expression 'downgrade' to describe what she wanted to see happen to the intake. There seems little doubt that Ms Parenta had the ability to limit the scope of Families SA's participation in an investigation, especially if all other authorities failed to take the initiative. I find that this is what she was referring to when she spoke to Mr Watkinson.

8.43. In coming to the above conclusions in respect of Ms Parenta I have borne in mind that they are of a damaging nature. I have kept in mind that findings of this nature should not be made lightly or on unconvincing evidence. I have also had regard to the fact that a possible explanation for Ms Parenta's attitude is less than clear and that therefore it might be argued that such an attitude is intrinsically unlikely. However, I do not regard the evidence upon which I have based my conclusion that Ms Parenta inappropriately

[140] Exhibit C100d, page 19
[141] Transcript, page 1230

attempted to forestall an investigation into Ebony's injury as in any way unconvincing. On the contrary, the evidence is support is clear, cogent and convincing.

8.44. I turn now to other unsatisfactory aspects of this investigation into Ebony's injury. On 12 August 2011 a number of events occurred in respect of the investigation. The strategy discussion that had been agreed upon the afternoon before took place on that day. Ebony's parents were interviewed by Ms Emma Sharpe of Families SA. The parents were also interviewed by a team from CPS that included Dr Donald and Mr Watkinson. Also on the same day a skeletal survey of Ebony was performed by a radiologist, Dr Bruce Clark. The survey was reported on later that day. I will deal with each of those events in turn.

8.45. The strategy discussion of 12 August 2011 was attended by a number of people including Dr Donald and Mr Watkinson. Ms Parenta and Detective Sergeant Richardson from SAPOL were connected to the meeting by way of telephone. Notes of this discussion were kept by a clinical coordinator[142]. Dr Donald is recorded as having stated that the explanation for Ebony's injury was cursory and not clear and that due to the child's age they needed to be clear in respect of the circumstances in which the baby was dropped. Dr Donald opined that the matter required a forensic medical assessment. There is reference in the note to the Families SA social worker speaking with the parents and, as observed earlier, Ms Sharpe would speak to the parents on the same day. The meeting concluded on the understanding that there was a need to delay any final assessment until the explanation from the parents was received, and that to this end CPS would also speak to the family as soon as possible. There was mention of the possibility of having the child's pram examined.

8.46. Ms Parenta's own note of the discussion[143] is similar in its terms to the CPS note. It records that Dr Donald was not satisfied with the parents' explanation and that a further discussion would be held if Dr Donald remained concerned after the parents were further spoken to. It is clear from her note that both Families SA and CPS would speak to the parents.

8.47. Ms Sharpe of Families SA spoke to the parents that day. Ms Sharpe gave oral evidence during the Inquest. She told the Court that she spoke to the parents separately which

[142] Exhibit C77, page 52
[143] Exhibit C81, page 245

distinguished her investigation from the later investigation by CPS who spoke to the parents together. Ms Sharpe made a detailed typed record of the separate interviews with Ebony's parents. In Bradley Napier-Tucker's interview with Ms Sharpe he said that at about 4pm to 4:30pm on the Monday afternoon, which was four days previously being 8 August 2011, Ebony had been in her bouncer on the lounge room floor and had started to cry. C had just awoken from sleep on the lounge so Bradley Napier-Tucker tended to Ebony by picking her up. He walked around the coffee table to get a nappy bag and as he bent down to pick up the nappy bag Ebony slipped out of his left arm and fell. As Bradley Napier-Tucker was using his right arm to hold the nappy bag he was not quick enough to catch Ebony who landed with her leg caught between the two wheels of the child's pram. Ebony's head was cushioned from the fall because she landed on his foot. He attempted to soften the fall before impact. Napier-Tucker said that the baby cried for 5 to 10 minutes. They did not notice any injury to her leg at that time. He said that it was not until the following afternoon that they noticed swelling to Ebony's leg. This did not improve over several hours. He went on to say that at approximately 3:30am on the Wednesday morning, which was 10 August 2011, they called a taxi and made their way to the nearest hospital, being the QEH[144]. Ms Sharpe recorded that she specifically asked Bradley Napier-Tucker whether he had been under the influence of anything when the incident occurred. He disclosed that he had a bong 1½ to 2 hours previously. Ms Sharpe recorded that she asked Bradley Napier-Tucker if he thought this had played a part in the incident, to which he had said that '*it may have slowed him down a bit*'. Bradley Napier-Tucker went on to say that he purchased $50 of marijuana at a time and that this lasted about a week. He indicated that C also has a smoke in the evenings. He said that he himself smokes every other day and smokes approximately four bongs on those days. He added that when he smoked he felt '*paranoid and nervous*'. He said that he had been smoking for about five years since he was 16. He told Ms Sharpe that he needed '*to get off the dope*' and asked her as to who might be able to assist with this. Ms Sharpe nominated DASSA and suggested that he should make contact with them while spending time in the hospital. Bradley Napier-Tucker also said that he would like to undertake a parenting course as he had no experience with babies and wanted to avoid any further incidents.

[144] There is no record of their attendance at the QEH prior to 9:22am in the triage note

8.48. Ms Sharpe then spoke to C. C was asked for her version of events in respect of the incident. Ms Sharpe has recorded that C '*reported almost verbatim what Bradley had said*'. Specifically, C said that she had just awoken from a nap. Ms Sharpe recorded this as having occurred 5 to 10 minutes earlier. C said Ebony was in her bouncer crying. Bradley Napier-Tucker picked her up and grabbed the nappy bag and as he did so Ebony slipped and fell. C said that Bradley Napier-Tucker had '*saved Ebony's head with his foot*'. As to marijuana usage, C said that for a period they had stayed off the substance but both started to use again after a stressful situation. C said that she did not smoke as much as Bradley Napier-Tucker and that he needed '*to do something about it*'.

8.49. Ms Sharpe's characterisation of C's account as being almost verbatim when compared to that of Bradley Napier-Tucker appears by and large, but not entirely, to be accurate. Both parents stated that C was awake after her nap. There is a clear impression from C's recorded statements to Ms Sharpe that she had witnessed the event including having discerned the reason why Bradley Napier-Tucker picked Ebony up, that she had seen his grabbing the nappy bag and that she had witnessed Ebony's fall at that time. The detail of Bradley Napier-Tucker's foot having either softened the fall or having saved Ebony's head was strikingly similar. The similarities between their accounts would be consistent with it being a true account aided by accurate recollection on both parents' part, or it would be consistent with it having been a fabrication. The fundamental similarity is that C was awake and that she was present when the incident occurred and that she witnessed the incident. In her evidence Ms Sharpe told the Court that she was certainly under the impression that C was telling her that she had witnessed the incident herself[145]. Ms Sharpe in her evidence told the Court that she had been alive to a suspicion that their stories had been rehearsed[146].

8.50. As to Bradley Napier-Tucker's cannabis consumption, as revealed in the interviews, Ms Sharpe told the Court that she did not believe that his expenditure when compared with his rate of consumption were congruent. She agreed with counsel assisting that there would have been a question mark in respect of the information that he provided in that regard, and that the same would apply to his odd assertion that he had been smoking for five years since he was 16 when in fact he was only 19 years of age at the time of the interview. It was clear to Ms Sharpe that Bradley Napier-Tucker had a

[145] Transcript, page 900
[146] Transcript, page 900

problem with marijuana, that there was a fair inference to be drawn that his drug consumption would inevitably continue until such time as he was able to get some assistance but that in reality he showed no inclination to cease using marijuana. In her evidence Ms Sharpe acknowledged that as things had currently stood at the time, Bradley Napier-Tucker had an intractable problem with marijuana consumption[147], that he was hands-on in respect of the handling of the baby and that therefore the risk of repetition of an incident such as the one he had described was something that would have to be considered, all of which was a reasonable acknowledgment on her part. I return to the question of cannabis consumption in a separate section.

8.51. Although Ms Sharpe recorded that C had reported the incident in almost verbatim terms when compared to what Bradley Napier-Tucker had said, it is noteworthy that the account of C as recorded by Ms Sharpe does not say anything about Ebony's leg being caught between the two wheels of the pram. Thus, the description 'verbatim' may not necessarily be wholly correct, at least as far as the minute detail is concerned. I did not necessarily understand Ms Sharpe to be saying that the accounts given by C and Bradley Napier-Tucker were absolutely identical when she said that they were verbatim. The absence within C's account of reference to the baby's leg being caught between the two wheels of the pram is consistent with her not having seen that aspect of the event. The issue is of some significance because of a suggestion made during the Inquest that the account that would be given by C during the subsequent CPS interview was manifestly inconsistent with what she had said to Ms Sharpe and that the inconsistency should have added to the suspicion that the explanation for Ebony's injury was false.

8.52. Mr Watkinson's note of the CPS parent interview records a description of the event as given by the father that is not inconsistent with the version that had been given to Ms Sharpe. It includes reference to the baby's leg descending into the gap between the two left-hand dual wheels of the pram. According to Mr Watkinson's note of what was said, the leg had descended into that gap right up to the thigh. The note described C having been awake for 5 minutes prior to the incident. The note records that C did see Ebony roll, but did not see her leg descend into the wheels of the pram. It records that the mother saw her leg when she stood up from the lounge. Mr Watkinson has noted in inverted commas '*leg wasn't stuck*'. On this version of events C was stating that she

[147] Transcript, page 908

was awake when the incident occurred and had been so for about 5 minutes, but that she did not see the leg trapped between the two wheels of the pram. Another note taken at the meeting appears to describe what Bradley Napier-Tucker had said of the incident, which is again not inconsistent with Mr Watkinson's description and with what Bradley Napier-Tucker had told Ms Sharpe. The note described the mother as having been asleep for four hours prior to the incident and that she jumped up when the baby was dropped. It specifically records that C said that she could not see the leg being caught as the nappy bag had been '*in front*', presumably meaning that it had obscured her view. She has described the leg as having come straight out from between the wheels and was not stuck when Ebony was picked up. This account also suggests that C had asserted that she was awake at the time of the incident.

8.53. There are references within the sets of notes made at the meeting to Bradley Napier-Tucker's and C's marijuana consumption. There is reference to Bradley Napier-Tucker having consumed marijuana four hours before the incident. He said that he had a '*few cones*' throughout the day.

8.54. To my mind there is no compelling inconsistency in the accounts provided by C. I have not accepted the submission that an obvious material inconsistency between the account given by C to Ms Sharpe and the account given to the CPS meeting should have been detected and should have been taken into account in assessing the genuineness or otherwise of the explanation as to how the child sustained its injury. However, as will be seen presently there were other more compelling matters that cast doubt on the explanation given by the parents.

8.55. On 12 August 2011 the skeletal survey of Ebony was conducted and reported on. The radiology report relating to the skeletal survey was prepared by a radiologist Dr Bruce Clark. The survey was conducted four days after the day that Ebony's parents identified as the day when Ebony had been involved in the incident with the pram and was conducted two days after the first radiological assessment had been undertaken at the QEH by Dr Pozza. It will be remembered that Dr Pozza's radiological report had originally given rise to the suspicion that Ebony's injury was older than the stated history of two days as given by the parents and that a non-accidental injury should be strongly considered. I find that the radiological report in respect of the skeletal survey conducted on 12 August 2011 and reported on by Dr Clark confirmed the suspicion that the injury was older than the stated two days.

8.56. I set out Dr Clark's report in full:

> 'REPORT: A fracture of the midshaft of the left femur is again noted with considerable angulation and fairly florid periosteal bone reaction.
>
> There is less obvious subperiosteal bone formation affecting the right femur, which most likely is considered to be physiological. The other bones show no clear evidence of this periosteal bone formation. No clear evidence of significant metaphyseal spurring and no other fractures are seen. The skull size appears normal.
>
> CONCLUSION: Established fracture of the midshaft of the right femur. I would say that the degree of subperiosteal bone formation would be more than expected for a fracture allegedly sustained on Monday, but of course it may be an accentuation of the presumed physiological subperiosteal bone formation noted on the intact right femur. No fractures are seen elsewhere.' [148]

8.57. Dr Pozza, the QEH radiologist who had reported on 10 August 2011, was called to give evidence about his report. Dr Donald gave his oral evidence after Dr Pozza gave his. In the light of certain evidence that was given by Dr Donald, it became necessary to recall Dr Pozza. It also became necessary to call Dr Clark, the radiologist who conducted the skeletal survey. When Dr Pozza was recalled he and Dr Clark gave concurrent evidence.

8.58. I deal firstly with the original evidence of Dr Pozza. Dr Pozza told the Court that he obtained a Fellowship at the Royal Australian and New Zealand College of Radiologists in 1999. He has qualifications in the United States of America. Dr Pozza has been working as a radiologist at the QEH since 1998. During Dr Pozza's training in the United States of America he spent a number of rotations through several hospitals which had specialised in the treatment of children. Part of his working time there involved paediatrics. He also underwent speciality training in paediatric radiology. In his evidence Dr Pozza explained that the amount of new bone formation that is referred to in his report was abnormally excessive and that it indicated that the injury was older than the stated history of two days. He said that the radiological evidence would suggest that the fracture was at least five to seven days old[149]. As to his stated concern that the fracture of the left femur may have been non-accidental, Dr Pozza suggested that a powerful force would have been needed to cause a fracture such as that in Ebony. He suggested that the fracture of a femur requires significant force such as that which might

[148] Exhibit C77, page 169
[149] Transcript, pages 598-600

be inflicted in a motor vehicle accident or in a fall from a significant height, for example the fall of a child from a tree or in the playground. By way of contrast, a fall from a bed or a chair would not be considered a height significant enough to produce that type of fracture[150]. Dr Pozza said that non-accidental injury is the most common cause of injury to the femur in a child in Ebony's age group. He said it was well documented that 60% to 80% of cases of this type of injury in children under one year of age are considered to be non-accidental. In his evidence Dr Pozza was asked to consider the veracity of the explanation that had been given by the parents. The following passage of evidence was given:

> 'CORONER
> Q. What do you say about that as a possible explanation for the injury that you observed radiologically.
> A. I guess I would say that the mechanism of injury with direct blow to the mid-shaft of the thigh is possible but the force required to do that would have to be quite significant. I think a small, a short fall, from the lap for instance where you're talking, what, 30 cm or so would not generate enough force to do this. It would have to be from a significant height.
> Q. What kind of height are you talking about.
> A. It would have to be from at least a standing height or above, and it would have to be not just a simple accidental drop, it would have to be more significant force.
> Q. Than simply the force of gravity, is that what you mean.
> A. Correct.' [151]

8.59. Dr Pozza told the Court that he was surprised that he had not been consulted during the course of the ensuing investigation into the cause of Ebony's injury[152]. He said that the findings in his report had been sufficiently concise and to the point. He believed that he had been stressing his concerns forcefully. He said that he would have expected someone to question him as to his findings. No person questioned him as to why he had reported that a non-accidental injury should be strongly considered. If he had been so consulted he would have reported that in his view the fracture was at least five to seven days old and not two days of age, and he would have advised that 60% to 80% of cases of this type of injury in a child under the age of one were to be considered as non-accidental. Asked specifically as to what he would have said if he had been asked his opinion as to whether the parents' explanation was adequate, he told the Court that

[150] Transcript, page 593
[151] Transcript, page 597
[152] Transcript, page 598

he would have disagreed with the suggestion that it was adequate on at least two counts, firstly that the force required to fracture the bone was not consistent with the stated fall as described and, secondly, that the age of the fracture was radiologically older than two days[153].

8.60. Dr Pozza would give further evidence when he was recalled. I return to this in a moment, but it is first necessary to describe the evidence of Dr Donald on the subject of the radiological material. On a number of occasions during the course of Dr Donald's oral evidence he suggested, in effect, that Dr Pozza had not been qualified to express an opinion about the age of the fracture or about the force required to cause it. He believed it was a '*real issue*'[154] that a non-paediatric radiologist would be '*presumptuous*' enough to draw conclusions about falling distances and the forces that might be generated. As well, he suggested that Dr Pozza had demonstrated a complete ignorance of physiological periosteal bone reaction. He suggested that radiologists are of limited utility in the context of the topics under discussion[155]. While agreeing that it may have been prudent to have spoken with Dr Pozza at the time, Dr Donald went so far as to say that this was so only from the point of view of Dr Pozza's education[156]. Dr Donald expressed disagreement with Dr Pozza's statements as to the degree of force required, or the height from which the fall would have needed to occur, and with the proposition that the amount of new periosteal bone formation was indicative of an age older than what had been stated by the parents. Dr Donald also interpreted Dr Clark's skeletal survey report in a manner not inconsistent with the proposition that the age of the injury was as stated by the parents. In his evidence Dr Donald at first suggested that he had not discussed the X-rays with Dr Clark[157], but later during cross-examination by counsel assisting Ms Kereru he suggested that in fact he had spoken to Dr Clark. He said:

> 'Yes, we met with him. We always - we don't rely on reports, we actually go and talk and look at the X-rays with the radiologist.' [158]

Dr Donald suggested that when Dr Clark was consulted it was common ground that the fracture had not been older than the asserted two days. And so to that extent it was

[153] Transcript, page 599
[154] Transcript, page 670
[155] Transcript, page 663
[156] Transcript, page 729
[157] Transcript, page 675
[158] Transcript, page 730

revealed at the time that Dr Clark's opinion differed from that of Dr Pozza[159]. In fact, as will be seen presently, both Dr Pozza and Dr Clark had held the same opinion.

8.61. Dr Donald's opinions as to the question of force, distance of the fall and new bone formation would become an intrinsic element of the view ultimately taken by CPS that Ebony's injury was adequately explained. This view would underpin the lack of action was taken in respect of Ebony notwithstanding her injury. I will return to that matter in a moment, but it is first necessary to consider further evidence that was given by Dr Pozza and also by Dr Clark.

8.62. Following Dr Donald's evidence Dr Pozza was recalled. As indicated above, he and Dr Clark gave concurrent evidence. Dr Pozza restated his view that the fracture was at least five days old, and with the aid of the imaging demonstrated why he thought this was so. Dr Clark gave evidence that in his opinion the age of the injury was about seven to ten days in age and possibly even two weeks old, that is to say possibly caused as much as two weeks prior to the X-rays taken on 12 August 2011. Dr Clark agreed with Dr Pozza's evidence that the quantity of new bone formation was the appropriate measure for the age of the injury.

8.63. Dr Clark suggested in his evidence that to produce a fracture like Ebony's would have required '*fairly massive force*'[160].

8.64. It will be remembered that Dr Donald stated in his evidence that he interpreted Dr Clark's report as not being inconsistent with the proposition that the injury could have been caused at the time the parents said it was caused. However, Dr Clark's evidence led me to the conclusion that this was not the way in which his report should have been interpreted. I accepted Dr Pozza's evidence that the injury was older than what had been stated by the parents, and I accepted Dr Clark's evidence in that regard as well. In his evidence Dr Clark did acknowledge that his report could have been open to misinterpretation in the way that Dr Donald said he had interpreted it[161]. However, contrary to Dr Donald's evidence, I was satisfied that Dr Clark had not actually been consulted about his report at the time. When Dr Clark was first asked in his oral evidence as to whether or not Dr Donald had consulted him, or whether anyone from CPS had asked him to provide further information about his findings, he said that

[159] Transcript, page 731
[160] Transcript, page 1137, 1141
[161] Transcript, page 1137

because of the time lapse between then and now he could not remember. He did say, however, that he had no recollection of Dr Donald being in his department, or of his coming down and chatting with him about the matter. Dr Clark said that if Dr Donald had spoken to him about the case, and specifically if Dr Donald had told him that the parents had asserted that the incident giving rise to the fracture had occurred on the Monday, he would have told Dr Donald that the radiology was not consistent with such an assertion[162]. I asked Dr Clark whether the father's explanation, involving as it did the accidental dropping of the baby with the entrapment of the leg between the two wheels of the pram, had been imparted to him at the time of his radiological examination. He said that such a scenario had never been put to him. All this tends to suggest to me that he was simply not consulted about the injury at all by any member of CPS. One would have thought that if Dr Donald or any other member of CPS had consulted Dr Clark, one of the first things that Dr Clark would have been asked about was his opinion as to the inherent likelihood or otherwise of the father's description of the manner in which the baby sustained the injury. Further, it is almost certain that Dr Clark would have expressed a contrary opinion about that and have also said to anybody who had taken the trouble to ask that the radiological evidence was inconsistent with the account given by the parents as to timing. To my mind it is highly unlikely, and I so find, that either Dr Donald or any other person from the CPS consulted Dr Clark about his radiological findings. Naturally this had meant that there had been no opportunity for any misinterpretation or other misunderstanding to be corrected. If Dr Clark's report had been open to misinterpretation, the confusion could have been clarified if Dr Donald had consulted Dr Clark at the time. This represented a serious missed opportunity for Ebony's case to have received proper evaluation.

8.65. Finally, Dr Clark and Dr Pozza said that in their opinion the pain associated with the child's injury would have been considerable. According to Dr Clark, the angulation of the fracture would have acted almost like a '*dagger within the tissues*', such that every time there was movement it would be like '*having a dagger stuck in your thigh*'[163]. He said the child would have been in much pain. Dr Pozza agreed with that suggestion, particularly having regard to the sharp edges of the fracture. He said that movement would have been '*extremely painful*'[164]. It should be observed that this level of pain

[162] Transcript, page 1139
[163] Transcript, page 1137
[164] Transcript, page 1138

would have meant that any longer delay in seeking medical treatment than what was admitted by Ebony's parents would have to have been regarded as all the more serious.

8.66. As indicated I have accepted the evidence of Drs Pozza and Clark as to the age of the injury. I prefer their evidence to that of Dr Donald. I am reinforced in this view because in the event Dr Donald's own counsel, Mr Keane, did not in any way attempt to offer a contrary view. To my mind, and I so find, the injury to the child occurred at a time more than two days prior to the presentation of the child at the QEH on 10 August 2011. The injury had been sustained at least five days earlier, and probably longer. If Dr Donald had consulted with Dr Clark or Dr Pozza that fact would have been established at the time. That aspect of the parents' explanation to my mind should therefore have been rejected at the time. Accordingly, the explanation as to how the injury was sustained as given by Bradley Napier-Tucker, and to the extent that it was supported by C, should have been viewed with a great deal of suspicion having regard to the fact that the injury would have required probably more force than what was generated by a simple dropping from the height that Bradley Napier-Tucker had described. Dr Clark's and Dr Pozza's views about the level of pain that the child would have been in when moved would also have been a highly relevant matter for the CPS to have taken into account in assessing the parental capabilities of Bradley Napier-Tucker and C. Neither radiologist was consulted on the issue of pain.

8.67. Before leaving this topic I should say something about the account regarding Ebony's broken thigh that C ultimately provided to investigating police after Ebony's death. Aside from a number of police interviews in which C participated at an early stage of the investigation into Ebony's death, on 11 July 2013 she provided a narrative witness statement to police[165]. The statement taker elicited what can only be described as a harrowing account of Ebony's life and predicament at the hands of Bradley Napier-Tucker from the time that she was released from hospital following her birth until her death. In the statement C makes reference to Bradley Napier-Tucker's cannabis habit that appeared to make him angrier. Bradley Napier-Tucker would also become frustrated with Ebony's crying and urge C to '*shut that fucking baby up*'. C states that she first became suspicious about Bradley Napier-Tucker hurting Ebony when she broke her leg at the beginning of August 2011. In her statement she describes the incident in the following way:

[165] Exhibit C7a

> 'I didn't get suspicious about Bradley hurting Ebony until she broke her leg at the start of August. One night I was asleep on the couch and Ebony was asleep in her bouncer, just near the couch, when I went to sleep. All of a sudden I got woken up by Bradley calling my name standing above me, holding Ebony who was crying. I said "What's wrong with her?" He said "I don't know she just started crying". He looked really worried. I didn't think anything of it at the time. I got up and got her a bottle. She drank her bottle and she was fine after that.' [166]

On that account C was woken at a time after the incident involving Bradley Napier-Tucker and Ebony, and on that basis could not have laid claim to firsthand knowledge as to the manner in which Ebony had sustained the injury. This account would appear to be inconsistent with her assertions to Ms Sharpe and to the CPS that she had been awake for five minutes prior to the incident. She now states that her knowledge of the incident, as recounted in her statement, was subsequently gained from what Bradley Napier-Tucker told her. C also stated that three days after the incident she noticed that one of Ebony's legs was swollen and at first thought that she may have been bitten by a spider. At that Bradley Napier-Tucker told C the following:

> 'Oh sorry, I didn't tell you this before but the other night I was holding her and I bent down to pick up the nappy bag and she fell and her leg got caught in the wheel of the pram.' [167]

Bradley Napier-Tucker had gone on to say that he had not told C about this incident because he had been scared. C asserts that she immediately rang a taxi and they took Ebony straight to the QEH where the leg was X-rayed and was found to have been broken. She said that Bradley Napier-Tucker examined the X-ray and he looked very worried. She added that when Ms Sharpe spoke to her and Bradley Napier-Tucker about the matter she '*just told her what Bradley told me*'[168]. C asserts in her statement that she became suspicious about the manner in which Ebony's leg had been broken and wondered whether Bradley Napier-Tucker had not caused it accidentally after all. She asserts that he was always stoned on marijuana when he came to the hospital and exhibited anger towards the nurses. He was paranoid that they were staring at him and that the CPS authorities were following him. Even at home he would look out the window and express a belief that they were looking for him.

8.68. C's account of what she had been told by Bradley Napier-Tucker appears to have been the real genesis of what she ultimately told Ms Sharpe and the CPS authorities. It was

[166] Exhibit C7a, page 6
[167] Exhibit C7a, page 7
[168] Exhibit C7a, page 17

essentially a concoction urged upon her by Bradley Napier-Tucker. It is interesting that Ms Sharpe at the time thought that there was an element of suspicion adhering to the 'verbatim' manner in which Bradley Napier-Tucker and C had separately delivered their accounts.

8.69. It must be acknowledged that the CPS authorities, including Dr Donald, were not to know that C would, following Ebony's death, provide the police with a different account of what had taken place. But the difficulty was that the version of events as provided by the parents was never the subject of robust challenge and was all too readily given credence. There was available material on which such a challenge could and should have been mounted. There was the radiological evidence that demonstrated that the aspect of the parents' account relating to the timing of the injury was false. There was also reason to believe that the amount of force involved in Napier-Tucker's description of the manner in which Ebony fell would have been insufficient to have caused the injury. Yet this evidence was never appreciated by the CPS for what it was. It was never elicited from the radiologists when it so easily could have been. Dr Pozza in particular told the Court that he remained surprised that he was not consulted. If there had been an appropriate challenge mounted by the CPS to the parent's account, based as it could have been upon good evidence to the contrary, it is not beyond the realms of possibility that the falsity of C's corroborative account may have been exposed, thus further exposing Napier-Tucker for what he was. It may have taken no more than a simple, 'we do not buy your account'. This represented another missed opportunity to have protected Ebony.

8.70. The outcome of the CPS investigation was recorded in varying ways within CPS' own records and within Families SA's records. In a report of the CPS signed by Dr Donald dated 30 September 2011 a forensic medical opinion is expressed that:

> 'Ebony's fractured left femur was adequately explained by the history of her having been dropped causing her left leg to fall between the front wheels of her pram, thus immobilising the leg. This would then have acted as a fulcrum, as her body fell backwards and sideways causing the bone to fracture transversely.' [169]

By covering letter dated 10 October 2011, this document was sent to Families SA and to the Sturt CIB.

[169] Exhibit C77, pages 185-193, See also Families SA documentation Exhibit C81, pages 25-27

8.71. Within CPS records there is a note of a telephone conversation of 16 August 2011 between Mr Watkinson and SAPOL in which the injury is described as '*adequately explained*'[170]. There is a further note of a 16 August 2011 conversation between members of CPS, including Dr Donald, with Ms Parenta of Families SA. The note, apparently made by Mr Watkinson, records that Dr Donald had explained that the father had provided a detailed explanation of the cause of the injury which was '*credible*'. In addition it is recorded that CPS will communicate with CAFHS that the injury was '*not inflicted*'[171].

8.72. Ms Parenta's own note of the 16 August 2011 conversation[172] records that Dr Donald had called to say that '*he was satisfied with his investigation in relation to the child's injury*'. The note also suggested that '*the parents' explanation was satisfactory – Terry is satisfied that the injury was accidental*'. Ms Emma Sharpe's note of the same telephone conversation of 16 August 2011 simply recorded:

> 'Father was quite detailed in his description of what occurred in re to Eboney (sic) falling. Liability of explanation?'

8.73. '*Liability of explanation?*' should probably read '*reliability of explanation?*'. Although it will be noted that there is no suggestion within that notation that Dr Donald said that he was satisfied that the injury was accidental, and that there is a question mark against the word '*explanation*', in her oral evidence Ms Sharpe told the Court that her understanding of what Dr Donald had said during the phone conversation was that he was satisfied that the injury was accidental[173]. On 14 October 2011, which is four days after the date of the letter covering the official CPS report, Ms Parenta made a file closure note within Families SA records[174] in which she wrote that '*the parents were cleared of causing the injury to the child*'.

8.74. When Dr Donald gave his oral evidence Ms Parenta's note of the 16 August 2011 conversation was put to him by Ms Kereru of counsel assisting. Dr Donald told the Court that he would never have said that the injury was accidental[175]. He suggested that that was an '*interpretation*' of what he had said. Dr Donald's assertion that he would not have said that he was satisfied that the injury was accidental makes sense in that his

[170] Exhibit C77, page 66
[171] Exhibit C77, page 67
[172] Exhibit C81, page 249
[173] Transcript, page 918
[174] Exhibit C81, page 28
[175] Transcript, page 749

written report did not say that it was accidental in terms, and in any case it could hardly be said that the asserted accidental nature of the injury was something that anyone could be satisfied of.

8.75. The conclusion of the CPS investigation in whatever way it was expressed was flawed in that it did not properly take into account the radiological evidence to which I have referred and the previous history of Bradley Napier-Tucker, which was not known to CPS. In any event, at best, all the CPS investigation could have revealed was that there was some consistency between the asserted mechanism of the injury, as explained by the father, and the injury. This by no means meant that the father, Bradley Napier-Tucker, had been telling the truth about how the injury was sustained, and in particular whether he had been telling the truth when he said that it was an accidentally caused injury. For a conclusion to have been reached as to whether the injury was accidental or otherwise, much more needed to be taken into consideration beyond a mere finding that the asserted mechanism of injury was a theoretical possibility.

8.76. Regardless of what was said during the conversation of 16 August 2011, the official CPS version was that conclusion expressed in the report dated 30 September 2011 as sent on 10 October 2011 to Families SA.

9. <u>The impact of drug consumption</u>

9.1. I have already referred to a number of facets of this particular issue.

9.2. It will be remembered that in his report in respect of the criminal proceedings, Dr Craig Raeside stated that Bradley Napier-Tucker had resorted to using cannabis to regulate his emotions with an acknowledgement that he had been smoking a significant amount of cannabis on a daily basis around the time of Ebony's death. There was also reference in other material tendered to the Court that Bradley Napier-Tucker's offending behaviour appeared to have revolved around his cognitive distortion and drug use, that his significant cannabis dependence and abuse had become problematic and that it had appeared to have escalated both before and after Ebony's birth, thereby further aggravating his frustration, aggression and paranoia. Reference is also made in those proceedings to the detriment to the family's finances that Bradley Napier-Tucker's cannabis use was contributing. It has to be acknowledged that not all of this information was available to the authorities prior to Ebony's death. However, there was a body of evidence known to the authorities to suggest that Bradley Napier-Tucker's cannabis

usage was an intractable one and was a usage that had caused, was causing and had the potential to cause detriment to his family. Furthermore, if a proper assessment had been made in relation to Napier-Tucker's habit, many of the matters to which Dr Raeside has alluded and the full extent of the drug issue may well have been established at the time. For example, one question that at the time was begging to be asked was how Napier-Tucker was funding his habit. It was a question that was never asked.

9.3. As far as C was concerned it was known at the time of the first Families SA intake that one of the concerns that was entertained in respect of her, and which was said to pose a '*safety risk for Eboney* (sic)', included significant alcohol and drug use on her part over at least two years[176]. This concern was raised within the context of many other issues that included a history of involvement in domestically violent relationships, suicidal ideation, personal hygiene issues, a lack of insight into her behaviour including extreme risk taking behaviour, aggression, a lack of empathy for others and a failure to engage with and a mistrust of services, all of which were rightly said to have generated concern about her '*parenting capacity*'[177].

9.4. In her witness statement[178] C refers to Bradley Napier-Tucker's general behaviour and its connection with cannabis consumption. She asserts that prior to Ebony's birth he would not allow her to buy baby clothes or furniture because he wanted the money for his cannabis. She said that he used to say '*I'm not wasting money on baby shit*'[179]. C asserts that after Ebony was born she could not use a mobile phone because Bradley Napier-Tucker would not allow her to purchase credit. She said that when Ebony was born and was taken home from hospital Bradley Napier-Tucker would just spend time outside smoking bongs and if that did not calm him down he would become angrier. C asserts that he made her smoke bongs too, but that she did not want to smoke them and he made her do so[180]. While this latter assertion is manifestly self serving, the connection between Napier-Tucker's cannabis consumption and aggression is a constant refrain in the evidence and can readily be believed. C said that when Ebony was in hospital with her broken femur, and when Bradley Napier-Tucker came to the

[176] Exhibit C81, page 73-74
[177] Exhibit C8a, page 74
[178] Exhibit C7a
[179] Exhibit C7a, page 3
[180] Exhibit C7a, page 5

hospital, he was always stoned. Every day he would smoke bongs before coming to the hospital[181].

9.5. As to the source of cannabis, C further stated that she was receiving a youth allowance and a baby bonus that provided about $1,400 per fortnight and that Bradley Napier-Tucker himself was obtaining $400 a fortnight unemployment benefits. He used to spend the income that was assigned to her to purchase marijuana. He did this every second or third day. He would purchase it from a named person whom he would meet in the vicinity of the Adelaide Oval. Although, as will be seen, Bradley Napier-Tucker's ongoing cannabis consumption was a matter known to the authorities as and when it was actually taking place, there is no evidence that any person ever asked him how he was funding his cannabis habit. Thus there is no evidence that any person in authority gave consideration to the question as to whether the money that was being spent on cannabis was causing a financial detriment to this family, nor to what extent. One does not require 20-20 hindsight to appreciate that this was a relevant issue for the child protection authority to consider.

9.6. Similarly, there is no evidence that the fact that Bradley Napier-Tucker's or C's cannabis possession and consumption was unlawful was ever given due consideration. There appears to have been in existence an attitude that cannabis consumption was to be regarded as something that was benign and if anything the norm in respect of families with whom the relevant child protection authorities came into contact, and that there was nothing out of the ordinary, or indeed particularly harmful, about cannabis consumption by the parents at any level. I will cite some examples of that in a moment. All of this overlooked the fact that in Ebony's case there was at least a demonstrable connection between the cannabis consumption of Bradley Napier-Tucker and the serious injury to Ebony's leg, or if not a demonstrable connection, a high degree of suspicion of such a connection. In any event there was an abundance of evidence known to the authorities that Bradley Napier-Tucker's cannabis consumption was a matter that was affecting his mood and behaviour and therefore most probably his ability to act as an effective and functional parent.

9.7. It is informative to identify the manner in which cannabis use in the child protection context was viewed by certain elements within the child protection community. For

[181] Exhibit C7a, page 7

example, when Ms Parenta was asked whether she would have considered Bradley Napier-Tucker's intractable problem with cannabis consumption, and a failure to receive any assistance in relation to that pattern of behaviour, to have provided a reasonable ground to suspect that Ebony was at risk as a result of an abuse of an illicit drug by a parent, she said:

> 'I would say that there was some risks, but the risk in relation to marijuana use is much lower than with other drugs such as amphetamines. Most of our clients use marijuana. Yes, it was a risk factor, I can see that, but it was not of the risk that would be associated with amphetamine use or other such as crack or cocaine or whatever.' [182]

9.8. Ms Penelope York who is a registered nurse and midwife employed by the Women's and Children's Hospital, and who was involved as a domiciliary midwife with C in respect of the post-natal care, in her evidence before the Court was asked about her suspicion that Bradley Napier-Tucker was smoking marijuana. Her response was that her organisation visited many families and that there was '*a lot of drug use out there*'. She said it is '*not necessarily a huge flag*'. She, like Ms Parenta, suggested that cannabis consumption needed to be distinguished from consumption of amphetamines or heroin. She regarded the level of risk posed to a baby when the parents are smoking marijuana as a minor risk compared even to alcohol[183]. All of this naturally overlooks the role the substance played in Ebony's injury.

9.9. It is wholly beside the point to compare the theoretical risk posed by cannabis consumption with that posed by, say, heroin, amphetamines or even alcohol. If there is evidence that cannabis consumption is affecting a parent's behaviour to such an extent that it poses a risk to a child, then such a scenario has to be dealt with having regard to the magnitude of the risk and its potential adverse consequences. Indeed, the risk may have two independent elements, and they are the effect it has on the parenting behaviour of the individual concerned and the fact that the cannabis habit may be depriving a family of proper financial support. It is no answer to say that the risk posed by cannabis consumption is not as high as that posed by the consumption of other harder drugs and can therefore be ignored. To say that in the context of a case such as Ebony's is also to overlook the fact that even if one were to accept the proposition that cannabis

[182] Transcript, page 1286 – Ms Parenta would reiterate this as Transcript, page 1287
[183] Transcript, page 568

was a relatively less harmful drug when compared to others, it was nevertheless a substance that had significant role to play in a serious child injury.

9.10. As seen in an earlier section of these findings Bradley Napier-Tucker, when asked by Families SA representative Ms Sharpe as to whether he had been under the influence of anything when the incident involving the child's broken thigh had occurred, had revealed that he had been smoking marijuana and had stated that it may have slowed him down a bit. He added that it made him feel paranoid and nervous. Bradley Napier-Tucker also revealed at the CPS meeting with Mr Watkinson, Dr Donald and others that he was a marijuana user who had cut back, but had used prior to the incident in question in that he had consumed '*a few cones*' throughout the day.

9.11. I should here also mention a matter that Mr Watkinson did not include within his handwritten note of that meeting but which is highly relevant to the issue of cannabis usage. On Monday 15 August 2011 Mr Watkinson emailed a Mr Brian Rees of SA Health in connection with the determination that the father's explanation for the broken thigh fitted with the injury and that CPS would therefore have no further role. In that email[184] Mr Watkinson stated that at the CPS meeting with Ebony's parents C had wanted to know why cars had been parked outside her house over the weekend. She was told that this was not related to the CPS investigation and so C and Bradley Napier-Tucker were encouraged to contact the police if they continued to be concerned. Worryingly, Bradley Napier-Tucker had then suggested to the meeting that C's concern about cars parked outside the house could be due to paranoia brought on by smoking. Bradley Napier-Tucker reportedly stated that their cannabis use was another reason that they had not wanted people to come into the home, referring of course to their inconsistent engagement with services. As well, it was said that initially they did not have all the baby items that they should have had and that this had been due to lack of money and so they did not want to be 'judged'. This ought to have been regarded as a concerning revelation coming from the mouth of Bradley Napier-Tucker himself, in that it tended to confirm that paranoid thinking was an element of either his own or C's behaviour, possibly brought about by their cannabis use. Moreover, the ongoing use of cannabis was given as a reason that they had not wanted people to come into the home. This would hardly have generated a positive belief that this couple would in future engage with services – this lack of engagement had already been evidenced and would

[184] Exhibit C77, page 73

also later prove to be the case once Ebony was released from hospital. There was also the suggestion encapsulated in Bradley Napier-Tucker's remarks that a lack of money in the first instance had meant that appropriate baby items had not been obtained. There does not appear to have been any connection drawn at that point between a lack of money and its cause being cannabis consumption when such a connection, one would think, could easily have been teased out from Ebony's parents.

9.12. All of these revelations, made as they were at the time Ebony was in hospital with a broken thigh, could hardly have been regarded as anything other than worrying in terms of Ebony's continuing safety once released from hospital.

9.13. Even taking at face value Bradley Napier-Tucker's story about how Ebony came to sustain her injury, there was at the very least a strong suggestion that his poor physical handling of the child had been brought about as a result of cannabis consumption. That would be the case regardless of whether or not the injury was caused accidentally. There was no basis for any confidence that a repeat of such an event would not recur.

9.14. The Children's Protection Act 1993 is the South Australian legislation under which child protection in this State is administered. The Act imposes the duty of child protection in this State upon the Chief Executive Officer of the Department being the administrative unit of the public service prescribed by regulation for the purposes of the Act. In this case the relevant entity was Families SA. Section 20(2) states, and stated at the time with which this Inquest is concerned, as follows:

> 'If the Chief Executive suspects on reasonable grounds that a child is at risk as a result of the abuse of an illicit drug by a parent, guardian or other person, the Chief Executive must apply for an order under this Division directing the parent, guardian or other person to undergo a drug assessment (unless the Chief Executive is satisfied that an appropriate assessment of the parent, guardian or other person has already occurred, or is to occur).'

It will immediately be seen that where the suspicion on reasonable grounds described in the section is entertained, the obligation imposed under this provision is mandatory. The obligation contained within the provision is imposed upon the Chief Executive.

9.15. Section 37(1a) of the Children's Protection Act 1993 is set out as follows:

> 'If the Minister—
>
> (a) knows or suspects on reasonable grounds—

(i) that a child is at risk as a result of drug abuse by a parent, guardian or other person; and

(ii) that the cause of the child being at risk is not being adequately addressed; and

(b) is of the opinion that the most appropriate response is an order under this Division for one or more of the following purposes:

(i) to ensure that the parent, guardian or other person undergoes appropriate treatment for drug abuse;

(ii) to ensure that the parent, guardian or other person submits to periodic testing for drug abuse;

(iii) to authorise or require the release of information regarding the treatment or the results of the test to the Chief Executive,

the Minister must apply to the Youth Court for such an order.'

It will be seen that the obligation created within this provision is mandatory. The obligation is imposed on the Minister.

9.16. I will deal with each of these statutory obligations in turn.

9.17. Section 20(2) of the Act is enlivened when there is a suspicion on reasonable grounds that a child is at risk as a result of the abuse of an illicit drug by a parent. In such a case the Chief Executive is obliged to apply for an order under Division 4 of Part 4 of the Act directing the parent to undergo a drug assessment unless the Chief Executive is satisfied that an appropriate assessment of the parent has already occurred, or is to occur. In this case there was no proper basis to believe that such an assessment would occur without an order. The order that must be applied for is an order from the Youth Court pursuant to section 21 of the Act that would include an order directing the parent to undergo a drug assessment to determine the capacity of that parent to care for and protect a child[185]. The obligation upon the Chief Executive to apply for such an order is not discretionary. This is to be contrasted with the powers of the Chief Executive contained in section 20(1) to apply to the Youth Court for an order under Division 4 of Part 4 of the Act where there is a reasonable suspicion that a child is at risk. There, the Chief Executive has a discretion as to whether an order under that Division will be applied for. In other words, if the Chief Executive suspects on reasonable grounds that a child is at risk as a result of the abuse of an illicit drug by a parent, as distinct from a risk that might be posed by other circumstances not connected with abuse of an illicit drug, the Chief Executive must apply for an order from the Court that the parents be assessed in the manner described above.

[185] Section 21(1)(ab)

9.18. 'Risk' as contemplated within these provisions is defined in the Act [186]. A child is at risk if, among other things, there is a significant risk that the child will suffer serious harm to his or her physical, psychological or emotional wellbeing against which he or she should have, but does not have, proper protection[187]. As well, a child is at risk if the child has been, or is being, abused or neglected[188], or where a person with whom the child resides has abused or neglected some other child and there is a reasonable likelihood of the child in question being killed, abused or neglected by that person[189], or where the guardians of the child are unable to care for and protect the child[190].

9.19. It is difficult to see how section 20(2) of the Act and the mandatory obligation within it was not enlivened in this case. I agree with counsel assisting, Ms Kereru, that the facts of this case were a 'perfect fit' for the operation of section 20(2) of the Act. There was evidence to suggest that the child's injury was contributed to by the father's abuse of cannabis and that this was so even if one were to have accepted his questionable version of events. There was evidence to suggest that Bradley Napier-Tucker's abuse of cannabis was an ongoing difficulty for him and was one that was for the time being intractable. There was every reason to suppose that his continued cannabis use placed Ebony at risk. In the Court's opinion there was evidence available that demonstrated that Ebony was at least at risk of suffering serious harm to her physical, psychological or emotional wellbeing, or of further abuse or neglect, and that the parents of Ebony were unable to care for and protect her. Further, there was reason to suppose that this risk was posed as a result of the abuse of cannabis by Bradley Napier-Tucker. At the very least there was suspicion on reasonable grounds that such a risk was in existence. Accordingly, section 20(2) of the Act was enlivened and an order should, as a matter of law, have been applied for under Division 4 of Part 4 of the Act. There was no such application made or even considered. It would seem almost inevitable that a Court to whom the application was made would have made an order authorising an assessment contemplated within the relevant provisions, namely a drug assessment to determine the capacity of Bradley Napier-Tucker to care for and protect Ebony. It is difficult to see how such an order could have been resisted.

---

[186] Section 6(2)
[187] Section 6(2)(aa)
[188] Section 6(2)(a)
[189] Section 6(2)(b)(ii)
[190] Section 6(2)(c)(i)

9.20. There is one further matter that requires discussion in respect of the operation of section 20 generally. It seems to the Court that if the mandatory requirements of section 20(2) were enlivened, then the discretionary requirements pursuant to section 20(1) might also be enlivened as well. In such a case, further orders pursuant to section 21 could be applied for including an order directing a party to the application who resides with the child to cease or refrain from residing in the same premises as the child[191], or an order directing a party to the application to refrain from having contact with the child[192].

9.21. Various witnesses were questioned about the possible effect of section 20(2) in this case. The overwhelming inference is that it never occurred to anyone involved with Ebony's matter that such an order needed to be applied for or that Napier-Tucker should have been assessed in terms of the provision.

9.22. It will be seen from the above analysis that the enlivening of section 20(2) of the Children's Protection Act 1993 would have occurred quite apart from any impact that Bradley Napier-Tucker's child protection history in relation to another child ought to have had in relation to an application pursuant to that provision. In addition, if the origin of Ebony's serious thigh injury had been properly considered at the time, the suspicion of risk to Ebony would only have been enhanced even if it had simply been based on the radiological evidence that suggested that Ebony's injury had occurred earlier than the parents had suggested and that for that reason the case had involved a greater level of neglect.

9.23. I now deal with the question as to whether section 37(1a) of the Act should have been considered. It will be seen that the obligation to apply to the Youth Court for an order under Division 2 of Part 5 of the Act is mandatory. One distinguishing feature between section 37(1a) and section 20(2) is that the obligation in section 37(1a) is upon the Minister. The fact that the obligation is upon the Minister is a reflection of the type of orders that the Youth Court is empowered to make under Division 2 of Part 5 of the Act. Section 37(1a) is similar to section 20(2) in that it is enlivened by suspicion on reasonable grounds that a child is at risk as a result of a drug abuse by a parent. Another matter that distinguishes section 37(1a) from section 20(2) is that in addition to the element of suspicion that the child is at risk, there must also be suspicion on reasonable grounds that the cause of the child being at risk is not being adequately addressed. This

[191] Section 21(1)(d)
[192] Section 21(1)(e)

distinguishing feature caused Mr Keane of counsel for the Minister for Health, the Minister for Education and Child Development and the Women's and Children's Health Network to submit that section 37(1a) would appropriately give rise to an application in circumstances where a section 20(2) application had already been made and that notwithstanding that application the cause of the child being at risk was not being adequately addressed. I would reject the suggestion that an application under section 20(2) is the precursor, as it were, to an application under section 37(1a). If the Minister suspects on reasonable grounds that the child is at risk as a result of drug abuse by a parent, and that the cause of the child being at risk is not being adequately addressed at the point in time at which the risk is suspected on reasonable grounds, then the Minister has no lawful alternative other than to apply to the Youth Court for an appropriate order. Mr Keane also submitted in effect that section 37(1a) is designed to address a situation where the risk is an ongoing one and a risk that would not be addressed adequately in the future. I do not agree with this interpretation. Again, if the cause of the child being at risk is not being adequately addressed at the time the risk is identified, then in my opinion section 37(1a) is enlivened.

9.24. This interpretation of section 37(1a) is supported by the nature of the orders for which the Minister might apply to the Youth Court. The orders that the Minister might apply for include orders that would ensure that the parent undergoes appropriate treatment for drug abuse, to ensure that the parent submits to periodic testing for drug abuse, or to authorise or require the release of information regarding the treatment, or the results of such testing, to the Chief Executive. The implication from the nature of these orders is that there is an existing set of circumstances posing a risk to the child as a result of drug abuse by a parent which requires the parent to undergo appropriate treatment for that drug abuse, and in order to support such treatment, to ensure that periodic testing for drug abuse is put in place.

9.25. There is one aspect of section 37(1a) that involves a requirement that the Minister form one of three alternative opinions in relation to a particular matter before the mandatory obligation in the provision is enlivened. As seen above, section 37(1a)(b) states that the mandatory obligation is triggered where the Minister is of the opinion that the most appropriate response is an order for one of three differing purposes as set out in that provision, relating to appropriate drug abuse treatment for the parent, periodic testing and for the release of information. This to my mind means that where the triggering

suspicions as to risk are entertained, the Minister would be obligated at least to give active consideration as to whether an order of the Court was necessary or desirable for the fulfilment of one of those purposes.

9.26. As with section 20(2), it is difficult to see how section 37(1a) was also not enlivened in this case. The additional requirement for the operation of section 37(1a), namely that the cause of the child being at risk was not being adequately addressed was clearly suspected on reasonable grounds. One only has to examine what Bradley Napier-Tucker himself said about his own cannabis habit to suggest that it was a habit that was not being addressed, adequately or at all.

9.27. Accordingly, in my opinion, section 37(1a) of the Children's Protection Act 1993 was triggered and that the Minister was under a mandatory obligation to apply to the Youth Court for an order addressing one or more of the purposes set out in section 37(1a)(b).

9.28. As to the Court's power to make an appropriate order under section 37(1a), section 38 gives the Court power to make certain orders where an application has been made under Division 2 of Part 5 of the Act. To my mind the Court's power to make an order in respect of an application under section 37(1a) is confined to the exercise of the Court's power under section 38(1)(a). This power enables a Court to require a parent to enter into a written undertaking to do a specified thing or to refrain from doing a specified thing and cites as an example a requirement to enter into an undertaking to undergo treatment for drug abuse, to submit to periodic testing for drug abuse and to authorise the release of information regarding such treatment, and the results of such testing to the Chief Executive. In addition, if the Court thinks fit, the Court may require the child to be under the supervision of the Chief Executive or some other specified person or authority for the duration of the undertaking.

9.29. In my opinion there was material in this case that could have enabled a Court to exercise its powers under section 38(1)(a).

9.30. This then brings the Court to a consideration of whether an application for a care and protection order under section 37(1) of the Act could have appropriately been applied for. Such an order can be applied for if the Minister is of the opinion that a child is at risk and that an order should be made to secure the child's care and protection. It will be noted that the power to make this application is that of the Minister and that the application is discretionary in the sense that the Minister may apply for an order under

Division 2 of Part 5 of the Act. It seems to the Court that if a child is at risk as a result of drug abuse by a parent, and that it was a risk that was not being adequately addressed, the Minister might also be of the opinion in some cases that an order under Division 2 of Part 5 of the Act should be made in respect of the child to secure his or her care and protection. If such an application was made, the Court would have had power to impose a number of orders including placing the child under the guardianship of the Minister[193], granting custody of the child to other entities, including the Minister[194] and to direct a person to cease or refrain from residing in the same premises as the child or to refrain from having any contact with the child except in the presence of some other person, or at all[195]. This power residing with the Minister to seek such orders from the Court, at least on the basis of risk posed by drug abuse by a parent, was never considered.

9.31. All that said, if there had been a proper enquiry as to Napier-Tucker's background and there had been a thorough CPS investigation into Ebony's thigh injury, it may well be that resort to section 20(2) and section 37(1a) of the Act would not have been needed, at least in the first instance, because the conclusion would have been almost irresistible that Ebony was in danger and that her immediate removal from her parents was essential.

10. Involvement of SAPOL

10.1. There were two circumstances in which SAPOL came to have involvement in the activities of this family. The first of those occasions occurred when Ebony was admitted to the WCH with the fractured femur. Detective Sergeant Michael Richardson of the Sturt Family Violence Investigation Section (FVIS) was a member of the group of individuals who took part in a strategy discussion on 12 August 2011. From his involvement in Ebony's matter at that time, Detective Sergeant Richardson knew of the background against which the Ebony had been hospitalised and knew of the issue relating to the age of the injury. He also knew of the involvement of the Child Protection Services and of Families SA.

[193] Section 38(1)(c)
[194] Section 38(1)(b)
[195] Section 38(1)(e)

10.2. In his capacity as a detective within the Sturt FVIS, Detective Sergeant Richardson would come to have a further involvement with this family. This occurred after an incident in September 2011 that I will now describe.

10.3. At approximately 6:45am on 13 September 2011 a 000 emergency telephone call was received by police. The call was received by Senior Constable Christopher Hoffman, a sworn police officer, who was on duty that day dealing with 000 calls. This call was recorded. An audio recording of the call was tendered during the course of the Inquest and was played to the Court[196]. A transcript of the call was also tendered in evidence. The caller was a Ms Belinda Tonkin who, with her husband, occupied a Brooklyn Park unit which was upstairs from but in close proximity to the unit which was occupied by Ebony and her parents. In the 000 call Ms Tonkin told police that a '*domestic*' was taking place in and around the unit below her, that there was a little baby present and that the mother of the child had yelled out for someone to call the police. She described the incident as having been ongoing for about 15 minutes to that point. Ms Tonkin said that she could hear the man of the family '*going ballistic*'. She told police:

> 'And she's just yelled out someone please call the police and she was walking outside and he's dragged her back in and he's doing all of this in front of the little baby in the pram.'

That was the extent of the conversation. Senior Constable Hoffman informed Ms Tonkin that police would be sent to the location immediately. It seems apparent that Ms Tonkin did not know the family involved, but there is no doubt that the incident Ms Tonkin was calling police about involved Bradley Napier-Tucker and C and that the baby she referred to was Ebony. Police would attend the incident.

10.4. Ms Tonkin has provided three witness statements to police. The first of these statements was taken on the day that Ebony's death was reported by her parents to Families SA, namely 15 November 2011[197]. The second statement is dated 27 April 2013[198]. The second statement deals with the incident of 13 September 2011 in greater detail than the first statement. In the first statement Ms Tonkin says nothing about any physical contact between the mother and the father during the course of this incident. In her second statement Ms Tonkin asserts that the arguing had been going on for about 15 to 20 minutes and that it was mainly the male person whom she could hear. She was

[196] Exhibit C102a
[197] Exhibit C12a
[198] Exhibit C12b

able to see something of the incident firstly from her bedroom window and then from her front door. In both of her statements she asserted that the male had thrown baby paraphernalia including baby clothes, a blanket and a mobile out of the front door of the downstairs unit. She decided to call the police. The female person came out of the unit to retrieve the baby items and said '*someone please help me*'. She said:

'He then came out as well and told her to come back inside while he held the door open.'

The police arrived some minutes later. In her second statement Ms Tonkin also described a subsequent incident where the male person had stood in the middle of the street and had screamed really loudly and had then gone back inside. She said that it was a normal occurrence to hear this couple arguing.

10.5. A further statement has been taken from Ms Tonkin on 30 October 2015[199]. This statement was taken in an attempt to clarify what she saw occur as between the mother and the father, and in particular what she had meant when she had told the police in her telephone call that the father had '*dragged her back in*'. Ms Tonkin was asked to listen to the 000 call recording. In her statement of 30 October 2015 she confirms that she was the person who made that call. Ms Tonkin asserts that from her vantage point upstairs she could see into the unit through the front door. The baby's pram was seen through the door. She states that after hearing the yelling coming from that unit she saw the mother walk from the unit out the front door. She emerged by about two or three steps and it was then that she heard the mother say something like '*call the police*'. She then saw the male come to the doorway. He was yelling. He then approached the mother and appeared to grab her by the hair at the back of the head and forcibly pull her backwards into the unit. Once they were both inside the unit the screen door was closed but Ms Tonkin could still hear much yelling and screaming. A few minutes later the male walked out and picked up all of the property that had been thrown out. The yelling and screaming ceased just as the police arrived.

10.6. There is no reason to suppose that if during the 000 telephone conversation Ms Tonkin had been asked to clarify what she meant by '*he's dragged her back in*', she would not have elaborated in the manner contained in her most recent statement of 30 October 2015. In addition, if Ms Tonkin had been spoken to by police on the day of the incident, or shortly thereafter, a conclusion is open that she would have told the police what she

[199] Exhibit C12c

has asserted in her most recent statement. However, there was enough information imparted by Ms Tonkin in her 000 call for the police operator to have concluded at that time that the incident had involved an assault by the male person upon the female person and that this had taken place in the presence of, and in the near vicinity of, the baby in the pram.

10.7. Senior Constable Christopher Hoffman prepared the computer aided dispatch (CAD) that would be made available by way of an in-vehicle computer to the attending police patrol. The CAD archive which represents a printout of the CAD that was made available to the attending patrol was tendered to the Inquest[200]. Senior Constable Hoffman recorded the information within the CAD as follows:

> 'RP: Tony Tonkin \AD:#16\SEE COMP:N\CALL ORIGIN:000\TX:compl states there is a domestic going at the unit across the courtyard from the compl and on the ground floor. Male and female yelling, female screaming for police to attend. There is a baby involved … unsure of unit number … ptrl to assess … nod'

It will be observed that the text of the dispatch contains no reference to the woman having been dragged back into the unit. Thus, the dispatch does not describe the commission of any alleged offence known to the criminal law.

10.8. The dispatch was responded to by Constable Darian Leske and Senior Constable First Class Osborne. The officers arrived at the premises at 7:03am. Constable Leske gave oral evidence. He had provided a witness statement dated 17 July 2013[201]. Constable Leske told the Court that the male and female were questioned in separate areas. The female, C, told Constable Leske that she and the male, Napier-Tucker, had been involved in a purely verbal argument and that they had not physically fought. No evidence of a physical fight could be observed by police. The baby Ebony was asleep in a cot in the living area. Police were told that the baby had slept through the whole incident. There was no discussion about any allegation that C had been physically dragged back into the premises. Constable Leske confirmed that he was not aware of any such allegation. I accept this evidence as the CAD document failed to describe that aspect of Ms Tonkin's report. Constable Leske told the Court that it did not occur to him that the officers should speak to the original provider of the information who was identified by name within the CAD as a Ms Tonkin of Unit 10 in that complex.

[200] Exhibit C102b
[201] Exhibit C35a

Constable Leske told the Court that Bradley Napier-Tucker did not appear to be affected by any substance such as alcohol or cannabis. There was no discussion about cannabis at that time. In cross-examination by counsel assisting, Constable Leske said that he could not recall anything being said about the male person having thrown things around. He also surmised that the reason they did not speak to the neighbour, that is to say the original provider of the information, was possibly because of the undesirability of police being seen to speak to a person whom the couple under investigation might deduce was the original informant. However, I think this was an afterthought on Constable Leske's part. I do not believe that this was the reason for police failing to speak with Ms Tonkin. As was pointed out in cross-examination, police could have made the necessary inquiry of the neighbour by returning at a later time or by telephoning that person.

10.9. The attending officers compiled a domestic abuse police incident report[202]. It simply stated that the complainant, C, had said that she had been involved in a verbal argument with her partner over family issues, that no offences were disclosed, that there were no other witnesses and that the child had slept through the entire incident. The statement that no offences were disclosed was based upon the information provided for the most part by C that the incident had been purely verbal, but the document was deficient in that there was other material available that would have established that C had been assaulted by Napier-Tucker. The statement that there were no other witnesses is clearly incorrect to the officers' knowledge at the time. The reporting person, Ms Tonkin, had clearly been a witness to something and was known to be so. Constable Leske told the Court that if this domestic violence incident had involved the commission of an offence, police would have taken positive action against the suspect, and that the action would probably have involved a report or an arrest. This in fact should have been the outcome. It was not, and it was yet another missed opportunity to protect Ebony.

10.10. The missed opportunity to intervene in this family and to protect Ebony from harm had two elements. Firstly, the original CAD report did not identify the commission of an offence and, secondly, the opportunity to have spoken to a witness, namely Ms Tonkin who could have identified such an offence, was not taken.

[202] Exhibit C102c

10.11. In her statement made on 11 July 2013 C[203] describes this incident. She asserts that Bradley Napier-Tucker became really angry and had started throwing things and smashing things in the unit. She had run outside and yelled out for someone to help her. Eventually the police arrived. She and Bradley Napier-Tucker had been spoken to separately. She said that she told police that Bradley Napier-Tucker had been throwing things around, but did not tell them that he had been assaulting her as she was too scared. In her statement she described assaults upon herself by Bradley Napier-Tucker from time to time. In respect of this particular incident she said that she was scared that Bradley Napier-Tucker would bash her more if he had thought that she may have told police that he was assaulting her.

10.12. I have already referred to the involvement of Detective Sergeant Richardson. It will be remembered that Detective Sergeant Richardson had been involved on behalf of SAPOL in the August 2011 investigation into Ebony's fractured thigh. On that occasion SAPOL's involvement had been limited due to the CPS conclusion that Ebony's injury could have had a benign origin. Detective Sergeant Richardson was the officer in charge of the Sturt FVIS. He told the Court that the domestic violence police incident report relating to Constable Leske's attendance on 13 September 2011 was received within the Sturt FVIS. On 14 September 2011 he appropriately tasked one of the Sturt FVIS investigators, Senior Constable Nadine Paynter, to conduct a follow-up and assessment in respect of the earlier police attendance. In his oral evidence Detective Sergeant Richardson explained that in the normal course of events when a report in relation to domestic violence is received, he would check the domestic violence history to ascertain whether his section had dealt with the alleged victim before, or whether any of the members of the section were currently dealing with that victim. In this case there was no domestic violence history as such. Mr Richardson explained the methodology of checking. It is fair to say that the record keeping in respect of the FVIS was unsatisfactory in that the normal course of checking would not have revealed an alleged child abuse matter such as the one that had been investigated in August 2011 in respect of the child's thigh injury. Detective Sergeant Richardson explained that standalone child abuse actions were not checked in the course of checking through domestic violence matters. When Detective Sergeant Richardson completed the domestic violence cover sheet for the purposes of briefing his

[203] Exhibit C7a page 6-7

investigator, Senior Constable Paynter, it did not occur to him that the C and the Bradley Napier-Tucker, both of which names he actually wrote on the cover sheet himself, were the names of the parents of the child in respect of whom his section, and he personally, had an involvement one month previously. It will be remembered that Detective Sergeant Richardson had taken part in the strategy discussion that had been conducted in respect of Ebony Napier's injury. Detective Sergeant Richardson assured me on his oath that he did not draw any connection in his mind between the family that had been involved the broken thigh incident in August 2011 and the domestic violence police incident report in respect of the police attendance at Brooklyn Park on 13 September 2011. It did not occur to him that both matters involved one and the same family. I carefully scrutinised Mr Richardson's demeanour when he gave that evidence. As incredible as all that may seem, I have to say that I do not disbelieve Mr Richardson about that.

10.13. Thus when Senior Constable Paynter attended at the Brooklyn Park address on 21 September 2011 she knew nothing of the history of this family as it existed prior to Constable Leske's attendance on 13 September 2011. In particular, she did not know that only a matter of a few weeks previously the baby in the family had sustained a very unusual injury in the form of a broken thigh. She did not know that at that time there had been an investigation that had included input from police. Naturally Paynter had no appreciation of the suspicions that had adhered to the account given by the parents in relation to that injury.

10.14. Senior Constable Paynter gave oral evidence before the Court. Ms Kereru, counsel assisting, invited Senior Constable Paynter in Court to read the Families SA intake relating to the broken thigh investigation. This document was included in material in the possession of Sturt FVIS because it had been made available to the section at the time of the August 2011 strategy discussion with Families SA and the CPS, but it was not seen by Senior Constable Paynter as the August 2011 matter was overlooked as part of her briefing for reasons I have already mentioned. Quite apart from dealing with the matter of the child's fractured femur, this document had also referred to a whole host of negative issues surrounding this family including significant alcohol and drug use, the fact that the mother was highly transient and had been involved in previous violent relationships, that she had exhibited suicidal ideation and extreme risk taking behaviours with poor impulse control and that the father had another son in New South Wales who was in the care of the Minister. If there was any doubt as to the impact this

information should have had at the time of Paynter's investigation it was dispelled by Senior Constable Paynter's understandable emotional response having read the document. Senior Constable Paynter said that if she had been aware of all that information she would have made certain that she saw the baby when she attended on 21 September 2011. She said as follows:

> 'I think if I had the information from the intake that - from interstate and he'd had a boy - a boy I think it was taken away from him before, and that there was - that Ebony had been injured previously and that she was dragged back in the house. I mean that would have in my mind, made me do more than what I actually did. I would speak to her further and do further follow-ups with her and made sure he wasn't home at the time and - yeah I think I would have done more definitely.' [204]

Senior Constable Paynter added that if the report of an actual assault on C by way of her having been dragged into the house had been included in the police incident report, she felt that Bradley Napier-Tucker would have been arrested for that with consequent bail conditions being put in place.

10.15. When Senior Constable Paynter attended at the premises she only saw C who said that her partner was at work. This in fact was not the case. It is now known that Bradley Napier-Tucker had been in the unit all along but had been in a location unseen by Paynter. C's witness statement reveals that Bradley Napier-Tucker had told her not to open the door to the officer who spoke to her through the screen door. Napier-Tucker remained out of sight. C states '*Bradley was there so I couldn't say anything. After she left, Bradley just continued doing what he was doing - hitting me and stuff and being controlling*'[205]. In her investigation diary Senior Constable Paynter would report the matter in bland terms, namely that the victim, C, had stated that the incident of 13 September 2011 had been the first time that she and her partner had argued and that this had been due to the stressors involved in having a new baby. She had said that CAFHS visited once per week. All of that meant that no particular risk was identified in respect of this family.

10.16. There is another matter that requires further comment. That is that if Senior Constable Paynter had insisted on seeing the baby she may have discovered that Bradley Napier-

[204] Transcript, page 1125
[205] Exhibit C7a, page 10

Tucker was on the premises after all. This would no doubt have aroused suspicion that C was acting and speaking under duress.

10.17. Finally this. As with other aspects of this case, the involvement of SAPOL was fundamentally flawed insofar as SAPOL had no information about the background of Bradley Napier-Tucker, information that was in the possession of the New South Wales authorities and which had not been obtained by Families SA.

10.18. Police would have no further involvement with the family after Senior Constable Paynter's attendance on 21 September 2011.

10.19. It is worthwhile contemplating what might have been done if Families SA had been notified of a violent incident involving Napier-Tucker and C had it been identified as such by police. Ms Loretta Parenta was asked about this by me. She told the Court that in the light of further information that would come from CAFHS regarding signs of aggression in Napier-Tucker that they had detected, she would have been very concerned if she had received further information that he had been involved in an incident in which, in front of the baby, he had dragged Ebony's mother back into the unit in an angry frame of mind as a result of which the police had to be called at the request of the mother. Ms Parenta said that Families SA would definitely have visited the family again in those circumstances. She went on to say that despite Ms Sharpe's having left the office the matter would have been allocated. She said:

> 'Well, we would have had to have found space somewhere because of the violence. Violence with an infant is extremely concerning'[206].

I accept that evidence. It highlights how the fact that SAPOL failed to appreciate the incident for what it was, namely a violent incident involving an assault, was another missed opportunity for Ebony to have been protected and this is so even without knowing anything of Napier-Tucker's earlier propensities.

11. <u>Events from the time of discharge of Ebony to her death</u>

[206] Transcript, page 1279

11.1. Ebony was discharged from the WCH into the care of her parents on 22 August 2011. The family continued to reside at the unit at Brooklyn Park from that date until 15 November 2011, the day on which Ebony's death was reported.

11.2. The salient features of this period were the attendance of police at the Brooklyn Park unit on the occasions that I have mentioned in the preceding section, the cessation of attempts by CAFHS to effect home visits and the closure of the file by Families SA on Friday 14 October 2011.

11.3. It is apparent that the final time Ebony was seen by any person who was either in authority or was a staff member of a service providing entity occurred on 23 September 2011 when child health nurse, Ms Gillian Marshall of CAFHS, made a home visit. I will come to the details of that in a moment. The final and sole occasion in this period on which Ebony was seen by a Families SA staff member occurred on 24 August 2011. On that day Ms Emma Sharpe of Families SA met C, Bradley Napier-Tucker and Ebony at the West Lakes shopping mall. I will come to the details of that in a moment as well. There were also the two visits by SAPOL on 13 September 2011[207] and 21 September 2011[208]. As already alluded to, Families SA were not advised of the two SAPOL attendances.

11.4. Other than Ms Sharpe, Ms Marshall and police, as far as is known the only other persons to have had any meaningful interaction with the family during this period were Mr and Mrs Grenci to whom I have earlier referred. Together they saw the family on Sunday 16 October 2011 at IKEA. Other than casual visitors to the unit, such as Napier-Tucker's drug dealer, it is likely that the Grencis were the last persons to see Ebony alive. Ebony was in a pusher at IKEA. Neither Mr nor Mrs Grenci describe anything untoward in respect of Ebony on this occasion. She appeared to be well dressed. C had smiled and said that Ebony was '*perfect*'. However, both Mr and Mrs Grenci noticed that C had lost weight, was hunched over and appeared distressed. Mrs Grenci observed a mark on her face that looked like a faded bruise. Mrs Grenci managed to separate C from Bradley Napier-Tucker so that she could speak to C alone. According to Mr Grenci, at one point Bradley Napier-Tucker attempted to prevent this. Nevertheless, under Bradley Napier-Tucker's gaze, but apparently out of his hearing, Mrs Grenci managed to strike up a conversation with C. C told her that Bradley Napier-

[207] On this occasion by officer Darian Leske
[208] On this occasion by officer Nadeane Paynter

Tucker had been violent and that she did not know what to do. She kept looking over at Napier-Tucker and she seemed scared. Mrs Grenci advised C to tell her caseworker. Unfortunately by then, C had resisted all engagement with CAFHS, and Families SA had closed its file two days beforehand on Friday 14 October 2011.

11.5. None of the authorities or entities that had provided any services to this family knew of the observations that had been made by Mr and Mrs Grenci on 16 October 2011. To all intents and purposes, at that point all contact with this family had been lost.

11.6. In her witness statement, C describes the events of Sunday 16 October 2011 and during the weeks that followed. She states that the bruise that was observed by Mrs Grenci was from Napier-Tucker having hit her. She confirms that Mrs Grenci told her to inform CAFHS or Families SA. C does not explain in terms why it was that she did not contact either service, but a reason can be inferred from the contents of her statement. She states that from 16 October 2011 forward Napier-Tucker's violence escalated. He was paranoid about the possibility of the child protection authorities, including Families SA, arriving at their premises. He deadlocked the doors of the unit so that C could not leave. He kept the curtains and blinds shut so that nobody could see in. On the occasions that any person knocked on the door he would first check through a window to see who it was and would only answer the door if it was his drug dealer. If C attempted to answer the door he threatened her with a knife and would physically drag her away from the door. From 16 October 2011 onwards Napier-Tucker was, on a daily basis, habitually violent towards Ebony. C believes that Napier-Tucker broke Ebony's arm that night. She describes the violence that she says he inflicted on Ebony thereafter. It included shaking, squeezing of the chest, bending of her fingers, hitting her over the head with a bottle and violently throwing her in various ways. During this period Napier-Tucker smoked bongs. C states that if she attempted to intervene she was assaulted by him. Eventually Ebony went into what C describes as a '*vegetable state*' and ultimately died. All of this occurred in the period after Families SA closed its file.

11.7. It is pertinent to describe the efforts of services to engage with the family in the period following Ebony's discharge from WCH on 22 August 2011. As alluded to above, Ms Sharpe of Families SA saw the family on 24 August 2011 at West Lakes. In a moment of uncharacteristic enlightenment Napier-Tucker had contacted her to tell her that they would like CAFHS to be involved and to conduct home visits. As a result, Sharpe

contacted CAFHS to arrange this. In the event CAFHS involvement would become thwarted. At West Lakes Ms Sharpe observed that on this occasion the family appeared to interact well. They purchased a number of items for the home. Ms Sharpe drove them home. C told Ms Sharpe that now that they were home from the hospital she was feeling much better. Napier-Tucker told Ms Sharpe that he was being more careful with Ebony. He also asserted that he had decreased his cannabis consumption but had not stopped, adding that he tended to smoke at night rather than during the day. That was the final occasion that anyone from Families SA had contact with the family. Ms Sharpe left the Woodville office on 16 September. Attempts to contact the family before she left were unsuccessful. The question of ongoing cannabis usage was not addressed.

11.8. The responsibility for home visits within CAFHS was assigned to Ms Gillian Marshall after she returned from leave in late August 2011. Ms Marshall would not be able to see Ebony at the Brooklyn Park address until 6 September 2011. Earlier attempts to contact the family through two telephone numbers had not been successful. Ms Marshall had made contact with Ms Sharpe at Families SA on 1 September 2011 to advise that Ms Marshall would be attempting to make that contact. In her oral evidence before the Court Ms Marshall explained that she did so because at that point there had been no success at contacting the family and that Families SA was the entity that had the power to effect entry. She also explained that at least in her mind there was still uncertainty as to the origin of Ebony's serious leg injury and that there was still a need for CAFHS to try to see the baby.

11.9. Ms Marshall told the Court of the detail of her visit of 6 September. Ms Marshall did not detect anything untoward about Ebony or her environment. Ms Marshall did not see Bradley Napier-Tucker on the premises on that occasion. C agreed to another home visit in a week's time. Ms Marshall advised Ms Sharpe by email dated 7 September 2011 that she had seen C and Ebony the day before and that Ebony had gained weight and that C appeared comfortable with her parenting. She mentioned another scheduled visit for 14 September 2011. Ms Sharpe's response of the same day asserted that Ms Sharpe was relieved that Ms Marshall had been able to touch base with the family and that Ms Marshall had no concerns at that stage. Ms Sharpe advised in the same

email that she was leaving her position at the end of the following week and that there would be a '*new person*'[209] at Families SA with whom Ms Marshall could make contact.

11.10. The further home visit appointment for 14 September 2011 was not kept because, according to a text from C, she had another commitment. A further home visit however took place on 23 September 2011. This would be the final home visit by any service. Again, there was nothing unusual detected about Ebony or her environment. However, when Ms Marshall attempted to discuss the possibility of C attending different groups, C told Ms Marshall that the problem was that Bradley Napier-Tucker '*doesn't go out*'. She described him as being quite flat and had become more withdrawn. She said that he still smoked marijuana but had decreased to two sticks a day. Ms Marshall did not see Bradley Napier-Tucker on the premises on this occasion. It seems unlikely that he was present but unseen elsewhere in the premises. This conclusion is available because when Ms Marshall explored with C the question of safety issues in the event that Bradley Napier-Tucker became too difficult, meaning if he tried to hit C or Ebony, C was able to speak openly about the subject and intimated that she would return to New South Wales in that event. She even said that she had some money saved. Ms Marshall formulated a plan to refer C to the Central Domestic Violence Service and provided her with an 1800 telephone number. Such was the level of Ms Marshall's concern, she elected not to provide C with any of the relevant domestic violence service pamphlets in case they were found by Napier-Tucker. She also told C that she would contact Families SA. C seemed surprised that Ms Sharpe was no longer involved as it will be remembered that Ms Sharpe had finished at the Woodville office on 16 September 2011.

11.11. Ms Marshall spoke to Ms Parenta on Monday 26 September 2011. She noted in her own handwritten record of the conversation[210] that she outlined to Ms Parenta her concerns about Bradley Napier-Tucker's '*behavioural changes*'. Ms Parenta's own note of this conversation[211] records that Ms Marshall said that she had no concerns about the parents' care of the baby and that the child was well looked after. She recorded that Ms Marshall had told her that C had said that Bradley Napier-Tucker had been using marijuana to treat some depression and anxiety as he had some difficulties in his life and that he is now trying to lessen his usage. Ms Parenta did record that C had said to

[209] Exhibit C81, page 4
[210] Exhibit C79, page 22
[211] Exhibit C81, page 23

Ms Marshall that Bradley Napier-Tucker was '*showing some signs of aggression*'. In this context it is recorded by Ms Parenta that Ms Marshall told her that she had asked C what C would do if Bradley Napier-Tucker became violent and C had said that she would take the baby and go back to New South Wales. There was also some discussion between Ms Marshall and Ms Parenta about the possibility of a family support worker and also a follow-up visit with Ms Parenta.

11.12. There would be no follow-up visit by Ms Parenta nor by any other person for that matter. On 30 September 2011 Ms Marshall received a call from C to suggest that she was not available for a home visit. The plan for a home visit to take place on 4 October 2011 was thwarted when Ms Marshall received a text message from C saying that they were busy at an appointment that day. A loose arrangement was made by text to the effect that there might be some availability on C's part the following week. Further attempts by phone to contact C elicited no response, and in fact on one occasion the person who answered immediately disconnected.

11.13. On 4 October 2011 Ms Marshall prepared a Family Home Visiting Case Review Summary Form that was drawn to the attention of Ms Ranford, her superior. The document described paternal mental health as an issue and queried domestic violence of an emotional kind, with goals including the protection of the baby from abuse, with the plan including collaboration with Families SA and the identification of a safety plan by reference to C's contingency plan to return to New South Wales[212]. The document mentions nothing about an inability to make contact with the family.

11.14. In her evidence Ms Ranford told the Court that the information from Ms Marshall contained within the 4 October 2011 document ought to have elicited a response from Families SA. She said:

> 'I would expect that they would give a response because this father was showing signs of using drugs, becoming more aggressive, that they would act straight away with that information.' [213]

I am not certain that this document was in fact provided to Families SA. Ms Ranford said that the information in it would have warranted contacting of the supervisor, which in fact Ms Marshall had already done. The appropriate response in Ms Ranford's view would have been a contact visit from Families SA, a discussion with the family and an

[212] Exhibit C79, page 26
[213] Transcript, page 842

assessment of the child concerning the issues that the mother had identified, including drug use and aggression.

11.15. CAFHS contacted Families SA on Monday 17 October 2011 at 4:59pm. At this time Ms Marshall sent an email to Ms Parenta, copied to Ms Ranford, in which she stated the following:

> 'Hi Loretta,
>
> I haven't been able to contact C, I last visited on 23/9/11, at that time I had made another appointment.
>
> Since then she has rescheduled once and not responded to text messages .. I did ring the mobile 0449 *** *** today once I asked for C, a female caller hung up. I have text a further offer for a visit however if this provides no response will send a letter if no response after review will close contact.
>
> Thought I should make you aware of this.' [214]

11.16. As will be seen in a moment, Ms Parenta had effectively closed Families SA's own involvement with this family the previous business day, namely Friday 14 October 2011. Ms Marshall's email of 17 October 2011 did not cause any revision of the Families SA decision to close the file. Ms Marshall's email of 17 October 2011 elicited from Ms Parenta a mere emailed acknowledgment and thanks but no meaningful response nor advice that Families SA had closed its file and no invitation to CAFHS to make a further formal notification. This email was sent by Ms Parenta on 18 October 2011 at 9:01am. It was the final communication between CAFHS and Families SA about Ebony. In her oral evidence Ms Parenta on numerous occasions was at pains to point out that she had no recollection of having received Ms Marshall's email of 17 October 2011. This evidence had been given at a time before her email of acknowledgment was located. Ms Parenta was then recalled to give further evidence. More of that in the next section.

11.17. Ms Marshall's email of 17 October 2011 foreshadowed that a letter would be sent and that if there was no response CAFHS would '*close contact*'. On 19 October 2011 a letter was sent by CAFHS to the parents' address referring to the inability to make contact with them and pointing out the fact that CAFHS services were voluntary. There was no response to that letter and so CAFHS effectively finalised their involvement with the family as of 1 November 2011. It would have been far better if CAFHS had

[214] Exhibit C79, page 46

made a further formal notification to Families SA through CARL. It would have meant that Families SA, who had closed their file, would have had no option but to deal with the concerns that formed the basis of Ms Marshall's informal email of 17 October 2011. But CAFHS were not to know that Families SA had closed their file.

11.18. It will be remembered that as far as is known the last persons to see Ebony at close quarters were Mr and Mrs Grenci. Ebony appeared to be safe and well on that occasion. However, Ebony would be dead within approximately three weeks and it was in the period following the mid October 2011 closure of the Families SA file and that last sighting by the Grencis that Ebony would suffer her multiple and in the event, fatal, injuries.

12. The closure of the Families SA file

12.1. As seen above the final known communication between CAFHS and Families SA prior to Ms Marshall's email of 17 October 2011 was Ms Marshall's telephone conversation with Ms Parenta on 26 September 2011. Following that there was a pattern of excuses given by C that meant that no further contact between CAFHS and Ebony's family occurred. It will be understood, however, that CAFHS had no coercive power to exert in respect of this family. They were simply providing a voluntary service that C could accept or reject as the case may be.

12.2. Ms Sharpe had left the Woodville office on Friday 16 September 2011 and had nothing further to do with the file. In the next month Families SA had little to do with the matter with the exception of Ms Parenta's telephone conversation with Ms Marshall of 26 September 2011 which in the event came to nothing.

12.3. It was then that Ms Parenta effectively brought Families SA's involvement, such as it had been, to an end on Friday 14 October 2011. It is difficult to see what it was that prompted this development at that particular time, except that it may have been prompted by Families SA's receipt of the CPS report regarding Ebony's injury that was sent on 10 October 2011. Ms Parenta gave some evidence about this measure which I will come to in a moment. The closure of the matter as far as Families SA were

concerned is reflected in what is described as a '*closure note*' compiled by Ms Parenta dated 14 October 2011[215]. I set out the terms of that note here:

> '**Note details:**
>
> The parents were cleared of causing the injury to the child but due to their youth, history and isolation there were concerns that they may have difficulty coping. The intake was moved to Protective Intervention Phase simply to facilitate some services being put in place.
>
> Given that they have engaged with Child and Youth Health and no further concerns have been raised then the case will now be closed.' [216]

Before dealing with the circumstances in which that note came to be compiled, the content of that note requires some discussion. In my view it was incorrect to suggest that the parents had been cleared of causing the thigh injury that Ebony had sustained. Even allowing for the view that was taken that the injury could, in a mechanical sense, have been caused by the entrapment of the leg in the manner described by Bradley Napier-Tucker, no person could have reached a firm conclusion that this suggested explanation represented the truth of the matter. It could hardly have been said that the explanation provided by Bradley Napier-Tucker was in any way proven. There was and ought to have been serious conjecture remaining about the manner in which the injury had been sustained, even without knowing what the radiologists would have said about the matter if they had been asked. In short, the parents had not been '*cleared*' of causing the injury. At best, the suggested mechanism was a possibility only, and in any event it is difficult to see how Bradley Napier-Tucker could have been cleared of having caused the injury to Ebony when, on his own dubious version of events, he had negligently dropped the child and had done so probably under the influence of cannabis. Furthermore, reference in Ms Parenta's note to the youth, history and isolation of the parents was something of an over simplification when one has regard to the nature of that history, and that is so even apart from the fact that in reality the history of Bradley Napier-Tucker was not known and this was as a result of Families SA failing to make the appropriate enquiries about his history. I do not fully understand the reference to the intake being removed to protective intervention phase unless it is a reference to the movement of an intake to that phase on 11 August 2011[217] which Ms Parenta told the Court was a reference to the first notification made to Families SA after the child was born. If that is correct then Ms Parenta's note that the intake was moved to protective

[215] Exhibit C81, page 28
[216] Exhibit C81, page 28
[217] Exhibit C81, page 136

intervention phase takes no account of the existence of the second notification which related to a more serious matter having regard to Ebony's injury. The first paragraph of Ms Parenta's note in many ways simply describes the matter of Ebony as routine, if not mundane. The second paragraph about the engagement of this family also takes very little account of their tendency not to engage except when it suited them and, in reality, places a gloss on what Ms Parenta had been told by Ms Marshall on 26 September 2011 concerning Bradley Napier-Tucker's behavioural changes and the concern that they generated. That communication occurring as it did in late September was the last communication and in reality there was no basis for Ms Parenta to suggest that the family's engagement with services had been continuing to mid October 2011. In fact they had not continued and had been the subject of some internal concern at CAFHS. While it was true that no further concerns had been raised by CAFHS, in fact information about whether there were any concerns or whether engagement had continued was not in Ms Parenta's possession. Certainly, if, say, when Ms Parenta formulated the closure note on 14 October 2011 she had by then been placed in possession of the information that Ms Marshall's email of Monday 17 October 2011 would contain, there is simply no way that it could have been said that the family were engaging with services and that no further concerns were in existence. The very lack of engagement outlined in Ms Marshall's email was a further concern in and of itself. So was the intimation in the email that lack of response to the letter would result in CAFHS closing contact with the family.

12.4. As I say, in the event it would have been better if Ms Moore and Ms Ranford had made a further notification to Families SA through CARL on 17 October 2011 to express their concerns.

12.5. Ms Parenta gave extensive oral evidence at the Inquest in relation to the Families SA effective closure of the file on 14 October 2011. Ms Parenta told the Court that the '*new person*', as mentioned in Ms Sharpe's email of 7 September, with whom Ms Marshall would need to touch base with after Ms Sharpe left the Woodville office was herself[218]. Ms Parenta said that it had been her intention to have another social worker take the place of Ms Sharpe, but she had no capacity to allocate the matter to another worker. She suggested that all other workers on her team were so inundated with child protection matters that they would have been unable to take on an extra case.

[218] Transcript, page 1262

Ms Parenta said '*they had absolutely no capacity to take it on*', and that was even having regard to the fact that Ebony's was a high risk case. When asked whether she had drawn her inability to allocate that file to the attention of any person, she said that she did not but that she should have brought it to the attention of the manager, being her superior. Ms Parenta said in relation to the closure of the file:

> 'When you say 'it never changes', the history doesn't change as such, but given that Child and Youth Health were saying they had no concerns about the parenting, that was why I closed it, but as I said, in retrospect, I think I closed it too early. But it was because I didn't have capacity, yeah.' [219]

12.6. It is noted, however, that the closure note says nothing about the lack of capacity to allocate the file to a Families SA worker being the reason, or part of the reason, for the closure of the file. In this regard Ms Parenta acknowledged that to have included reference to a lack of capacity would have been the usual practice and it would be a practice that would involve the manager becoming aware of the reason for the closure of the file. She said '*I don't know why I didn't do that, I really don't*'[220]. Ms Parenta told the Court that she accepted that it was a mistake, but that the outcome may well have been the same because the fact was that they had no capacity to allocate. Ms Parenta also suggested that there would be no reason to keep the closure of a file such as this, and for the reasons that she was closing it due to lack of capacity, from her manager. She was asked:

> 'Q. Why would you not confide in your manager then even on an informal basis.
>
> A. Well, actually pinning them down on an informal basis was not always easy but all I'm saying is I do not know why I didn't send it to the manager as a closure and high risk. I think what I did was I put too much store by the fact that Child and Youth Health were involved.' [221]

12.7. Ms Parenta agreed with Ms Kereru of counsel assisting that her closure note did not convey the true reality of Ebony's matter as it stood on 14 October 2011[222].

12.8. Ms Parenta in her original evidence stressed on a number of occasions that she had no recollection of receiving Ms Marshall's email on the Monday following her closure of the file on the previous Friday. But she agreed, in a qualified manner admittedly, that if she had seen the email of Ms Marshall on 17 October 2011 there would have been

[219] Transcript, page 1264
[220] Transcript, page 1267
[221] Transcript, page 1267
[222] Transcript, page 1273

good grounds to reopen the file. She said '*yes, there could have been, yes*'[223], but said that there may have been difficulty reopening an already closed file. What Ms Parenta did say, however, was that the 17 October 2011 email may have invited a further formal notification by CAFHS and that this could then have, as it were, reignited Families SA's interest in Ebony. All throughout this discussion in the course of her evidence Ms Parenta was at pains to point out that she had no recollection of receiving that email[224]. I did observe, however, that Ms Parenta never actually denied receiving it.

12.9. Ms Parenta's original oral evidence before the Court was interrupted by a number of days due to a prior commitment on her part. When she resumed her evidence she was extensively cross-examined by Mr Anthony Keane of counsel for the Minister for Education and Child Development. Again during this cross-examination Ms Parenta stressed that she had no recollection of receiving the 17 October 2011 email of Ms Marshall. However, following counsel's final addresses, and before these findings were delivered, a further search of Ms Parenta's email account resulted in the discovery not only of Ms Marshall's email within Ms Parenta's government account, but also the very short response of 18 October 2011 from Ms Parenta to which I have already alluded. It simply stated '*Thanks Gillian - Loretta*'. Neither Ms Marshall's email of 17 October 2011, nor Ms Parenta's response of 18 October 2011, had been included within the Families SA file[225] that was tendered to the Court. While Ms Marshall's email was included within the CAFHS file, Ms Parenta's short response email was not. This circumstance enabled Ms Parenta to assert that she could not recall having received Ms Marshall's email. The fact that neither Ms Marshall's email nor Ms Parenta's reply were included within the Families SA file that was compiled and tendered to the Inquest[226] was a regrettable circumstance that should not be repeated. The same comment applies to the fact that although Ms Marshall's email was included within the CAFHS file[227], Ms Parenta's response email was not included. These circumstances caused a great deal of wasted time in this Inquest. Worse, for a time the Inquest proceeded on a false premise, namely that there was a possibility that Ms Parenta never received Ms Marshall's email when the reality is that not only did she receive it, she had replied to it. I have had no explanation provided as to why emails

[223] Transcript, page 1274
[224] Transcript, pages 1273, 1274, 1485 and 1486
[225] Exhibit C81
[226] Exhibit C81
[227] Exhibit C79

as important as these are were not included, particularly within the Families SA file. In future, this Court requires all correspondence, whether by way of email or otherwise, to be printed and to be included in a hard copy file that is tendered to the Court. At the moment, this Court can have very little confidence that all relevant material will be provided to it in the course of an inquiry such as this. The South Australian Government is now on notice that in future the non-inclusion of material in government files tendered to this Court will not be tolerated and an investigation into the circumstances in which such material is not included will be rigorously carried out.

12.10. In the light of the revelation that Ms Parenta had received and had responded to Ms Marshall's email of 17 October 2011 after all, in January 2016 Ms Parenta was recalled to answer further questions based upon the discovery of her responding email of 18 October 2011. In her evidence on this occasion Ms Parenta acknowledged that she must have read Ms Marshall's email and that she clearly must have responded[228]. When asked as to whether she was acknowledging that she had taken on board the information contained within Ms Marshall's email, Ms Parenta said:

> 'I don't know that I can actually acknowledge that. I don't know what I - I can't take myself back there because I can't remember it. All I am saying is, clearly, I received the email, and clearly, I responded.' [229]

Ms Parenta there seems to be saying that she still has no recollection of this exchange of emails. She added that it was not possible to keep all information in one's mind, which one can accept, but acknowledged that she must have overlooked Ms Marshall's email on this particular occasion[230]. Ms Parenta also reiterated that by the time she received Ms Marshall's email the file would have already been closed, and even though further notes could have been placed on Ebony's Families SA file, it would be unlikely that anything further would have been done due to the fact that the file was closed[231]. She acknowledged that she could have asked for updates from Ms Marshall. She added that she did not believe that she should have, only that she could have[232]. She suggested that if CAFHS had concerns at that time the process was for them to have made another notification. She said:

---

[228] Transcript, page 1734
[229] Transcript, page 1735
[230] Transcript, page 1735
[231] Transcript, page 1744
[232] Transcript, pages 1744-1745

> 'No. Their role is to decide when they need to notify. I could have suggested it but their role is to know when they need to make a notification.' [233]

While a notification could have been made, Ms Parenta also suggested that it would not necessarily mean that a file would be automatically reopened[234]. Throughout this part of her evidence Ms Parenta was endeavouring to mitigate the obvious shortcoming in her approach to this new piece of information from Ms Marshall by resorting to technicality when the reality was that worrying information had come her way and she had ignored it. When the obvious point was made in her cross-examination that she had closed the file on a certain understanding and that the very next working day that understanding had been shown to be incorrect, and that as a consequence one would then be obliged to revisit the original decision to close the file, she said:

> 'I honestly think I overlooked that email, I honestly think I've overlooked it; I haven't obviously given it the weight that it needed.' [235]

She stated that she did not remember whether it had occurred to her that from 17 October 2011 forward no entity, including Families SA and CAFHS, would keep in touch with that family[236]. She said that she did not know whether an earlier entity, and I think she must have meant Streetlink, were still involved. In fact they were not still involved.

12.11. When asked as to what should have been done on receipt of the email, Ms Parenta said that was a difficult question because the file was already closed, but she acknowledged that she could have followed up with CYWHS (she meant CAFHS) and probably should have[237]. Ms Parenta in the event resorted to continually pointing out that the file was closed and would normally only be reopened with a further formal notification. She acknowledged that she could have raised the whole issue with her immediate superior, acknowledged that she did not, but that she probably should have[238]. Ms Parenta said that an appropriate Families SA response would have depended upon the capacity to allocate the matter[239]. The following exchange took place during her evidence:

---

[233] Transcript, page 1745
[234] Transcript, page 1734
[235] Transcript, page 1745
[236] Transcript, page 1746
[237] Transcript, page 1747
[238] Transcript, page 1748
[239] Transcript, page 1748

'Q. Even if there wasn't another notification, having received Marshall's email, can I suggest to you that doing nothing was not an option.

A. Well, the file was already closed as such, and it was one of the risk factors. It is not an automatic reopen. It's just not like that. It is not an automatic reopen. It would have had to have been another notification and it would have been reassessed.

Q. So did Families SA have a policy at that point in time that a file that was closed on an erroneous basis had to stay closed.

A. No, no, it didn't. It wouldn't have, no.' [240]

12.12. It is difficult to see how Ms Parenta's stance in relation to Ms Marshall's email can be sensibly defended. The exact same situation regarding this family's disengagement from services that had occurred at the beginning of August 2011 had to her knowledge recurred as at the middle of October 2011. Furthermore, it would have been idle for Ms Parenta to have speculated as to whether CAFHS would make any further notification when Ms Marshall had made it clear in her email that failing a response to CAFHS' letter, they would close their file, which in fact they did do. To my mind it would not have been reasonable for Ms Parenta to have expected CAFHS to necessarily make any further notification in the event that engagement was not re-established having regard to the air of finality contained in Ms Marshall's email. This seems to be yet another example of where Families SA had abdicated its responsibility for Ebony's protection to another entity that was singularly incapable of enforcing any kind of engagement with this family.

12.13. It is abundantly clear that Ms Marshall's email contained matters of genuine and significant concern. The concerns related to an existing state of affairs, namely the family's disengagement. Ms Parenta seems to have been more focussed on form rather than substance. It is no answer in my view to say that because the file was closed an existing concern that had been conveyed to Families SA could therefore, as a matter of formality, be put to one side. It is also no answer to say that Families SA were entitled to wait for further developments that may or may not be communicated to them as far as engagement was concerned. In this regard it is noteworthy that Ms Parenta's response to Ms Marshall's email was peremptory and invited no further communication.

12.14. The issue regarding the closure of the file and other issues prompted Mr Keane of counsel for the Department that encompasses Families SA to submit to the Court that

[240] Transcript, page 1750

there was a lack of professional judgment exercised in the whole process of Ebony's notifications by Ms Parenta's team and by Ms Parenta herself when closing the file in particular. Rather, he suggested that there was evidence of pre-judgment in that Ebony was seen to be at low risk at all stages of the process and that the focus of Ms Parenta had been on how to close the file and how to find a way to avoid doing the necessary casework and engaging in the necessary investigations. He asserted that this indicated a lack of professional judgment on her part. Coming as it did from counsel for the entity that continues to employ Ms Parenta, Mr Keane's submission was an extraordinary indictment.

12.15. In the course of Mr Keane's cross-examination Ms Parenta volunteered that because of remaining concern about Ebony's safety, she had attempted to involve the office's high risk infant supervisor. As well, she said that she had also attempted to involve the High Risk Infant Team (otherwise known as Safe Babies). Ms Parenta said that when Ebony died she had been extremely distressed and that the two things that had provided her with some peace of mind was the fact that she had endeavoured to involve those two entities in Ebony's matter.

12.16. Ms Parenta said that she had enquired of a Ms Rachael McCulloch if there had been any vacancies within the High Risk Infant Team that might have accommodated Ebony's matter. Ms McCulloch was the supervisor of that team at the time. Ms McCulloch had told her that there had been no vacancies on that team. Ms Parenta explained that Ms McCulloch was part of the leadership team at the Woodville office because the High Risk Infant Team came under the Woodville manager's overall responsibility. At a leadership meeting Ms Parenta in effect asked if Ms McCulloch's team could take on Ebony's case.

12.17. Ms Rachael McCulloch was called to give oral evidence following Ms Parenta's evidence. Ms McCulloch was the supervisor of the Safe Babies team in 2011. One of the Families SA offices that were serviced by that team included the Woodville office. Ms McCulloch, an experienced social worker, was an impressive and careful witness. I accepted her evidence.

12.18. Ms McCulloch said that although she knew Ms Parenta she had not had a great deal to do with her. Ms McCulloch said that she participated in leadership meetings of the kind Ms Parenta described. Ms McCulloch told the Court that she had no recollection

of Ms Parenta discussing a file with her and asking whether or not her team had the capacity to take on a matter. She said it was possible that at that time they may have been working at capacity. However, Ms McCulloch said that she would have invited Ms Parenta to submit a referral form and to go on a waiting list that may have been as long as one to six months. She would have enquired as to the nature of the matter before making such invitation. Ms McCulloch told the Court that if the nature of Ebony's matter had been explained to her she would have regarded it as not a suitable matter to be referred to her team because of the high degree of risk involved in Ebony's circumstances. She said that such a matter should remain with the district centre[241].

12.19. Asked for her reaction if a person in making a request for her to take on a case such as Ebony's had said that if Safe Babies did not take the file on they would close the file, Ms McCulloch said '*I would have been concerned enough to talk to the district manager about it*'[242]. The district manager of which she spoke would have been the manager of the Woodville office, who would be Ms Parenta's superior. She would have asked the manager to speak to the relevant supervisor. She was asked:

> 'Q. In relation to a case of the nature that I've just described to you, is that the kind of case that you would close without telling your manager.
>
> A. No.' [243]

The alarming risk that Ms McCulloch would glean from the circumstances of Ebony's case was in her view posed by the injury and lack of satisfactory explanation for that injury. She regarded that risk as existing irrespective of whether the injury was shown to have been intentional or may have been accidental[244].

12.20. As to the question of the father's cannabis consumption, Ms McCulloch suggested that it would at least raise a concern that the father was not putting the infant first. It would be concerning that he was engaging in drug use and, notwithstanding, was continuing to care for the infant.

12.21. Ms McCulloch suggested that a supervisor in Ms Parenta's position would understand the nature of the Safe Babies services and be aware of the acceptable risk categories that Safe Babies work with and the type of babies that would be suitable for referral.

---

[241] Transcript, page 1535
[242] Transcript, page 1538
[243] Transcript, page 1538
[244] Transcript, page 1539

In this regard Ms McCulloch produced the Safe Babies team practice guide[245]. This document makes it plain that it would not be appropriate to transfer a case to the Safe Babies team where the level of danger to the infant is significant, and/or there is little potential or willingness by the parent/caregiver/s to safely care for their infant in the immediate longer term.

12.22. I was satisfied by Ms McCulloch's evidence that an approach to her to take on Ebony's case would have been rejected simply on the basis of risk. In my view, although Ms McCulloch's evidence does not preclude the possibility that Ms Parenta consulted her, it must have been on a very informal basis. As well, it is perplexing as to why Ms Parenta would not mention any of her concerns to her own superior if, as is likely, she had made an approach to Ms McCulloch and had been rejected.

12.23. Finally on this topic I refer to the evidence of Ms Karen Walters who was a Families SA family support worker at the Woodville office. Ms Parenta asserted in her evidence that at one point she had a desire to involve Ms Walters, who had been a high risk infant family support worker, to become involved in Ebony's case. However, Ms Parenta asserted that following Ms Sharpe's departure from the office on 16 September 2011, Ms Walters also left the office for a period of several weeks. In her evidence Ms Walters explained that her duties at the Woodville office were to support the senior social worker which might involve visiting the client on a regular basis depending on the needs of the client. She told the Court that she had a conversation with her supervisor, Ms Parenta, about a case on which she might be called upon to work. She said it was a casual conversation in which she was asked about her availability, to which Ms Walters said that she did have capacity. In due course she spoke to Ms Parenta further about the matter and asked what was taking place with the case. To this Ms Parenta had said that she would not be required at that time. Ms Walters presumed that they were either going to close the case, that they had been unable to contact the family or other decisions had been made. Ms Parenta did not indicate what she was planning to do with that file. Ms Sharpe had then left the office. Ms Sharpe emailed Ms Parenta on Friday 16 September 2011, Ms Sharpe's last day at Woodville, to inform Ms Parenta that she had not closed the Ebony file, that she had not been able to make contact with the family but that she had asked Karen Walters to attempt to do so the following week as she would like her assessment on the family. It is clear from this

[245] Exhibit C108a

email that Ms Sharpe was not only expecting her own departure from the Woodville office, but also the imminent albeit temporary departure of Ms Walters as well. Ms Walters told the Court that this arrangement would have been somewhat misconceived in that Ms Walters herself would not, in any case in the first instance, have gone out and seen a family without the social worker present[246]; this despite the fact that Ms Sharpe recorded by way of a file note Ms Walters' willingness to do so. Ms Walters said that for her to act, she would have had to wait for a social worker to be allocated the case. She said that she would have gone straight to Ms Parenta to explain all of this and not have indicated a willingness to be involved. In any event Ms Walters' evidence rather suggests that her contemplated involvement was finished some weeks before the file was closed by Ms Parenta.

12.24. It is clear that Ms Parenta at no stage informed her own superiors that she was intending to close the file, or had closed it.

13. Conclusions

13.1. Ebony Simone Napier was born at the Women's and Children's Hospital (WCH), Adelaide on 4 July 2011. She died at premises at Brooklyn Park on about 8 November 2011. She was 4 months of age at the time of her death.

13.2. Ebony's mother was C who at the time of Ebony's death was 17 years of age. Her father was Bradley Napier-Tucker who was 19 years of age at the time of Ebony's death.

13.3. On the afternoon of 15 November 2011 Ebony's parents attended at the Families SA office at Woodville where they informed staff that Ebony had been lying dead at their home for about a week. Ambulance personnel then attended at the Brooklyn Park unit that was the home of Ebony and her parents. There they discovered Ebony deceased in her cot. There was evidence of decomposition that was consistent with her parents' assertion that Ebony had been dead for some time.

13.4. The cause of Ebony's death was ascertained at a post-mortem examination. The cause of her death was blunt head trauma. I find that to have been the cause of Ebony's death. Ebony had sustained a number of internal head injuries that consisted of both previous and recent injury. There were subdural haemorrhages of varying ages, the oldest of

[246] Transcript, page 1558

which was of some weeks duration. There were also a number of skull fractures together with subcutaneous bruising suggesting that there had been a number of separate blows to her head. I find that Ebony's blunt head trauma, which caused her death, resulted from multiple blows to the head by or against a hard object or surface.

13.5. There were other injuries to Ebony from which the conclusion can be drawn that she had been serially brutalised over a period of time. These injuries included multiple bony injuries to differing parts of Ebony's skeleton, including the spine, rib cage and upper and lower limbs. There were 48 old healing rib fractures and 4 recent rib fractures. There were crush fractures to the thoracic vertebrae. There were injuries to the upper limbs as well as to the feet. The fractures were of differing ages.

13.6. There was evidence of a healing fracture through the midshaft of the left femur. This was the only injury that was identified during Ebony's short life.

13.7. Many of Ebony's injuries suggest that she had been compressed by way of encirclement of hands around her chest and had sustained finger and toe fractures consistent with squeezing or stomping.

13.8. Leaving aside for the moment the thigh injury that was identified during her lifetime, I find that Ebony's injuries had been deliberately inflicted.

13.9. I find that Ebony's injuries, including her fatal injuries, had been inflicted by her father Bradley Napier-Tucker. Leaving aside the thigh injury which requires separate consideration, I find that Bradley Napier-Tucker had inflicted Ebony's injuries by intentional and deliberate applications of force to her person that included shaking, squeezing of the chest and throwing or dropping her against objects. I further find that cannabis consumption played a significant role in the aggressive behaviour of Bradley Napier-Tucker.

13.10. Leaving aside Ebony's thigh injury, I find that Ebony's injuries, including the fatal head injuries, were inflicted on and subsequent to Sunday 16 October 2011. Sunday 16 October 2011 was the day on which Ebony was probably seen for the last time by any person or persons other than possibly Bradley Napier-Tucker's drug dealer. In any event 16 October 2011 was the last occasion on which Ebony was sighted by any person who had any sense of responsibility. Ebony would not be seen by any such person until

ambulance personnel attended at the Brooklyn Park address on 15 November 2011. She was deceased at that time.

13.11. In January 2011 C and Bradley Napier-Tucker came to South Australia from Goulburn in New South Wales. At that time C was under the parental responsibility of the New South Wales Minister responsible for child protection. That status would conclude on C's 18th birthday which occurred in December 2011. C's status in New South Wales would not be carried over into any similar status that existed in South Australia. It is apparent and I find that C came to South Australia without the knowledge and permission of the New South Wales authorities who had responsibility for child protection.

13.12. C and Bradley Napier-Tucker had met in Goulburn in about October 2010 and commenced cohabitation shortly thereafter. C soon became pregnant to Bradley Napier-Tucker. When C and Bradley Napier-Tucker arrived in South Australia in early 2011 C was already several weeks pregnant with Ebony.

13.13. Ultimately, through the care and compassion shown to C and Bradley Napier-Tucker by Mr and Mrs Bruno Grenci, accommodation was found for C and Bradley Napier-Tucker at the Brooklyn Park unit.

13.14. The New South Wales authorities had identified a number of negative characteristics in respect of C that included significant alcohol and drug use, mistrust of services and a lack of engagement with services, a history of involvement in domestically violent relationships, suicidal ideation, other health issues and extreme risk taking behaviours, poor impulse control and an ability to become aggressive when challenged. These alleged characteristics would be made known to the South Australian authorities who had responsibility for child protection.

13.15. Bradley Napier-Tucker also had an involvement with the New South Wales child protection authorities, both in his personal capacity and in respect of two young children, one of whom he was said to be the father, namely M. Bradley Napier-Tucker's own child protection records with the New South Wales Department of Community Services (DoCS), now known as the Department of Family and Community Services, recorded negative aspects in respect of his relationship with his parents, including physical abuse of himself and drug use on the part of his mother and sister as well as general neglect, loitering and truancy and a history of violent and aggressive behaviour.

In respect of the child M, DoCS records contained allegations of a desire if not an attempt on the part of Bradley Napier-Tucker to remove the newborn child M from the hospital that had resulted in the attendance of police at the hospital. As well, it was recorded that while in the hospital following his birth, Bradley Napier-Tucker and the mother of this child had argued about money and drug issues as well. Allegations that Bradley Napier-Tucker and the mother of the child smoked cannabis in the presence of M once out of hospital were also recorded. There are records relating to information provided by Bradley Napier-Tucker's own mother that Bradley Napier-Tucker had assaulted the infant M and had screamed abuse at the child such that the child M had taken on a fearful and anxious demeanour when held by a person. The child M had ultimately been removed from the custody of the child's mother. There were other allegations, of a less substantiated nature, that Bradley Napier-Tucker had been seen to abuse another small child on a number of occasions, including slapping the child across the face with an open hand and inflicting other applications of force to the child's body, including striking and pulling the child by the arm. There were allegations that Bradley Napier-Tucker was an abuser of cannabis. Other than the fact that Bradley Napier-Tucker was said to have been the father of the small child M in New South Wales, the South Australian child protection authorities were not informed of Bradley Napier-Tucker's history at any stage during the life of Ebony.

13.16. When Ebony was born a notification was made by a WCH social worker to the Families SA Child Abuse Report Line (CARL). The notification was based on legitimate concerns surrounding C's age, lack of support systems and her status in NSW. This notification was appropriately made and was duly recorded by the CARL worker. The notification was transmitted to the Woodville office of Families SA. This was a Tier 2 notification. Shortly after the notification was received the matters concerning C as recorded in NSW DoCS records that I have mentioned, were identified by Families SA staff. Families SA staff were also advised of the existence of a child, now known to have been M, in respect of whom Bradley Napier-Tucker was the father. No information about Napier-Tucker apart from that bare piece of information was ever made known to Families SA. Families SA would make no further inquiry in relation to the background of Bradley Napier-Tucker.

13.17. The existence of the child now known to be M in respect of whom Bradley Napier-Tucker was the father was first communicated by the New South Wales DoCS to Mr

Ryan Balkwill who was a team supervisor at the Woodville Families SA office. Ms Loretta Parenta was another Families SA team supervisor at the same office. Ms Parenta's team would have responsibility in relation to the notification that was made to CARL shortly after Ebony's birth. Ms Emma Sharpe was a social worker within Ms Parenta's team who worked in the Woodville office between 11 July 2011 and 16 September 2011. None of those three individuals at any stage made any inquiry of the New South Wales authorities in respect of the background of Bradley Napier-Tucker. The importance of the information concerning Bradley Napier-Tucker's background cannot be overstated. This is so even without the benefit of hindsight in light of the outcome of Ebony's death at the hands of Bradley Napier-Tucker. The information concerning Bradley Napier-Tucker's background could have made all the difference in respect of Ebony's safety. Indeed, any measures that were taken during Ebony's short life in respect of her care and protection were flawed insofar as those measures were undertaken without any regard to Bradley Napier-Tucker's background or propensities. The failure to establish Bradley Napier-Tucker's background through the New South Wales child protection authorities was an egregious oversight, the incompetence being all the more culpable having regard to the relative ease with which the information about Bradley Napier-Tucker could have been obtained and the fact that the neglect in failing to obtain the information persisted over the entirety of Ebony's life.

13.18. During the course of the Inquest it was suggested, particularly by Ms Loretta Parenta, that a reason for not obtaining information regarding Bradley Napier-Tucker's background was due to a perceived responsibility or onus upon the New South Wales authorities to inform the South Australian authorities of those matters. I do not accept that suggestion. The obligation to provide care and protection to Ebony, having regard to the original notification to CARL, was that of Families SA, not the New South Wales authorities. Therefore, it was incumbent upon the South Australian authorities to obtain any relevant information about Bradley Napier-Tucker. The fact that he was said to be the father of a small child who had been removed from the custody of the mother was sufficient information to have enlivened the curiosity of Families SA staff as to what other information the New South Wales authorities may have possessed in respect of Bradley Napier-Tucker. I find that it simply did not occur to anyone in Families SA who was connected with the matter of Ebony's notification to seek out that information. It should have occurred to them. It was a core element of Ebony's protection.

13.19. As to the likely impact of information concerning Bradley Napier-Tucker in the initial stages of the first notification, in the opinion of the Court that information would have been highly relevant to consideration as to whether, even at that early stage, Ebony should pursuant to the relevant provisions of the Children's Protection Act 1993, have been removed from her parents' custody following her release from hospital. The potential danger that Ebony may have been in given the alleged dysfunctionality of her mother and the aggressive tendencies of her father was a matter that would have required careful consideration, and not just in hindsight. There was also the question of possible drug abuse in the history of both parents that needed to be taken into consideration.

13.20. In the event a Families SA staff member would visit the home of Ebony and her parents on 1 August 2011 for the first time. The only other home visit occurred later in August 2011. On 10 August 2011 Ebony would be presented to The Queen Elizabeth Hospital (QEH) with a fractured left femur.

13.21. In the period between Ebony's discharge from hospital following her birth which occurred on 8 July 2011 and her presentation to the QEH with a broken leg on 10 August 2011, Ebony was seen by domiciliary care nursing staff arranged through the WCH. The fact that these services were provided did not in any way alleviate or diminish the responsibility that Families SA had in respect of Ebony's care and protection. This is not to diminish the importance of domiciliary care entities in child protection. But there was, I find, a strong element of abdication of child care and protection responsibility by Families SA upon the domiciliary care nursing staff who visited the family. The period in question, as well as the period following Ebony's discharge following her admission for a broken leg, would be characterised by an increasing level of concern entertained by service providers such as Child and Family Health Services (CAFHS), a worrying disinclination on the part of Ebony's parents to engage with those services and a perplexing ongoing level of insouciance to the whole affair within certain quarters of Families SA.

13.22. In the period between the two hospital admissions it was identified that Ebony's parents were disengaging from and avoiding services. In addition, strong evidence of Bradley Napier-Tucker's cannabis habit of consumption was also observed but no particular notice was taken of it. It was not even recorded. His aggressive streak was also seen. The risks identified in the original intake, based almost exclusively upon the negative

characteristics that had been assigned to C by the New South Wales authorities, and which had been told to the South Australian authorities, were being played out in July and early August 2011. C was behaving true to form in that the New South Wales information imparted shortly after Ebony's birth to the South Australian authorities about C's mistrust of services was already being manifested in inconsistent, if not a lack of, engagement with services and there was also the suggestion that Bradley Napier-Tucker's drug abuse had not been completely ruled out in their household. The reality was, as had been observed by one domiciliary care worker but not documented, that Bradley Napier-Tucker was consuming cannabis. However, Bradley Napier-Tucker's general propensity towards aggressive and controlling behaviour had been noticed by domiciliary care staff and at one visit had even been the subject of adverse comment to them by his mother. This had been reported to Ms Parenta of Families SA, as was an increasing level of concern entertained at the end of July 2011 by domiciliary care staff.

13.23. There is, I find, a worrying tendency within the child protection environment to regard cannabis consumption as having limited importance and to downplay the dangers associated with the consumption of cannabis within a family setting such as this. For that reason there appears to be a level of undue tolerance to the activity. This is coupled with a singular lack of curiosity as to the means by which cannabis consumption is being funded in a given case and whether the activity is also contributing in a fiscal manner to the detriment of an already vulnerable family. Ebony's is a case in point. This case should establish beyond doubt that the deleterious impact of cannabis consumption in a setting such as this should never be underestimated.

13.24. Ms Sharpe of Families SA saw the family at their Brooklyn Park address on 1 August 2011, but after this Ebony's parents resisted all attempts to communicate with them or engage with them, even to the point where a letter had to be sent by Ms Sharpe of Families SA that contained something of a hollow warning in respect of the possible consequences of further disengagement. It is within the period between 1 August 2011 and 10 August 2011 during which nothing was known about the circumstances of the family that the Court finds that Ebony sustained her serious thigh injury.

13.25. Ebony's parents presented Ebony to the QEH on 10 August 2011. Ebony had a broken left femur that was diagnosed by X-ray at that hospital. On any version of events that was known at that time, Bradley Napier-Tucker was undoubtedly the person who

caused that injury. That same day Ebony was transferred to the WCH where she would remain until 22 August 2011, at which time she was discharged into her parents' care and resumed cohabitation with them at the Brooklyn Park address.

13.26. Following Ebony's admission to the WCH with a broken femur a second notification was made by Dr Kent of the hospital to CARL concerning Ebony's injury. This notification was made on 10 August 2011. It was noted in the Families SA record of Dr Kent's conversation with CARL that:

> 'The injury sustained by the infant was consistent with the explanation given by the parents and that there was no suspicion of the injury being inflicted.'

I am uncertain as to how this assessment came into being. The assessment was totally inconsistent with what was known and considered about the injury at that time. At that time there had been an explanation given by the parents, but no assessment could have been made, or had been made, at that point about whether the injury was consistent with that explanation. As well, it could not be said at that point that there was no suspicion that the injury had been deliberately inflicted. However, the manner in which this report to Families SA was recorded would unfortunately set the tone for Families SA's lack of enthusiasm in respect of the investigation into Ebony's injury that then needed to ensue.

13.27. There was an investigation into the cause and circumstances of Ebony's thigh injury in which Child Protection Services (CPS), which is an entity accommodated within the WCH, took the lead. Other participants in the investigation included SAPOL and Families SA in the person of Ms Loretta Parenta and Ms Emma Sharpe. The investigation into this injury would turn out to be a truncated and ill-informed affair that lacked proper cohesion and which wholly failed to protect Ebony. The investigation was also carried out in the absence of any knowledge of Bradley Napier-Tucker's background or propensities and so, as with every other measure that was taken in respect of Ebony's care and protection, the investigation was flawed from the outset. But even allowing for the absence of that information, the manner in which this investigation was carried out meant that it was a flawed investigation regardless.

13.28. I have a moment ago spoken of an explanation for Ebony's thigh injury, as given by the parents, that was recorded by Families SA as being consistent with the injury and which was said to attract no suspicion. That explanation, provided principally by

Bradley Napier-Tucker and corroborated to a degree by C, was that Bradley Napier-Tucker had accidentally dropped Ebony and that Ebony's left leg had been caught in the space between the two dual wheels of her pram. The parents stated that this incident had taken place two days prior to Ebony's presentation to the QEH on 10 August 2011. When asked by Ms Sharpe of Families SA whether he had been under the influence of anything when the incident occurred, Bradley Napier-Tucker disclosed that he had consumed a bong 1½ to 2 hours previously and that it may have *'slowed him down a bit'*. He added that when he smoked cannabis he felt paranoid and nervous and that he needed to '*get off the dope*'.

13.29. I was satisfied by cogent and compelling evidence that, relying upon the prematurely recorded conclusion as to the origin of the injury within Families SA records, Ms Loretta Parenta of the Woodville office attempted to dissuade members of CPS to proceed with an investigation into the origin of the injury. The reasons for Ms Parenta's reluctance to participate in any investigation remain less than clear.

13.30. I find that the explanation proffered by Ebony's parents in respect of Ebony's injury was intrinsically unlikely on the available evidence at the time and should have been assessed as such. I was satisfied from evidence of two consultant radiologists that Ebony's thigh injury had been sustained significantly earlier than the two days suggested by Ebony's parents. That conclusion had been reached by the two consultant radiologists and their opinion could have been made available to CPS had it been asked of them. Indeed the original report of Dr Pozza, the radiologist from the QEH, suggested in plain terms that the injury was older than the stated history of two days. The radiologist who conducted the skeletal survey at the WCH, Dr Clark had held the same opinion. I find that during the course of the CPS investigation neither radiologist was consulted when they should have been so consulted. If they had been consulted there would have been no conclusion available other than that the parents had not been truthful about the occasion on which Ebony had sustained her injury.

13.31. Furthermore, the mechanism by which Ebony was said to have sustained her injury I find was intrinsically unlikely. Again, had the radiological experts been consulted about the matter, grave suspicion should have been entertained about the truthfulness or otherwise of the parents' explanation for the injury. In short, the suspicion that the injury was deliberately inflicted remained a grave suspicion from beginning to end. This suspicion would have been heightened and brought into sharp focus if at the time

of the CPS investigation Families SA, who were a participant in the investigation albeit reluctantly so, had accessed the available information about the alleged propensities of Bradley Napier-Tucker in respect of small children. The investigation lacked proper cohesion; it required consideration to be given to other elements beyond merely establishing whether the explanation provided by Napier-Tucker was a theoretical possibility. This lack of cohesion and failure to address all essential requirements of an investigation such as this was due in part to Ms Parenta's lack of appetite for the task. Any proper investigation into whether an injury such as Ebony's was deliberately inflicted or not could not have failed to take into account the propensities and background of the parents. No reasonable person in Ms Parenta's position as an experienced member of a child protection agency could have failed to understand that. It is also surprising that SAPOL, which was a participant in the investigation, would also not have recognised Bradley Napier-Tucker's background as an essential element in the investigation. Equally perplexing is the blind eye that was turned to the criminality of Napier-Tucker's behaviour regarding cannabis and that of his supplier or suppliers.

13.32. Of particular concern is the evidence, which I accept, that for the duration of Ebony's injury prior to her eventual presentation to the QEH on 10 August 2011 she would have been in considerable pain and discomfort. I find that this period was greater than two days and so the fact that medical attention was not sought for Ebony immediately after an injury was sustained reflected very poorly, and manifestly so, on the parenting capabilities of C and Bradley Napier-Tucker.

13.33. There was also the question of Bradley Napier-Tucker's cannabis consumption probably contributing to the cause of the injury on anyone's version of events.

13.34. At the conclusion of the CPS investigation which I find was flawed, a powerful conclusion was available that if Ebony were to be released into the custody of her parents following her recovery from her thigh injury, she would be in a situation of serious danger. For that reason she should have been removed from her parents' care and not have been allowed back into their custody following her discharge from the WCH.

13.35. At the very least, having regard to the risk that was posed to Ebony by the cannabis habit of Bradley Napier-Tucker, a mandatory application under section 20(2) of the

Children's Protection Act 1993 for orders that Bradley Napier-Tucker be assessed pursuant to that provision should have been made. Consideration should have been given to invoking section 37(1a) of the same Act. I do not know why no consideration was given to this issue beyond the fact that cannabis consumption is a tolerated circumstance and that it never occurred to anyone to consider it.

13.36. Ebony's injury should have at least provided a valuable lesson to anyone involved in her care that disengagement from services could potentially involve catastrophic consequences for this family. Furthermore, it meant that this family required the closest scrutiny and that future attempts to disengage should be viewed with heightened concern.

13.37. Ebony was released from the WCH into the care of her parents on 22 August 2011. Between that date and 23 September 2011 there were visits by CAFHS but ultimately it became apparent that these services were being avoided such that engagement with services again ceased. The sole contact with a member of the staff of Families SA occurred on 24 August 2011 when Ms Sharpe met Ebony and her parents at West Lakes shopping precinct and then later that same day at the Brooklyn Park unit.

13.38. On 13 September 2011 police were called to the Brooklyn Park unit following information that had been imparted to police through communications that an incident involving domestic violence inflicted by Bradley Napier-Tucker in respect of C had there taken place. The attending police were not informed that the incident had involved alleged domestic violence because it was not included in the computerised CAD information. The assault that had been allegedly perpetrated by Bradley Napier-Tucker on C and which had reportedly occurred in the presence of Ebony consisted of C being dragged back into the unit by Bradley Napier-Tucker. This was not established by police during the course of their attendance at the flat. Attending police had no idea as to the existence of such an allegation. C failed to report it when spoken to by police, and the independent witness who had seen and reported the matter was not spoken to. Thus it was that no offence was detected by police when it should have been. If the offence had been detected, firstly it may well have involved the arrest and prosecution of Bradley Napier-Tucker for assault on C, but it also would have significantly added to the profile of risk in respect of Ebony. When police again attended at the premises on 21 September 2011 to further investigate the matter, the alleged assault was still not identified. As well, police did not associate this family with the events of August 2011

in which Ebony had been the subject of an investigation in respect of a broken femur that had been sustained at the hands of her father, accidentally or otherwise. This was so despite the fact that the same officer of SAPOL, who had a position of responsibility at the Sturt Family Violence Investigation Section, had been part of a strategy discussion that had taken place in August 2011 with CPS and Families SA in respect of Ebony's injury.

13.39. The failure to identify an offence of alleged domestic violence in September 2011 and the failure of police to identify this family as the same family that had been involved in respect of Ebony's thigh injury was a missed opportunity to have properly assessed the risk of further domestic violence within that family, and the risk that it may have specifically posed to Ebony. This is all the more so when Bradley Napier-Tucker's alleged propensities in respect of small children had also not been identified.

13.40. In the event Ebony's parents again became disengaged from services in the period following her release from the WCH, and Ebony was not seen by any service providing entity after 23 September 2011. Appointments were thereafter not kept, phone calls were not returned and all attempts to contact the family were resisted. As far as is known Ebony was last seen by Mr and Mrs Grenci on Sunday 16 October 2011.

13.41. On Friday 14 October 2011 Ms Loretta Parenta of Families SA placed a note on the Families SA file that effectively closed their file and ended any and all participation of Families SA in Ebony's care. The file note stated that the parents had been cleared of causing Ebony's thigh injury and that because the parents had engaged with health services and that no further concerns had been raised by them, that the case would now be closed. This note was erroneous in that in the opinion of the Court the parents had never actually been cleared of causing the injury to the child in the sense that it had been established that the injury had not been deliberately inflicted. At best there was an opinion formed that the cause of injury as described by the parents was mechanically feasible. Moreover, on anyone's version of events Bradley Napier-Tucker had caused the injury and had done so under the influence of cannabis. Thus it is difficult to see how it could be said that the parents had been cleared of having caused the injury. The closure note was also erroneous in that although the family had engaged with health services in the period following Ebony's release from the WCH, the reality was that engagement had ceased as of 14 October 2011 and had been non-existent since 23 September 2011.

13.42. On Monday 17 October 2011 Ms Gillian Marshall, a child health nurse with CAFHS, emailed Ms Loretta Parenta advising that the family had last been visited on 23 September 2011 and that attempts to contact the family since then had been unsuccessful and that, if anything, had been actively resisted. The email also advised that a letter would be sent to the family and that if no response was received CAFHS would end contact with that family. I find that Ms Parenta received that email, understood it and replied on Tuesday 18 October 2011 by merely expressing thanks. I accept Ms Parenta's acknowledgment that she failed to give the information in Ms Marshall's email the weight that it deserved.

13.43. It would have been far better if CAFHS had made another notification to CARL instead of sending Ms Parenta an email that was so easily dismissed.

13.44. Ms Parenta's stated reasons for closing the file were completely undermined by Ms Marshall's email in that all engagement with services had ended which was a concern in and of itself. The Court finds that the file should not have been closed, or at least should have been re-opened in the light of Ms Marshall's email of 17 October 2011. If there had been any technical difficulty standing in the way of re-opening, which I find difficult to accept, it could easily have been overcome by Ms Parenta inviting CAFHS to make a further formal notification through CARL. Following this, Families SA should have taken action to establish whether Ebony was safe. This action should have been taken on an ongoing basis between Monday 17 October 2011 and Tuesday 15 November 2011.

13.45. As to the explanation for the file being closed, based as it was upon an alleged lack of capacity to allocate the matter, Mr Keane, counsel for Families SA, urged the Court to reject Ms Parenta's suggestion that workload issues could legitimately explain why different more positive responses on her part were not made[247]. Rather, he suggests, it was simply a case of lack of appropriate professional judgment on her part[248]. This submission, coming as it did from counsel for the entity that continues to employ Ms Parenta, was an extraordinary indictment. This Court understands probably better than most that a claim of lack of resources in a given issue, particularly when it relates to the workings of a government entity, is an assertion that is easily made, difficult to refute and even more difficult to substantiate. It is quite beyond the scope of an inquiry of

[247] Transcript, page 1668
[248] Transcript, page 1674

this nature to arrive at a definitive conclusion about an issue such as that, especially after a significant passage of time. While acknowledging that Ms Parenta's claim that she simply did not have the capacity to allocate the file after Ms Sharpe left the office cannot be completely ruled out, I do observe that Ms Parenta did not mention in her closure note any such difficulty as being a reason for closing the file. Nor did Ms Parenta ever advise any of her superiors at Families SA that human resources were an issue. This to my mind casts grave doubt upon any assertion that lack of resources was an issue, but as I say, it is difficult for this Court to accurately judge whether any asserted claim of lack of resources has validity. All this Court can do is to repeat the recommendation made by the State Coroner in the matter of the death of Chloe Valentine that a proper assessment should be undertaken to ascertain the most effective resource allocation method for Families SA and that the assessment should include a consideration of the volumes of work and what resource effort is needed to carry out the work satisfactorily.

13.46. Ebony's death could have been prevented if:

- Families SA at the outset had taken steps to ascertain the background and propensities of Bradley Napier-Tucker;
- Families SA had taken a keener interest in and had maintained oversight over Ebony's care and protection in the period between the date of her birth and 10 August 2011 when she was presented to the QEH with a broken thigh, as distinct from abdicating its responsibilities in that regard to other services;
- A cohesive and thorough investigation into the cause and circumstances of Ebony's thigh injury had been carried out by CPS, Families SA and SAPOL that took into account the opinions of the radiologists and Bradley-Napier-Tucker's background;
- An erroneous view that Ebony's parents had effectively been cleared of having caused her thigh injury and that the injury was adequately explained had not been entertained;
- Ebony had been removed from her parents following the investigation into her thigh injury;
- Measures pursuant to section 20(2) and/or section 37(1a) of the Children's Protection Act 1993 concerning Bradley Napier-Tucker's cannabis habit had been considered and carried out;

- SAPOL had the means in place to have associated the events of 13 and 21 September 2011 at Brooklyn Park with the circumstances of Ebony Napier's thigh injury during the previous month;
- SAPOL had identified the commission of an alleged offence of assault by Bradley Napier-Tucker upon C arising out of the report to police of 13 September 2011;
- Families SA had taken a keener interest in and maintained oversight over Ebony's care and protection in the period between her release from the WCH on 22 August 2011 and her death, as distinct from abdicating its responsibilities in that regard to other services;
- Families SA had not closed Ebony's file on 14 October 2011;
- Families SA, on receipt of the CAFHS email of 17 October 2011 had either re-opened Ebony's file or had invited CAFHS to make a further notification to CARL;
- Families SA had taken the necessary steps to ensure that Ebony's family engaged with services in the period between 14 October 2011 and 15 November 2011;
- Families SA had recognised that Ebony's family's disengagement from services, and the concomitant lack of scrutiny by any responsible person or entity, in the period between 14 October 2011 and her death placed Ebony at risk of further neglect or injury.

14. Recommendations

14.1. Pursuant to Section 25(2) of the Coroners Act 2003 I am empowered to make recommendations that in the opinion of the Court might prevent, or reduce the likelihood of, a recurrence of an event similar to the event that was the subject of the Inquest.

14.2. I make the following recommendations directed to the attention of the Minister for Education and Child Development, the Chief Executive of the Department for Education and Child Development, the Minister for Child Protection Reform, the Minister for Health, the Chief Executive of the South Australian Department for Health and Ageing, the Minister for Police and the Commissioner of Police.

14.3. I repeat the recommendations made by the State Coroner of South Australia in the matter of the death of Chloe Lee Valentine[249] to the extent that those recommendations are relevant to the death of Ebony Simone Napier, namely Recommendations numbered 22.3, 22.4, 22.5, 22.7, 22.8, 22.11, 22.12, 22.13, 22.14, 22.15, 22.16, 22.18, 22.19, 22.20 and 22.21 (and would add that Recommendation 22.21 be extended in its operation to the supervisors of social workers if a supervisor is not a qualified social worker). By referring to a select number of the State Coroner's recommendations that this Court adopts, I do not mean to imply that the remaining recommendations should not be implemented.

14.4. I recommend the implementation of a uniform national child protection structure that would comprise the following elements:

a) A nationwide database in respect of all information that has been and will be gathered in relation to child protection cases throughout the entire country. The national database should be immediately accessible by workers within the child protection authorities of each individual State and Territory, thereby obviating the need for specific inquiries to be made as between one State child protection authority and another State child protection authority, or by the use of interstate liaison officers. For example, a child protection worker employed within Families SA should be able to have immediate access to information about the child protection history of an individual whose history is contained within records created and kept in another Australian State or Territory. I further recommend that insofar as it is necessary, legislation should be introduced to facilitate such nationwide access to child protection information in order to overcome any privacy considerations;

b) In circumstances where an individual moves from one State or Territory to another there should be automatic transfer of guardianship, custody, parental responsibility and like orders as between the States and Territories of Australia;

c) That where a State child protection authority loses contact with a child who is the subject of a child protection matter within that State, the authority should

[249] Inquest 17/2014

immediately place an alert that informs all other State and Territory protection authorities of the fact that contact has been lost with the child in question.

14.5. I recommend that the Minister for Health and the Chief Executive of the South Australian Department for Health and Ageing take steps to ensure that where members of the staff of health services have detected drug abuse in a family environment in which children are present, that such drug abuse be immediately reported to the Families SA Child Abuse Report Line. This should occur both in cases where Families SA have an existing notification in respect of a child or children of such a family and in those cases where they do not.

14.6. I recommend that it be recognised that an essential element of any investigation into a notification to Families SA in respect of a child is a thorough investigation into the background of the parents of the child or of any person in loco parentis to a child. This is particularly necessary in circumstances where the family concerned has come to this State from another State or Territory and little is known about the family. It is also particularly necessary in cases in which one or both parents, or a person in loco parentis to the child, is him or herself under the guardianship of a Minister responsible for child protection in another State or Territory (or is of equivalent status). It should be assumed, unless demonstrated otherwise, that a person who is under the guardianship of the Minister responsible for child protection in another State or Territory (or is of equivalent status) and who has come to this State without the knowledge or permission of the authority administering child protection in the State or Territory from which the person has come, has come to this State in order to avoid the regime that his or her interstate child protection status has imposed.

14.7. I recommend that the Child Protection Service, Families SA and SAPOL recognise that an investigation strategy in respect of an injury to a child comprises more than a bare assessment as to whether the injury is consistent in a mechanical sense with an explanation proffered for that injury. An investigation needs to take into consideration the background and propensities of persons connected with the child and the intrinsic likelihood or otherwise of the explanation having regard to all of the relevant circumstances. A person should not be regarded as having been 'cleared' of having deliberately caused an injury to a child except in circumstances where the investigators are satisfied with some certainty that the injury was not deliberately caused.

14.8. I recommend that the Child Protection Service recognise that an investigation conducted by the Service should take into account the medical opinions of all physicians involved in the child's matter, including but not limited to the opinions of radiologists who have conducted or reported on radiological investigations.

14.9. I recommend that in the following circumstances the closure of notifications and files within Families SA in respect of child protection matters should only be authorised by an officer superior in rank and position to that of Supervisor:

i) in cases where physical harm has been sustained to a child in respect of whom a notification has been made, or in cases where such physical harm has been reported;

ii) where domestic violence has occurred or has been reported within a family, where such domestic violence has not necessarily involved the specific child to whom the notification relates;

iii) in cases where there has been a reported disengagement by the family from health and other services which to that point in time have been provided.

14.10. I recommend that all other Families SA file closures be reported to an officer of higher rank than Supervisor as and when those files are closed.

14.11. I recommend that in cases where the family of a child who is the subject of a notification to Families SA has disengaged with health and other services, that such disengagement be immediately reported to Families SA by way of further notification or otherwise, and that in such circumstances a Families SA worker should immediately be dispatched to the home of that family to investigate the reason for disengagement from services. In all such cases the family should be warned, both in person and in writing, that any further disengagement from services might well involve the taking of action against that family pursuant to the Children's Protection Act 1993. I further recommend that Families SA thereafter continue to monitor on a regular basis the engagement of that family with health and other services, and to insist upon regular reports from those services concerning the engagement or otherwise of that family with those services. I recommend that under no circumstances should a file ever be closed where reported disengagement from health and other services has taken place.

14.12. I recommend that the Minister for Education and Child Development, the Minister for Child Protection Reform, the Chief Executive of the Department for Education and

Child Development, the Minister for Health and the Chief Executive of the South Australian Department for Health and Ageing conduct a full reassessment of the manner in which health services, including the Women's and Children's Hospital, the Children, Youth and Women's Health Service, and Child and Family Health Services and Families SA interact in cases involving child protection matters.

14.13. I recommend that Families SA ensure that there are systems in place that will result in the escalation of Families SA scrutiny and oversight of notified matters in circumstances where the subject family has been reported as having disengaged from services.

14.14. I recommend that Families SA instruct all staff that the closure of a notification file does not of itself relieve Families SA of the responsibility for the care and protection of the relevant child. Families SA should urge staff not to place undue emphasis on the formality of file closure, but rather to examine the substance of any further information that comes to hand regarding the risks posed to a child who was the subject of the original notification. I further recommend that Families SA implement a system that would, in cases that have involved high risk to a child, facilitate the continued monitoring and scrutiny of families notwithstanding the closure of a notification file.

14.15. I recommend that Families SA introduce requirements and measures that would ensure that where due to a lack of resources any matter is not being adequately managed or investigated, the matter is immediately drawn to the attention of the Chief Executive of the Department for Education and Child Development.

14.16. I recommend that staff members of services such as Children, Youth and Women's Health Service and Child and Family Health Services be trained in specific child protection issues and that they be encouraged to have regard to the need in given cases to assertively engage with families. Families who disengage from services should be reported to Families SA as and when such disengagement occurs.

14.17. I recommend that where a family has been engaged with health or other services, and where Families SA intends to close its file, that the various service entities be advised of that intention before closure actually occurs.

14.18. I recommend that regular formal inter-agency liaison meetings occur as between the various service providers and Families SA to discuss families at risk.

14.19. I recommend that the Minister for Police and the Commissioner of Police ensure that data retention systems are in place such that reported incidents involving the same family are together collated. Such a system should enable police officers to ascertain immediately whether a family in respect of whom they are conducting an investigation has been the subject of any previous interaction with police or has been the subject of any notification to Families SA.

Key Words: Child Abuse; Child Protection; Families SA (Department of Education and Child Development); Domestic Violence

In witness whereof the said Coroner has hereunto set and subscribed his hand and

Seal the 28th day of January, 2016

Deputy State Coroner

Inquest Number 16/2015 (1846/2011)