CORONERS ACT, 2003

SOUTH *AUSTRALIA*

FINDING OF INQUEST

An inquest taken on behalf of our Sovereign King at Adelaide in the State of South Australia, on the 9th day of September, the 29th and 30th days of November, the 5th, 6th, 7th, 8th, 9th, 12th, 14th, 15th and 20th days of December 2022 and the 28th day of June 2024, by the Coroners Court of the said State, constituted of David Richard Latimer Whittle, State Coroner, into the death of Caleb Evans (a pseudonym-name suppressed).

The said Court finds that Caleb Evans aged 2 months, late of (suppressed), South Australia, died at (suppressed) in the State of South Australia on the 30th day of November 2018 as a result of an unascertained cause, in an unsafe sleeping environment, on a background of respiratory tract infection. The said Court finds that the circumstances of his death were as follows:

1. Suppression order

1.1. In this Inquest a suppression order was made prohibiting from publication the names, images, addresses and any evidence tending to identify the deceased and their family members. In this Finding the relevant parties have been assigned pseudonyms for ease of reading and to ensure anonymity.

2. Introduction and reason for inquest

2.1. Baby Caleb Evans (baby Caleb) was born on [redacted] September 2018. He died on 30 November 2018. He was just under 11 weeks old. He was the third child of Ms Angela Evans[1] and his father was Mr Leon Sawyer.[2]

[1] DOB [redacted]
[2] DOB [redacted]

2.2. Ms Evans gave birth to her first child, Dawn, on [redacted] 2015. Her father is Mr Seth Miller. Ms Evans' second daughter Eva was born on [redacted] 2017. Her father is Mr David Stewart. Ms Evans was pregnant with Dawn at 14 years of age, Eva at 16 years of age, and baby Caleb at 17 years of age.

2.3. Since the birth of Dawn in 2015, numerous notifications were made to the Department for Child Protection (DCP) about Ms Evans' capacity to care for the children. A common theme throughout the notifications was that Ms Evans and the children were living in squalor.

2.4. The last notification made concerning baby Caleb was on 20 November 2018. Ten days later, baby Caleb died.

2.5. Ms Evans provided an account of the evening leading up to baby Caleb's death in an affidavit[3] and in a conversation with police which was recorded on video.[4] She stated that she put baby Caleb to bed at approximately 10pm on 29 November 2018 on a fold-out sofa[5] in the lounge room of the family home. She lay on the chaise of the sofa with baby Caleb and fell asleep cuddling him. She did not use a pillow. She propped baby Caleb's head up on her left arm as he lay on his back next to her. She shared a lightweight mink[6] blanket with him. Baby Caleb's older siblings were sleeping on the mattress part of the fold-out sofa.[7] Ms Evans said she also had a friend sleeping over on this evening, on the other side of the sofa, under the air conditioner on the wall.[8]

2.6. Ms Evans' account was that she woke up at approximately 3:45am on 30 November 2018 anticipating baby Caleb to wake up for a bottle. She looked at baby Caleb and he was very pale, so she put her hand on his forehead and felt that he was cold. She grabbed her mobile phone and immediately called for an ambulance.

2.7. Baby Caleb was in asystole upon the arrival of the SA Ambulance Service (SAAS).[9] He was transported by SAAS to the Port Pirie Hospital but was unable to be revived.

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[3] Exhibit C5
[4] Exhibit C31b, Video DMW2
[5] This was a U-shaped sofa with a fold-out bed in the middle and to one side of the bed a chaise section
[6] Ms Evans' description
[7] Exhibit C31b, Video DMW2 at 03:22
[8] It is curious that Ms Hawthorn details in her affidavit, Exhibit C7, that '*I was drifting off to sleep and shortly after went to bed*'
[9] Exhibit C8, paragraph 7

3. State of house at the time of baby Caleb's death

3.1. Detective Brevet Sergeant Kym Mayger of South Australia Police (SAPOL) attended at the Evans family home on the morning of 30 November 2018, after baby Caleb's death. He recorded on video the state of the house during a walk-through.[10]

3.2. Crime Scene Investigator, Brevet Sergeant Allison Huppatz, attended the home on 30 November 2018 to examine the scene, collect evidence and take photographs. In her affidavit[11] she described the house as being in a '*dirty, untidy, disgusting state*'[12] and described the following observations, which are consistent with what can be observed in Detective Mayger's video:

- Faeces on the floors;
- Rotten food in the pantry and on the floor and stove in the kitchen;
- Several baby bottles in the kitchen containing putrid liquid which appeared to be curdled milk;
- There was no food in the fridge other than some frozen meat in the freezer;
- There was a small amount of food in the pantry, but it was infested with cockroaches;
- There was a baby formula tin open on the kitchen cupboard surrounded by dead flies;
- Inside all rooms of the house there was a strong smell of urine, faeces and rotting food;
- Clean and dirty clothes on many surfaces in all the rooms;
- A mop bucket on the bathroom floor which contained putrid liquid; and
- A cot contained a soiled nappy and clothing.

3.3. Detective Mayger undertook a squalor assessment using the SA Health Severe Domestic Squalor Assessment and the home scored 21/30.[13] A score of 12 or more indicated moderate or severe squalor requiring intervention.

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[10] Exhibit C31b
[11] Exhibit C22
[12] Exhibit C22, paragraph 20
[13] Exhibit C31a, page 83

3.4. Detective Mayger's view, based on his observations of the home, was that the house was likely to have been in squalor for a number of months.[14]

3.5. Based on the video of the walk-through of the home, the crime scene photographs, Detective Mayger's opinion following his inspection of the home, and the fact that a visitor to the home on 14 September 2018, who sighted only the lounge room, described food scraps everywhere and general waste scattered on all surfaces including mail, snack boxes and general household trash,[15] I find that the home was likely in a squalid state for a number of months in the lead up to baby Caleb's death - likely for the entirety of his short life.

4. Reason for inquest

4.1. An inquest was held per Section 13 of the *Coroners Act 2003* (SA) to explore both the cause and circumstances of baby Caleb's death.

4.2. That Ms Evans and her offspring were living in squalor was a matter that had been brought to the attention of the Department for Child Protection (DCP) on a number of occasions, both before and after baby Caleb's birth.

4.3. This inquest considered the impact of the squalid state of the home on baby Caleb's death, and whether baby Caleb's death could have been prevented by the DCP assuming a more vigorous role in the protection of baby Caleb.

4.4. The inquest also examined the involvement with baby Caleb of Child and Families Health Services (CaFHS).

4.5. All coronial findings must be based on proof of relevant facts on the balance of probabilities. I am guided by the principles enunciated in *Briginshaw v Briginshaw*, having the effect in this jurisdiction that a coroner should not make adverse findings against, or comments about individuals, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

4.6. I have considered all of the evidence but here refer to it only in such detail as appears warranted by its forensic significance and the interests of narrative clarity.

[14] Transcript, page 134
[15] Exhibit C26, page 649

5. Evidence at inquest

5.1. At the inquest I heard oral evidence from the following nine witnesses:

1) Detective Brevet Sergeant Kim Mayger of Port Pirie CIB undertook the coronial investigation into baby Caleb's death. He also undertook a criminal investigation into whether offences of neglect had been committed by baby Caleb's mother.

2) Dr Stephen Wills undertook a post-mortem examination of baby Caleb. Dr Wills is a Senior Specialist Forensic Pathologist at Forensic Science South Australia (FSSA). He is a fellow of the Royal College of Pathologists in the UK and a fellow of the Royal College of Pathologists of Australasia.

3) Associate Professor Dr Michael Starr is a Consultant Paediatrician, Infectious Diseases Physician and Consultant in Emergency Medicine. His position is Staff Specialist in General Paediatrics, Infectious Diseases and Emergency Medicine, and he is Director of Paediatric Education at the Royal Children's Hospital Melbourne and Honorary Clinical Associate Professor at the University of Melbourne. His qualifications are Bachelor of Medicine, Bachelor of Surgery and Fellow of the Royal Australasian College of Physicians (Paediatrics and Infectious Diseases). Dr Starr was engaged by the Coroners Court to provide an independent expert opinion.

4) Ms Rachel Mayfield was the case manager at Targeted Intervention Service of Uniting Country SA in 2018. She was involved with the Evans family in the period leading to baby Caleb's death.

5) Mr David Armour is a Senior Practitioner at the Child Abuse Report Line for DCP. He has been in this role since 2016.

6) Ms Dianne Longman was a Supervisor in the DCP Port Pirie Office in 2018.

7) Ms Susan Macdonald is an Executive Director for the DCP.

8) Mr Patrick Kinnear was the Manager of the Port Pirie and Kadina Office of the DCP in 2018.

9) Ms Lynne Kurtzer was, at the time she gave evidence, the Acting Co-Director of CaFHS.

5.2. In addition to the oral evidence, the Court received into evidence records from the Port Pirie Hospital, the medical practices which baby Caleb had attended, DCP, CaFHS and Uniting Country SA (UCSA), as well as affidavits from a number of witnesses who were not called to give oral evidence, namely:

- Ms Tamara Evans (baby Caleb's maternal grandmother);
- Ms Angela Evans (baby Caleb's mother);
- Mr Leon Sawyer (baby Caleb's father);
- Ms Tanisha Hawthorn (friend of Angela Evans);
- Dr Peter Blumbergs (FSSA);
- Dr Penny Kostakis (FSSA);
- Mr Scott Payne (SAAS);
- Detective Paul Ward (SAPOL Major Crime);
- Constable Joel Morley (SAPOL);
- Brevet Sergeant Craig Robertson (SAPOL);
- Ms Christine Mackinnon (midwife Crystal Brook Medical Centre);
- Brevet Sergeant Allison Huppatz (SAPOL);
- Dr Prasanna Jayasinghe (medical practitioner, Terrace Clinic);
- Dr Janine Tee (forensic paediatrician);[16]
- Ms Josephine Probin (CaFHS, retired);
- Ms Jessica Trapodi; and
- Ms Jacqueline Campbell (DCP).

5.3. With the leave of the Court, the following counsel appeared to represent witnesses and interested parties:

- Ms S Giles, Counsel Assisting;
- Ms A Doecke for the Chief Executive of the DCP and CaFHS;
- Mr J Homburg for Ms Dianne Longman;
- Ms K Smith for Ms Rachel Mayfield.

[16] Dr Tee provided a report, which was not in affidavit form

5.4. Following the conclusion of the inquest, I received comprehensive written submissions from counsel.[17]

6. Cause of death

6.1. The inquest heard evidence from two witnesses as to the cause of baby Caleb's death: Dr Wills, Senior Specialist Forensic Pathologist and Associate Professor Dr Michael Starr, Consultant Paediatrician, Infectious Diseases Physician and Consultant in Emergency Medicine.

6.2. The cause of death was not entirely straightforward. Their evidence focussed on two factors that may have caused or contributed to baby Caleb's death; a respiratory tract infection and an unsafe sleeping environment.

6.3. Respiratory tract infection

6.4. Baby Caleb had been unwell with respiratory symptoms for several weeks leading up to his death. According to Ms Evans:

> 'When baby Caleb was about 2.5 weeks old he developed a viral respiratory infection which never cleared up … baby Caleb's symptoms included heavy breathing, when he was sleeping he would gasp for air, he would have coughing fits and his lips would turn blue, and he had an audible crackling sound when he was breathing.' [18]

6.5. Baby Caleb was diagnosed with a respiratory tract infection on 6 November 2018,[19] and also attended both the hospital and general practitioner (GP) on 23 October 2018[20] about a persistent cough and noisy breathing.

6.6. Dr Jayasinghe treated baby Caleb for a respiratory illness in the days leading up to his death[21] and on 23 November 2018 prescribed an antibiotic, amoxycillin, and referred baby Caleb to a paediatrician.[22] A nasal swab revealed the presence of rhinovirus.

6.7. Dr Jayasinghe again saw baby Caleb on Monday 26 November 2018 and noted that he was still coughing but not in respiratory distress and his lungs were clear.[23] His plan

[17] Counsel for Ms Mayfield made no submissions
[18] Exhibit C5, paragraph 6
[19] Exhibit C13, pages 61-75
[20] Exhibit C12, pages 13-14, discharge summary
[21] Exhibits C23 and C23a
[22] Exhibit C23, paragraph 14
[23] Exhibit C23, Exhibit C14, page 4

was for baby Caleb to continue antibiotics and return for review on Friday, 30 November 2018.[24]

6.8. In his oral evidence, Dr Wills stated that '*respiratory tract infection*' is more appropriately expressed as a factor in baby Caleb's death rather than *the* cause of death.[25] He concluded that the respiratory tract infection was a factor in baby Caleb's death based on the pneumonia he observed in baby Caleb's lungs.[26]

6.9. However, there was a divergence of opinion between the experts as to whether the respiratory tract infection contributed to baby Caleb's death.

6.10. Dr Starr was of the opinion that the small foci of acute pneumonia in the lungs as observed at post-mortem does not necessarily indicate that baby Caleb had pneumonia at the time of death. His evidence was that the small foci of acute pneumonia in the lungs were likely caused by a virus, rather than the bacterial pathogens identified at post-mortem.[27] Dr Starr's evidence was that the small foci of pneumonia could have been caused by rhinovirus,[28] adenovirus, or any other virus.[29]

6.11. Dr Starr indicated that the lack of consolidation in the lungs noted at post-mortem was relevant, because pneumonia causes consolidation in a focal area, and if baby Caleb had a severe respiratory illness, he would have expected to see some consolidation in the lungs.[30] Dr Starr's evidence was that the x-ray taken of baby Caleb's chest on 7 November 2018:

> '… shows an inflammatory change around the airways that were probably caused by a virus and I think would be consistent with some tiny patches around the lungs of pneumonia as described by the pathologist caused by a virus maybe from the stage, as I say quite possibly already improving. Certainly not severe or life threatening.'[31]

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[24] FSSA undertook testing on blood to ascertain if there was the presence of amoxicillin in baby Caleb's blood at the time of death. It was not detected, but the evidence of Dr Wills was that the absence of amoxycillin in baby Caleb's blood at post-mortem does not necessarily suggest he was not being given the antibiotics he was prescribed. Given Professor Starr's evidence about the fact that baby Caleb did not in fact require antibiotics at that time, whether or not he was being properly administered the amoxycillin prescribed by Dr Jayasinghe is therefore of no consequence.

[25] Transcript, page 180

[26] Transcript, page 179

[27] Transcript, page 227

[28] Rhinovirus was detected in baby Caleb at post-mortem (Exhibit C2)

[29] Transcript, page 227

[30] Transcript, page 228

[31] Transcript, page 232

His evidence was that if baby Caleb had died moments after this x-ray, he would anticipate findings as found in the post-mortem report, and that '*there's no way that caused the death*'.[32]

6.12. Of Dr Jayasinghe's observations of baby Caleb on 26 November 2018, Dr Starr indicated that '*he's observing a well baby that's still got a cough*'.[33] He indicated that it is possible for the small foci of pneumonia to have been on baby Caleb's lungs at the time of his consultation with Dr Jayasinghe on 26 November 2018 but for Dr Jayasinghe to have observed, as recorded, that there was no respiratory distress, clear lungs and conducting sounds.[34] He also stated it is possible that baby Caleb's condition deteriorated between that appointment and his death, but noted that there is no evidence of that. In particular, despite Ms Evans mentioning that the day before his death she could hear a '*crackle sound*',[35] she did not describe baby Caleb as being otherwise unwell that day.[36] Also of note is Ms Tamara Evans' observation in relation to a visit with baby Caleb the day before his death that '*I remember baby Caleb being happy on this day. He had a little bit of a cough but actually seemed to be breathing a bit better than normal*.'[37]

6.13. As to whether baby Caleb did in fact have a respiratory tract infection at the time of his death, Dr Starr's evidence was that '*technically, yes, he had a respiratory infection, not one that would kill you*'. As to whether the respiratory infection was a factor in baby Caleb's death, Dr Starr opined that '*I couldn't say that it was a factor, it may have been*'. He was firmly of the view that the unsafe sleeping environment is much more likely to have been a factor.[38]

6.14. <u>Baby Caleb's sleeping environment</u>

6.15. Safe sleeping recommendations are well-known and widely available. Dr Wills stated:

> 'The ideal sleeping environment for a baby is on their back in a cot with their feet at the base on a firm approved mattress without soft toys, without pillows and the more you move away from that then the less safe it becomes.' [39]

[32] Transcript, page 233
[33] Transcript, page 236
[34] Transcript, page 239
[35] Exhibit C5
[36] Transcript, page 239
[37] Exhibit C1a, paragraph 21
[38] Transcript, page 245
[39] Transcript, page 175

6.16. Dr Wills detailed in his post-mortem report that:

> 'The risk of unexpected death in infancy is increased when infants co-sleep with adults, particularly in unsafe sleeping environments such as sofas. Some of this increased risk is thought to be mediated by asphyxia which may include being overlain or having respiration restricted in some way by a sleeping adult or by bedding or the sleeping surface. In such circumstances it is rarely possible to confirm or exclude asphyxia and/or overlaying; positive post-mortem findings typically being non-specific or absent.' [40]

6.17. If I accept Ms Evans' account of where everyone in the household was sleeping on the evening of baby Caleb's death, and in particular where baby Caleb was sleeping relative to her, and if indeed baby Caleb and Ms Evans remained in those positions for the duration of their sleep that evening, then factors that would have made that sleeping environment unsafe were:

6.17.1. Sleeping on the couch. According to Dr Wills:

> 'Sofas are one of the known risk factors of an unsafe sleeping environment probably because of the corners and easy to get wedged or trapped or some form of airway obstruction.' [41]

According to Dr Starr, if baby Caleb was sleeping next to the arm of the chaise lounge on the couch, that would have been unsafe due to the risk of being sandwiched into the arm rest and being smothered and asphyxiated in that spot.[42]

6.17.2. Co-sleeping with his mother. The risks associated with that include the risk of being sandwiched between the mother and the armrest and being smothered and asphyxiated in that spot.[43]

6.17.3. The fact that Ms Evans was a smoker.[44] According to Dr Starr:

> 'Being close to another person in close quarters appears in and of itself to be a risk, particularly if they're a smoker they can inhale the smoke from that person.' [45]

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[40] Exhibit C2
[41] Transcript, page 175
[42] Transcript, page 220
[43] Transcript, page 220
[44] Although there is no evidence of whether or not Ms Evans was a smoker at the time of baby Caleb's death, she reported that she smoked 12-15 cigarettes a day during the pregnancy with baby Caleb (Exhibit C5, paragraph 4), and a packet of cigarettes is observed in the photographs of the home on the morning of baby Caleb's death, and so the evidence suggests that Ms Evans was a smoker at the time of baby Caleb's death.
[45] Transcript, page 214

6.17.4. The gap between the chaise section of the sofa and the fold-out mattress. There is evidence that there was a 16cm gap between the mattress of the fold-out sofa and the chaise portion of the sofa.[46] According to Dr Starr:

> 'The risk is falling into that gap and becoming wedged, being - and then having their airway blocked by one mechanism or another. The little baby, of course, has got a small airway that if the baby fell into that space or became - even not fell into it completely, but head became ... into that, they would potentially be smothered and asphyxiated.' [47]

6.17.5. The '*mink*' blanket covering Ms Evans and Baby Caleb. Dr Starr explained that loose materials in a bed with a baby create a risk of the baby becoming encumbered in that.[48]

6.18. However, Ms Evans was not called to give oral evidence in this inquest. Therefore, she was not cross-examined, nor did she have the opportunity to comment on whether she maintains her account in her affidavit or the explanation she gave to Detective Mayger depicted in the video. For that reason, I can place only limited weight on Ms Evans' account of baby Caleb's sleeping position at the time of his death. There is also no way of knowing how Ms Evans moved in sleep or how baby Caleb moved in his sleep or when in the night his death occurred.[49]

6.19. However, the presence of a pressure mark on baby Caleb's chin and neck, as described in detail in the post-mortem report, causes me to doubt that baby Caleb was positioned on his back in his mother's arm for the duration of his sleep in the lead up to his death.

6.20. According to Dr Wills:

> 'The presence of a pressure mark on the inferior aspect of the chin, aligning with a faint red mark upon the left anterior aspect of the neck, suggest the deceased's chin and neck may have been positioned, at some point, over an edge or linear structure of some kind, possibly a seat cushion.' [50]

[46] Transcript, pages 120-121
[47] Transcript, page 223
[48] Transcript, page 225
[49] Transcript, page 197
[50] Exhibits C2 and C11

6.21. Although Ms Evans told police that mark was caused by baby Caleb rolling on to a toy, police did not accept that explanation and Major Crime Detective Paul Ward expressed his opinion that:

> 'When in the folded out position the metal frame supporting the mattress is consistent with the deceased laying on it which created the linear mark on the deceased which ran from the deceased chin to the left shoulder.' [51]

6.22. Dr Wills was clear that mark was not causative of baby Caleb's death,[52] and that it is impossible to tell whether that occurred before or after baby Caleb's death. He stated that, '*all it means, that either around the time of death or after death that area of the body was potentially resting on something with an edge*'.[53] However, the presence of that linear mark on baby Caleb's face suggested he has, at some point during his sleep, been in a position other than that as described by Ms Evans – on his back, in her arm.

6.23. If baby Caleb was in fact sleeping on the mattress of the fold out bed with his siblings, rather than on the couch next to his mother as she described, that too would have been unsafe because:

> '… the area is filthy, for starters. There are pillows there which - and a blanket - so the risk of becoming encumbered in that as a baby would be increased. You don't want loose materials in a bed with a baby, so those are the main factors. And then co-sleeping with the other children around a baby would be a risk.' [54]

6.24. Without making any finding as to the precise position baby Caleb was in in the hours before or when he died, the evidence indicates that baby Caleb was sleeping in an unsafe sleeping environment, because according to the report of Dr Janine Tee, there was no safe sleeping environment for a baby in that house as observed shortly after baby Caleb's death. Dr Tee stated:

> 'The observed condition of the porta cot and timber cot was not considered suitable or safe for an infant to sleep in, nor was the condition of the remaining bedding in the home suitable for use.' [55]

6.25. I find therefore that at the time of his death, baby Caleb was in an unsafe sleeping environment.

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[51] Exhibit C9, paragraph 7
[52] Transcript, page 190
[53] Transcript, page 190
[54] Transcript, page 221
[55] Exhibit C24

6.26. Both Dr Wills and Dr Starr expressed the opinion that baby Caleb's unsafe sleeping environment was likely a factor in his death.

6.27. Relative contributions of respiratory tract infection and unsafe sleeping environment

6.28. In his report Dr Wills stated under the heading of cause of death '*respiratory tract infection (please see comments)*'.[56] Dr Wills was asked why he had expressed the cause of death in his report in this manner with '*(please see comments)*' and his evidence was:

> '... we can prove that he's got a potentially pathologic significant respiratory tract infection but also the circumstances suggest there may well have been other factors involved and clearly there's good evidence as to co-sleeping and an unsafe sleeping environment, high risk factors for infant deaths …
>
> what I wanted to bring attention to, well we know he's got a respiratory tract infection that's potentially significant but there are also risk factors that I wanted to draw the reader of my report's attention to which is why I specifically put "please see comments" to make sure that those risk factors were not overlooked.' [57]

6.29. A difficulty with identifying the possible contribution of an unsafe sleeping environment to an infant's death is that in such deaths there are usually no positive findings at autopsy to conclusively confirm the death was caused by, or contributed to, an unsafe sleeping environment.[58] Dr Wills stated that:

> 'The typical finding in a co-sleeping death or potentially overlaying death or head caught in the pillow, you generally wouldn't find anything specific at all, that's the negative autopsy is what you would expect in those circumstances.' [59]

6.30. Both Dr Wills and Dr Starr agreed that the relative contributions of the respiratory tract infection and unsafe sleeping environment to baby Caleb's death could not be determined.[60]

6.31. Counsel Assisting submitted that in the face of Dr Starr's doubt as to whether the respiratory tract infection did contribute to baby Caleb's death,[61] coupled with the

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[56] Exhibit C2
[57] Transcript, page 180
[58] Transcript, page 176
[59] Transcript, page 184
[60] Transcript, page 183
[61] Dr Starr's evidence was that the respiratory tract infection may have been a factor in baby Caleb's death, not that it certainly was. His evidence (page 244) was to conclude respiratory tract infection was a factor in baby Caleb's death, '*I'd want to see that he actually was sick from this respiratory illness beforehand, to feel that it was likely to have been a factor in his death. Granted those organisms were seen there post-mortem, but he had respiratory symptoms in the preceding weeks, but he was getting better, if anything, and he didn't have a severe infection either clinically or at post-mortem. So, those various germs might have been a factor in his death, but I can't say they were a factor in his death*'.

difficulty in assessing the relative contributions of the respiratory tract infection and the unsafe sleeping environment, baby Caleb's cause of death can be most appropriately expressed as '**unascertained, in an unsafe sleeping environment, on a background of respiratory tract infection**'. This correctly expresses my conclusion as to the cause of death and I so find.

7. Did the home environment contribute to baby Caleb's death?

7.1. In her report, forensic paediatrician Dr Janine Tee from the Child Protection Services at the Women's and Children's Hospital concluded that:

> 'The environment in which the children were living placed them at risk of both physical and psychological harm and was not considered to be adequate in relation to what is necessary for optimal child health and wellbeing.' [62]

I accept this opinion and find that the home in which baby Caleb lived placed him at risk of physical and psychological harm and was not adequate for optimal child health and wellbeing.

7.2. However, the role of the squalid home environment in contributing to baby Caleb's death is unable to be determined.

7.3. It is possible that the squalid state of the home contributed to baby Caleb suffering a respiratory tract infection at the time of death. Dr Wills' evidence was that he attributed baby Caleb's death to a respiratory tract infection in his post-mortem report due to the presence of the small foci of pneumonia in baby Caleb's lungs. Dr Starr's evidence was that rhinovirus or adenovirus (or any other virus) could have accounted for the small foci of pneumonia in baby Caleb's lungs at post-mortem (rhinovirus was detected at post-mortem). In his report Dr Starr indicated, in relation to baby Caleb having had rhinovirus in the lead up to his death, that '*poor hygiene practices by those caring for baby Caleb may have contributed to infection*'.[63]

7.4. When asked whether there could be any connection between the home environment and baby Caleb being infected with rhinovirus, Dr Starr stated:

> '… it's spread by direct contact and respiratory droplets and so people in close quarters and living in the bush and sharing very close spaces are a risk, so that happens in any home environment, an environment where things are not kept clean, hands aren't washed and so

[62] Exhibit C24
[63] Exhibit C33

> on, the risk would be higher … I'd say it would have been more likely to have occurred in this environment, but as we know the common cold is spread very readily in households.' [64]

On the basis of this evidence, it is possible that the behaviour of the people in the home contributed to baby Caleb contracting the respiratory tract infection.

7.5. Furthermore, whilst it may be that the squalid state of the home was one reason why baby Caleb was sleeping in an unsafe sleeping environment at the time of his death, I accept that there are a number of other reasons why Ms Evans may have chosen to put baby Caleb to sleep in an unsafe environment, the availability of more suitable alternatives notwithstanding. Ms Evans was not called to give evidence about this, and it would be speculative to make a finding that the absence of adequate bedding is the explanation for baby Caleb's unsafe sleeping position.

7.6. Thus, while the squalid state of the home *may* have contributed in some way to both baby Caleb's respiratory tract infection and the decision to have baby Caleb sleep in an unsafe sleeping environment, in the face of an unascertained cause of death, I cannot conclude on the balance of probabilities that the squalid state of the home contributed to his death.

8. The relevant legislation

8.1. The *Children's Protection Act 1993* was in operation throughout most of the period of Ms Evans' pregnancy with baby Caleb. That Act was subsequently repealed on the full commencement of the *Children and Young People (Safety) Act 2017* (CYPSA) on 22 October 2018, the month before baby Caleb's death. The CYPSA was introduced subsequent to the findings and recommendations of the Nyland Royal Commission into Child Protection in the report 'The Life They Deserve' and incorporated many of the recommendations made by the Royal Commission.

8.2. The focus of this inquest was the DCP response to notifications made about baby Caleb (and his siblings). Due to the date on which the CYPSA commenced relative to baby Caleb's death, some notifications that were the subject of scrutiny at the inquest were made under the Children's Protection Act, and some were made under the CYPSA.

[64] Transcript, page 208

9. Ms Evans' involvement with DCP prior to pregnancy with baby Caleb

9.1. On 5 August 2015 and 4 November 2015,[65] two Unborn Child Concern (UCC) intakes were raised in relation to Ms Evans' first child Dawn. Ms Evans (then aged 14 years) was reported to be engaging with support services but there were concerns about her ability to manage the care of the infant once born. The DCP referred the case to the DCP Linking Families Team who successfully referred the case to Uniting Care Wesley Country South Australia (UCWCSA). The DCP found Ms Evans was attending her scheduled appointments with her midwife and was receiving support from a BoysTown worker and closed the case on 1 December 2015.

9.2. On 22 January 2016,[66] a Tier 2 intake was raised in response to two e-CARL[67] notifications made on 17 December 2015 (prior to Dawn's birth) and 24 December 2015 (after Dawn's birth on [redacted] 2015). It was reported that Ms Evans had been referred to the Child and Adolescent Mental Health Services (CAMHS) by her GP on 2 November 2015 for suicidal ideation and depression. Ms Evans was also experiencing volatile mood swings and was engaged in conflict with her family. Concerns were raised that Ms Evans had not attended her CAMHS appointments on 30 November and 15 December 2015. Ms Evans gave birth to Dawn on [redacted] 2015. Ms Evans' poor mental health, poor engagement with mental health services, and her young age and immaturity were thought to represent a significant risk to the infant. It was noted that BoysTown, CAMHS and Environmental Health were offering support to Ms Evans, a referral had been made to Child and Youth Health and the midwifery team would continue to support her for six weeks postnatal. The case was closed on 25 January 2016, with a comment recorded that '*according to the intake a 6-week midwife input will occur to monitor the baby and mother*'.

9.3. On 25 February 2016[68] and 18 August 2016,[69] two Tier 2 intakes were raised when concerns were reported about Dawn's living conditions. Ms Evans was living with her boyfriend and his family and was reported to be withdrawing from support services and Dawn was said to have a poor attachment with Ms Evans. The intakes were both

[65] Exhibit C26
[66] Exhibit C26
[67] E-Child Abuse Report Line
[68] Exhibit C26
[69] Exhibit C26

'*closed no action*' ('CNA' was the Department for Child Protection parlance and will here be used interchangeably with 'closed no action') due to workload issues.

9.4. On 8 and 10 November 2016,[70] a UCC and a General Practice intake were raised when it was reported that Ms Evans was pregnant with her second child.

9.5. Between February and May 2017, leading up to the birth of Ms Evans' second child Eva, three Tier 2 intakes[71] were raised for Dawn and two UCC intakes were raised for unborn Eva. These intakes each contained the same information that Dawn was being neglected and may have been at risk from drug users coming to the home. Ms Evans was said to be using cannabis daily with her partner Mr Stewart. The notifier was uncertain if Ms Evans was engaged with antenatal care but was concerned Dawn was not receiving adequate medical checks. The DCP referred the first Tier 2 intake to the UCWCSA Family Preservation Program, and the following two intakes were allocated for investigation and assessment. The DCP caseworker contacted some of the service providers believed to be working with Ms Evans to gain their feedback on her engagement and progress and received varying responses. While the Environmental Health worker provided feedback saying that Ms Evans was engaging with a cooking program, the CaFHS worker stated that '*Angela continues to either engage superficially with services or not at all*'.

9.6. Email correspondence between the DCP, CAMHS and CaFHS in May 2017 indicated that CaFHS was likely to cease involvement with the family '*…as [the] mother will not address mental health concerns which effectively impacts on the delivery of the Family Home Visiting Program*'. CaFHS highlighted the following outstanding concerns:

- continues to either engage superficially with services or not at all;
- has suicidal ideation without any formal mental health assessment;
- no plan of action for the birth of new baby or after the baby arrives;
- no psych and parenting capacity assessment.

9.7. Ms Evans also failed to engage with CAMHS in relation to her own mental health which resulted in the case being closed.

[70] Exhibit C26
[71] Exhibit C26

9.8. On 9 June 2017, the UCWCSA advised the DCP caseworker via email that Ms Evans had cancelled four appointments and they were yet to start working with her. Follow-up feedback from UCWCSA on 29 June 2017 indicated that '*Angela is engaging well*' and Mr Stewart was engaging with DASSA and planning to participate in anger management counselling. Ms Evans had been to the GP about her mental health, but the GP would not provide mental health support until after the birth of Ms Evans' second child. A Structured Decision Making (SDM) risk assessment was completed with an outcome of '*high*' being recorded. Closing the case with a high-risk outcome was recorded as being appropriate because it was assessed that there were services in place. The services included the Department of Education, CaFHS, Yourtown, DCP financial counsellors, Environmental Health, UCWCSA, DASSA, a GP, an obstetrician and Housing SA.

9.9. On 29 June 2017, the outcome rationale recorded for the Tier 2 intakes stated, '*…the alleged risk grounds screened-in were not identified due to any evidence of serious neglect due to the mother's actions/inactions*'. Concerns in relation to the home environment were also not substantiated. As part of the investigation drug tests were undertaken by Ms Evans and Mr Stewart. Ms Evans' test was negative; however it was reported that Mr Stewart's results indicated that he had high levels of cannabis in his system. Mr Stewart agreed to engage with Drug and Alcohol Services (DASSA) to address his drug use.

9.10. The case was closed on 29 June 2017, [redacted] days prior to the birth of Eva, with the risk being assessed as '*high*'. The recorded rationale referred to adequate support services being in place at the time of closure and highlighted the positives which included Ms Evans' attachment with Dawn, her appropriate parenting skills, and her ability to meet Dawn's medical needs.

9.11. On [redacted] July 2017, a notification was raised in relation to the birth of Eva. The Port Pirie Hospital was discharging Ms Evans and Eva who were going to live with Ms Evans' parents. The notifier reported the mother was 16 years old and Eva was her second child. The notifier said that mother and newborn had been discharged without any issues at present. This particular notification was recorded to be a '*notifier only concern*' (NOC).

9.12. The code NOC is used where a notification does not meet the criteria or threshold for intervention by the DCP. A NOC effectively closes off a notification and no further action will be taken. This procedure applies to notifications in which a CARL worker considers that the report does not constitute reasonable suspicion of child abuse or neglect as defined by the Act and can also be used when the information or observations on which the notifier formed his or her suspicion do not constitute reasonable grounds for the suspicion. The decision and rationale recorded for the NOC assessment stated that:

> '… despite the fact the family have a CP history and are considered young to have two children under the age of 19 months, there is insufficient information reported today to reasonably assume that the child is at significant risk of serious harm and/or neglect and therefore RN09 (Young Age of Guardian) could not be met.'

9.13. On 23 October 2017, a General Practice intake was raised after an informant had told the notifier that several days ago, they had seen Dawn being shown by another young child how to use a tampon. The decision and rationale assessed the report as '*general practice*' and for information only because there was no information to determine if the incident was of a sexual nature.

9.14. On 30 November 2017, a Tier 2 intake was raised when it was reported Eva's father, Mr Stewart, had threatened to kill Ms Evans. Dawn and Eva were alleged to have been exposed to the verbal argument and similar incidents had occurred on previous occasions. The intake was closed with an outcome of CNA by the Port Pirie office on 5 December 2017 due to a lack of capacity across the office to allocate the case.

10. Notifications made during Ms Evans' pregnancy with baby Caleb

10.1. The first notification made in relation to baby Caleb was on 14 March 2018 and was raised as a UCC.[72] A notification was raised in relation to Dawn and Eva.[73] The notifier informed the CARL hotline that the family was at that time living in Port Augusta. The record of notification reads:

> 'Young family … living in squalor - appears to be 2 females, 3 males and 5 children. The house is filthy and is only cleaned when they have house inspections through the real estate. All children under school age. There are faeces, rubbish and dirty clothes along hallway and in front yard … The house appears to allow transient people to stay there.

[72] Exhibit C19, page 21
[73] Exhibit C26, page 180

> There is rubbish all through the property which raises concerns over the welfare of the children residing at the home.' [74]

10.2. This notification was assessed as a Tier 2 notification,[75] requiring a response by DCP within three days, with the ground of '*NEG5*' meaning inadequate basic care. The notification was 'closed no action' on 19 March 2018, due to a lack of capacity to allocate.[76] That means that DCP received this notification and then closed it without making any further enquiries or taking any action in relation to the information that was reported to them. Ms Macdonald's evidence was that:

> 'The Port Augusta Office's inability to respond was reflective of the broader picture for DCP during that period, with DCP closing without actioning 55.5% of matters screened-in for a response in that financial year.' [77]

10.3. This was the first time DCP was notified that baby Caleb was to be born to a mother who was living in troubling circumstances that were unlikely to be suitable for a young infant. It was the first opportunity for DCP to intervene at an early stage to assess and possibly improve Ms Evans' preparedness for baby Caleb's arrival. The inability of DCP to respond to this notification, resulting in a closure of this notification without any further inquiries being made, was a significant missed opportunity for DCP to intervene and assist Ms Evans to make changes to her circumstances to improve her preparedness for a third child and to ensure baby Caleb would not be in an unsafe living environment when born. This was not, however, the only notification made about these concerns before baby Caleb was born.

10.4. The next notification in relation to baby Caleb was made on of 3 May 2018 (while Ms Evans was still pregnant with baby Caleb). This notification also related to Dawn and Eva. The notifier reported the following information about the living conditions of the children:

- Cat faeces on the floor in the living room. There are three cats living in the house. '*One of the cats did a poo under the TV unit and the mother did not clean it up*';

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[74] Exhibit C26, page 179

[75] Transcript, page 530; Ms Macdonald described the tiering system According to The Life They Deserve at page 119, the tiering system under the Childrens Protection Act 1993 was as follows:
- Tier 1: Immediate response to all reports of children in danger, participating in a coordinated investigation with police and CPS
- Tier 2: Thorough investigation of reports of children at risk, possibly involving other key agencies
- Tier 3: Responding in a less intrusive manner and engaging the family in a shared approach where there are high needs in the family but low risk to children in the short term

[76] Transcript, page 334 and Exhibit C36, paragraph 9

[77] Exhibit C36, paragraph 52

- There was food rubbish (scraps and leftover food) in the lounge room and kitchen. This included a half chicken carcass;
- There are used nappies (containing urine and faeces) throughout the house in the bathroom, lounge and children's room;
- There was a very strong odour (cat urine/faeces) coming from the home;
- The home is not hygienic, and Eva has been sick with a lung infection for a few weeks … notifier believes Eva has been sick due to the state of the home.

10.5. Again, this notification was a UCC in relation to baby Caleb.[78] In relation to Dawn and Eva it was screened-in for a child protection response as a Tier 1 intake.[79] The Tier 1 intake was initially assessed as a Tier 2 but was reassessed by the CARL supervisor using the SDM Screening and Response Priority Assessment tool. The reassessment was based on the faeces and dirty nappies within the home presenting an imminent health risk to the wellbeing of two young children within the home.

10.6. DCP Port Pirie caseworker Ms Amanda Diggens attended the home with her supervisor Ms Dianne Longman.[80] The C3MS[81] note of their visit includes the following detail:

> 'There was a smell of cat urine, there was additional dirt and bits and pieces on the flooring throughout the home, there was some laundry in the laundry room, there were dirty dishes spread around the kitchen. There were some food scraps like biscuits on the floors, the flooring is vinyl and was visibly dirty and sticky. There was evidence that some cleaning had started, but the home was still unhygienic … bedroom one had a cat poo on the floor … the house was dirty and there were a few safety issues. Another bedroom was closed as it posed a safety threat to the children and the third bedroom contained a bed with vomit on the sheets.' [82]

10.7. Following the inspection, Ms Longman and Ms Diggens met Ms Evans at her mother's house where Ms Longman found her to be overwhelmed by the DCP's involvement.[83]

[78] Exhibit C19, page 25 is the UCC
[79] Exhibit C26, page 186 in relation to Dawn (same as Eva)
[80] Exhibit C26, page 198
[81] DCP electronic case management system
[82] Exhibit C26, page 198
[83] Transcript, page 437 referring to paragraph 6 of her statement dated 8 June 2022; Exhibit C31a, page 37

10.8. Ms Diggens completed a Safety Assessment[84] and a Safety Plan.[85] The plan stipulated assistance to help Ms Evans clean the house. Two skip-bins were delivered and subsequently collected from the home address.[86]

10.9. On 22 May 2018 Ms Diggens returned to the home address and noted that Ms Evans had made improvements. No concerns were noted.[87]

10.10. On 29 May 2018, Ms Diggens made a referral to the Targeted Intervention Service (TIS) of UCSA.[88] UCSA is a not-for-profit social and community services organisation operating in South Australia. Their engagement is on a voluntary basis, and they have no legislative power to make families engage with their support services.[89]

10.11. Ms Diggens returned to the family home in company with Ms Vicki Jacobs from UCSA on 7 June 2018. An inspection of the home was noted to show no cat urine or faeces.[90]

10.12. The DCP caseworker attended the home again on 14 June 2018 to discuss why Ms Evans had not started her engagement with UCSA, following that visit. It became evident that UCSA did not have the correct phone number for Ms Evans, but the situation had been remedied and UCSA at that point had the correct contact details for Ms Evans.[91] Ms Diggens reported the house was clean. A smell of cat urine was detected but thought to be emanating from the air conditioner.[92]

10.13. Three weeks after that, with the knowledge that UCSA had been unable to contact Ms Evans until 14 June 2018, DCP closed their case on 6 July 2018.[93] The UCSA records report details of subsequent home visits on 19, 25 and 28 June 2018.[94]

10.14. The DCP case closure document recorded that the investigation outcome was that the alleged risk grounds of NEG5 inadequate basic care were not identified. The case was closed at a time when an SDM Safety Assessment dictated that the children were

[84] Exhibit C26, page 236
[85] Exhibit C26, page 206
[86] Refer Tax Invoices at Exhibit C26, pages 28, 34
[87] Exhibit C26, page 202
[88] Exhibit C16, page 4
[89] Exhibit C34, paragraph 2
[90] Exhibit C26, page 217; See also Exhibit C16, page 99 (dated incorrectly as 12/06/18)
[91] Exhibit C36, paragraph 32; Exhibit C26, pages 219, 223
[92] Exhibit C26 page 221
[93] Exhibit C26, page 225
[94] Exhibit C16, pages 97-98

'*conditionally safe*'[95] and an SDM Risk Assessment for Abuse and Neglect indicated that the children were at '*moderate*' risk.[96]

10.15. The case closure note indicates that '*mother has engaged with UCSA TIS program and has other appropriate services in place for her pregnancy and the children's health*'.[97] It is unclear why the author of this note concluded that Ms Evans had engaged with the TIS program. The UCSA notes indicate that there had been engagement with Ms Evans on a number of occasions between 14 and 28 June 2018, but by 2 July 2018, before DCP closed its case, Ms Evans was already starting to avoid engagement with UCSA.

10.16. Ms Evans declined the UCSA worker's attempts to visit between 2 and 10 July 2018,[98] and on 10 July 2018 the UCSA worker emailed DCP stating '*Just wondering if you've flicked the closed box on the Evans case as yet… Angela has cancelled home visits and declined to schedule a phone call last Friday due to appointments for the baby*.'[99] There is no indication that DCP liaised with UCSA before they closed the file on 6 July 2018. If that had occurred, the lack of engagement would have come to DCP's attention and, Counsel Assisting has submitted, should have caused DCP to consider it inappropriate to close their case. The documents also suggest that DCP did not respond to the email from the UCSA case manager on 10 July 2018.

10.17. Ms Macdonald's assessment of DCPs action in this matter was that:

> 'DCP responded assertively to this by assisting Ms Evans to restore that home environment to a standard suitable for children. DCP further recognised the importance of referring Ms Evans to a non-government agency (UCSA) to provide additional intervention to address the underlying factors that were contributing to the barriers preventing Ms Evans from maintaining a safe household for the children. Referring Ms Evans to UCSA for further intervention was a reasonable course of action, particularly given that the state of the house was a major risk factor identified.'[100]

10.18. Counsel for DCP contends that it was appropriate for DCP to close its file arising from the May 2018 notification on 6 July 2018. DCP contends that between the notification on 3 May 2018 and 6 July 2018 DCP workers visited the Evans' home on four occasions. After the initial visit, each subsequent visit found the state of the home to

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[95] Exhibit C26, page 239 - meaning '*one or more safety threats are present, and in-home protective safety interventions have been planned or taken. Based on safety interventions, all children will remain in the home.*'
[96] Exhibit C26, page 233
[97] Exhibit C26, page 227
[98] Exhibit C16, page 96
[99] Exhibit C16, page 96
[100] Exhibit C36, paragraph 53

be suitable. The children were sighted on each occasion and at no time was there concern about the condition of the children nor their development or wellbeing. After the house was cleaned up, the ongoing concerns related to Ms Evans' ability to manage her mental health and develop her ability to meet her children's needs. There were no imminent safety threats to the children whilst the case was open. DCP concedes that, with the benefit of hindsight, it can be said that ultimately Ms Evans' engagement was not sufficient to make sustainable changes. However, that was not predicted at the initial stages of the engagement.

10.19. However, Counsel Assisting has submitted that it was inappropriate for DCP to close its case on 6 July 2018 following the 3 May 2018 notification, as they could not have been satisfied at that time that UCSA engagement had sufficiently addressed the issues in the household. Counsel Assisting has submitted that there was clearly scope for DCP to have ascertained a better understanding of Ms Evans' engagement with UCSA before the case was closed, which would have informed DCP that she was already demonstrating a reluctance to engage before DCP closed their case. Furthermore, consideration should have been given to a parenting capacity assessment for Ms Evans at this time. Ms Longman appropriately conceded that in hindsight, following her visit in May 2018, that would have been a good opportunity to refer Ms Evans for a parenting capacity assessment.[101]

10.20. Counsel for the DCP has properly conceded that '*with the benefit of hindsight it can be said that ultimately Ms Evans' engagement was not sufficient to make sustainable changes. However, that was not predicted at the initial stages of the engagement*'. I agree with the submission of Counsel Assisting that on 6 July 2018 DCP had insufficient information from UCSA about Ms Evans' engagement with that service provider to be satisfied that the issues in the household had been sufficiently addressed. Accordingly, I find that it was premature to conclude that there was '*no further role for DCP*' [102] and to close the case.

10.21. The next notification made about baby Caleb and his siblings was on 14 September 2018.[103] The notifier[104] stated that Dawn and Eva appeared uncared for, and that there

[101] Transcript, page 480
[102] Exhibit C26, page 231
[103] Exhibit C19, page 36 and Exhibit C26, page 240
[104] The notifier was midwife Ms Lena Boxall. She has consented to her identity as a notifier being disclosed, as per the email Exhibit C43

were food scraps everywhere and general waste was scattered on all surfaces. The house was cluttered with furniture and there were potential hazards, but the notifier could not be sure what they were. The notifier mentioned there was a mattress on the floor in the lounge room and that she was unsure if Ms Evans was prepared for a baby. The notifier said that Ms Evans was struggling to care for her two children, was immature, and lacked basic life skills. The notifier expressed concerns that Ms Evans had previously been involved with services but was not engaged at that time. The notifier advised that in the past when the mother was working with the DCP she was held accountable for her actions and an improvement was noted, but after the DCP had closed the case, the mother had been unable to maintain the gains. The notifier, who identified herself as a midwife that had visited the home, shared her opinion that Ms Evans would likely require supervision to ensure she was able to meet the needs of all three children.

10.22. This notification was treated as a UCC in relation to baby Caleb. This UCC remained open until DCP was notified of his birth three days later, at which time it was closed as a NOC. Ms Macdonald agreed that based on the UCC from 14 September 2018, there were reasonable grounds to suspect that baby Caleb may have been at risk[105] and there was reason to be concerned about a pattern of risk for these children and the pattern of cumulative harm.[106] There was no reason for DCP to think that those concerns had resolved themselves two days later when they were notified baby Caleb had been born.[107] The 14 September 2018 notification in relation to Dawn and Eva was also closed as a NOC.

10.23. In relation to this notification Ms Macdonald conceded '*It was possible to have screened it in*'.[108] Mr David Armour's evidence was that he would have screened it in for a response,[109] but that did not mean that the person who actually assessed that notification and did not screen it in made the wrong decision.[110] Ms Macdonald stated:

> 'I consider that it is likely that the changes to the practice would mean that currently (in 2022) this notification would have been likely screened-in for a response…'. [111]

[105] Transcript, page 687
[106] Transcript, page 686
[107] Transcript, page 687; Exhibit C19, page 46, Notification of baby Caleb's birth was made on [redacted] September 2018
[108] Transcript, page 688
[109] Transcript, page 373
[110] Transcript, page 399
[111] Exhibit C36, paragraph 54

10.24. Counsel Assisting has submitted that a NOC was not an appropriate response to the notification of 14 September 2018. Even before his birth, DCP had ample reason to be concerned that baby Caleb may be born and go home to an environment which was both unsuitable and unsafe for him. Closing this notification as a NOC once baby Caleb was born was a significant missed opportunity for DCP to intervene to take steps to ensure baby Caleb's safety.

10.25. It was submitted for DCP that the Court should not find that there was an error in assessing the 14 September 2018 NOC. However, DCP contends that the Court could find that if current policy settings applied, the notification would likely have been screened-in given the potential for cumulative harm and there was an opportunity for DCP to further assess the child protection concerns including whether the UCSA intervention was addressing those concerns.

10.26. Whilst I accept, based on the evidence I heard from Mr Armour, that this notification was not improperly closed as a NOC based on the policy settings at the time, it is concerning those policy settings allowed this notification, against the background of notifications made in relation to Ms Evans, to be closed off as a NOC. At the time this notification was made, there was clear evidence of a pattern of risk for baby Caleb and his siblings, and DCP had sighted the house in a squalid state only months earlier. It is entirely unacceptable that a notification alerting DCP to the same concern again could be closed with no response. I find that this notification deserved a child protection response. In making this finding, I am not asserting that the call taker made a decision which was not open to them, but rather, that the policies at the time were either inappropriate or ineffective, if they did not ensure this notification was screened-in for a response.

10.27. This was a significant lost opportunity for DCP to gain information about the environment which baby Caleb would be going home to, and to prevent him from returning to a home which placed his physical and emotional safety at risk.

11. Notifications made after baby Caleb's birth

11.1. At the time of baby Caleb's birth on [redacted] September 2018, UCSA was still engaged to work with Ms Evans and her family as a result of the referral made to UCSA by DCP following the 3 May 2018 notification.

11.2. Ms Evans had been involved with UCSA on and off since May 2017. In January 2018 UCSA had a discussion with Ms Evans in which she advised she did not need any support and did not require a worker at that time.[112] However, following the referral from DCP to UCSA after the notification of 3 May 2018,[113] UCSA again became involved with Ms Evans, with the first visit from UCSA post the 3 May 2018 notification taking place on 12 June 2018.[114] There were home visits on 19 June 2018,[115] 25 June 2018[116] and 28 June 2018[117] involving UCSA delivering cleaning supplies and bedding and offering support and advice about maintaining a cleaner home environment.

11.3. In July 2018, Ms Rachel Mayfield took over as the UCSA case manager for Ms Evans. She first met with Ms Evans, along with her mother Tamara Evans and the former UCSA case manager, on 25 July 2018. During this meeting Ms Evans' mother raised her concerns that Ms Evans' mental health was '*going downhill*', that they were unsure if DCP still had an open case for Ms Evans, that Ms Evans wanted support in getting childcare one day a week for her two eldest children, and that she was due to have her third child in 8-9 weeks.[118] Following this meeting Ms Mayfield contacted DCP who advised her that DCP had closed their case in relation to Ms Evans, and that they could not write a letter of support for Ms Evans to receive the special childcare benefit, as the DCP case was closed.[119]

11.4. According to the affidavit of Ms Mayfield, Ms Evans was:

> '…somewhat receptive to engaging with our services during the month of June, but from the time I took over in July, there was a distinct lack of engagement on her part, cancelling numerous scheduled home visits.'[120]

Scheduled home visits for 31 July, 3 August and 10 August 2018 were all cancelled by Ms Evans.[121]

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[112] Exhibit C16, page 102
[113] Exhibit C16, pages 4-7
[114] Exhibit C16, page 99
[115] Exhibit C16, page 98
[116] Exhibit C16, page 97
[117] Exhibit C16, page 97
[118] Exhibit C16, page 95
[119] Exhibit C16, page 95
[120] Exhibit C34, paragraph 8
[121] Exhibit C16, page 95

11.5. Ms Mayfield undertook a home visit on 14 August 2018.[122] Her record of that visit notes that as she arrived at the home Ms Evans folded up a fold-out sofa. Ms Evans stated they had been sleeping on the sofa as it is warmer in the living area of the home than the other bedrooms. The note also records that Ms Evans' bed had washing all over it with no bedding, and the girls' bedroom had a toddler bed and a single bed, again with no bedding. This was despite the fact that a previous UCSA worker had delivered linen to the home on 25 June 2018.[123] At the conclusion of this visit it was agreed that Ms Mayfield would attend again in seven days' time, on 21 August 2018.

11.6. Ms Evans cancelled the visit scheduled for 21 August 2018 and cancelled another visit on 23 August 2018.[124] On 29 August 2018 Ms Mayfield visited the home but no one answered the door. On 30 August 2018, Ms Mayfield emailed DCP caseworker Ms Amanda Diggens to advise that Ms Evans had not been actively engaging in home visits.[125] Ms Mayfield's evidence was that she did not receive a response to that email.[126] On 4 September 2018, Ms Mayfield attended the home and on arrival received a text message from Ms Evans indicating she was not home.[127] Ms Mayfield went on leave from 4 September until 2 October 2018 during which time there was no direct contact with Ms Evans. On 11 October 2018 Ms Mayfield conducted a home visit, but rather than taking place at Ms Evans' home, she visited Ms Evans at her mother's home, at Ms Evans' request. Given that visit did not take place in Ms Evans' home, it was clearly of limited value in assessing the home environment.

11.7. On 18 October 2018 Ms Mayfield attended the home and there was no answer. The visit was rescheduled.[128] On 24 October 2018, Ms Mayfield attended at the home. Ms Evans was standing out the front. Ms Evans indicated she did not want Ms Mayfield to come into the property as the house was messy and she was ashamed.[129] Ms Mayfield did not enter the property on this occasion. Ms Evans cancelled a visit scheduled for 1 November 2018, and then on 13 November 2018 Ms Mayfield attended for a home visit. Ms Mayfield indicated that she could hear a baby crying but was

[122] Exhibit C16, page 94
[123] Exhibit C16, page 97
[124] Exhibit C16, page 92
[125] Exhibit C16, pages 19, 32
[126] Transcript, page 262
[127] Exhibit C16, page 90
[128] Exhibit C16, page 86
[129] 24 October 2018

unsure if that was coming from Ms Evans' house. The visit did not take place as Ms Evans did not come to the door.[130]

11.8. On 20 November 2018 Ms Mayfield made a notification to the DCP via the CARL hotline.[131] Ms Mayfield's evidence was that she made the notification because she suspected the children were being neglected in the home environment by Ms Evans not maintaining a healthy home.[132] Ms Mayfield's evidence was that due to the lack of engagement and cooperation by Ms Evans, she was unable to make an informed assessment on the condition of the house or her capacity to provide adequate care for her children, and because these were the issues that DCP had referred Ms Evans to UCSA for support with, that is why she referred the matter back to DCP.[133]

11.9. When making the notification, Ms Mayfield informed CARL:

- That she was referred to work with the family by DCP;
- That a number of attempts had been made to conduct home visits;
- That Ms Evans had advised her she was too embarrassed to have anyone visit her home. That Ms Evans told her that when she is doing poorly, she disengages from supports;
- The front yard had about 30 empty juice pop top bottles laying around, there was piles of rubbish leaning up against the fence and household rubbish scattered about;
- Initially the referral was made due to the squalor conditions of the house, with rubbish and faeces throughout the house, and the mother is not engaging voluntarily with the service and therefore no assessment can be made on the conditions of the house, or provide any support to the mother; and
- That UCSA would be closing the referral due to the lack of engagement from Ms Evans.

[130] Exhibit C16, page 85
[131] Exhibit C19, pages 55-63
[132] Exhibit C34, paragraph 11
[133] Exhibit C34, paragraph 11

11.10. The notification made by Ms Mayfield on 20 November 2018 was screened-in by the call centre and assessed as requiring a response '*within 10 days*'. The decision and rationale indicate that:

> 'The supporting service has been unable to engage with the mother or gain entry into the home when the initial concerns were raised in regard to the squalor conditions inside and outside the home. C3MS indicates there has been little or no change seen inside or outside the house and due to the lack of the mother's voluntary engagement and the supporting service closing, and the vulnerable age of the children in the home, it is considered this warrants statutory intervention to assess the children's safety.'[134]

11.11. According to Mr David Armour, Senior Practitioner with CARL who was involved in deciding the appropriate tiering for this particular notification:

> 'It was assessed as a within 10 day, as at that point in time we did not have information to say that the house was immediately unsafe. We actually didn't have any information at all about how the state of the house was. We cannot apply an immediate response for something that we just don't know.'[135]

He explained that application of the SDM Screening and Priority Assessment tool to this notification meant that none of the '*within 24-hour criteria*' were present, and so the '*within 10 day*' response was selected.[136]

11.12. There was the ability to override that prioritisation, with the tool indicating that '*although no 24-hour criteria are marked, unique circumstances, not captured by the response priority assessment, support a final response priority decision of within 24 hours*'.[137] Mr Armour's evidence that there was not then, nor is there now, any guidance around what would be considered '*unique*' circumstances,[138] but that he did not consider the fact that this notification was being made by an agency that had been engaged by DCP to work with the family, and the agency was reporting back to DCP that it had been unable to complete that task, to be a unique circumstance.[139] He also did not consider baby Caleb's young age, of less than 10 weeks, to be a unique circumstance which would cause him to upgrade the priority response to a within 24 hour response. In Mr Armour's view, there were no unique circumstances that could

[134] Exhibit C26, page 245
[135] Transcript, page 335
[136] Transcript, page 377
[137] Exhibit C36, page 69
[138] Transcript, page 386
[139] Transcript, page 387

have caused him to upgrade the priority of this response from '*within 10 days*' to '*within 24 hours*'.[140]

11.13. The initial notification for which UCSA became involved, the notification of 3 May 2018, was a Tier 1 notification. According to Mr Armour's evidence, a Tier 1 response is equivalent to the current 24-hour response, and a within 10 day response is equivalent to the Tier 2 under the former tiering system. Mr Armour agreed that:

> 'The notification on this particular topic, the concerns around the squalor of the house, in May of 2018, it was a Tier 1. At the time it was referred back, it essentially became equivalent to a Tier 2.' [141]

11.14. Counsel Assisting has submitted that it was hardly appropriate for a Tier 1 matter to be referred to a service, and for that service to report back that they have been unable to provide that service due to lack of engagement, that the matter then becomes Tier 2. That notification by Ms Mayfield should have raised alarm bells that Ms Evans' children were again living in the squalor as observed by the DCP on 3 May 2018 – or worse – and been dealt with as the equivalent of a Tier 1 response, that being a '*within 24 hour response*'.

11.15. However, Counsel for DCP has submitted that the notification made on 20 November 2018 by Ms Mayfield did not provide any precise details of the immediate risk of harm to the children. The last time that Ms Mayfield was inside the house (on 14 August 2018) it did not pose a risk of harm to the children. Counsel acknowledged that Ms Mayfield had a good basis to suspect that the home was in a poor condition, but submitted there was no evidence that there was an actual threat to the children's safety at the time of the report. Counsel for DCP submitted that I should find the 20 November 2018 notification was properly prioritised in accordance with the SDM and the applicable assessment framework.

11.16. In my opinion, a proper assessment of the circumstances, as they presented to DCP upon the 20 November 2018 notification, having regard to the 3 May 2018 notification and what occurred thereafter, should have led to DCP concluding by inference that the newborn baby may have been at immediate risk of harm, leading to an upgrade of action time to within 24 hours. Positive evidence of an actual threat to the children's safety was not required.

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[140] Transcript, page 386
[141] Transcript, page 388

12. 20 November 2018 - Notification sent to Port Pirie office

12.1. The notification was sent to the Port Pirie office as a '*within 10 day*' priority.

12.2. In the months leading up to November 2018 when this notification was received by the Port Pirie office, the office had been experiencing a period of significant staffing shortages and a resulting lack of capacity to respond to notifications.

12.3. The affidavit of Ms Jacqueline Campbell set out the position with respect to staffing in the Port Pire DCP office throughout 2017 and 2018.[142]

12.4. Recruitment and retention of staff at the Port Pirie office was problematic during 2017 and 2018. The Intake Team supervisor left the DCP in December 2017 and the Protective Intervention Team supervisor left in early January 2018.[143]

12.5. During the period February 2018 to 8 October 2018, Ms Dianne Longman - who was technically the Supervisor of the Guardianship Team - was the only supervisor in Port Pirie, despite the fact there should have been three supervisors in the office – one for each of the Guardianship Team, the Assessment and Support Team, and the Protective Intervention Team. Ms Longman was effectively supervisor for all three teams during that period.

12.6. Ms Macdonald stated that during the period following baby Caleb's birth ([redacted] September 2018) there were between four and five vacancies in the Port Pirie office[144] in addition to the supervisor vacancies[145] and at times during 2018, the Port Pirie office was operating with 25% of its professional budgeted full-time staff positions vacant.[146]

12.7. At a managerial level, the Port Pirie and Kadina offices shared a Manager, Mr Patrick Kinnear and a Business Manager, Mr Mark Congdon.[147] During 2018 the offices also shared the role of reviewing notifications assessed by the DCP CARL and forwarded to the Port Pirie office for consideration. The obligation to review notifications fell to the Assessment and Support Team supervisor.[148]

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[142] Exhibit C40
[143] Transcript, page 408
[144] Exhibit C36, paragraph 61
[145] Transcript, page 610
[146] Transcript, page 611
[147] Transcript, page 406
[148] Transcript, page 835

12.8. In order to assist Ms Longman while she essentially had responsibility for three Supervisor roles at once, the Kadina office shared some of the workload of the Port Pirie office, including assessing incoming notifications.[149] Ms Jan Hutchinson was the supervisor of the Assessment Support Protective Intervention (ASPI) Team at Kadina for the duration of 2018, and throughout 2018 she was often responsible for assessing notifications that came in for the Port Pirie office.

12.9. DCP records adopted by Mr Kinnear during his evidence show that in 2018 Ms Longman remained the supervisor of the Guardianship Team and was fulfilling the role of supervisor for the Port Pirie ASPI team, other than between 1 January 2018 and 4 February 2018 when Ms Keryl Jamieson was the supervisor for the Protective Intervention Team and between 8 October 2018 and 31 December 2018 when Ms Lucy Walles was the supervisor for the Assessment and Support team.[150]

12.10. On 8 October 2018 Ms Lucy Walles commenced as a supervisor in Port Pirie for the Assessment and Support Team, but the supervisor position for the Protective Intervention team remained vacant for the remainder of that year. In addition to prolonged vacancies in the supervisor positions, there were other positions vacant in the Port Pirie office throughout 2018 for significant periods, including a vacancy for a care and protection worker in the Assessment and Support Team from the beginning of 2018 until 26 October 2018, and two social worker positions vacant for the majority of the year. Ms Macdonald conceded that the lack of staffing was a significant issue for the Port Pirie office at this time.[151]

12.11. On 23 November 2018, three days after the notification was sent to the Port Pirie office, it was marked as '*not proceeding*' and sent for CNA approval to the Manager, Mr Patrick Kinnear.[152] Nothing happened in relation to the notification between that date and until after baby Caleb's death.[153] It was not until after baby Caleb's death on 30 November 2018 that the CNA was approved[154] so that the notification relating to baby Caleb's death could be raised. Mr Kinnear's evidence was that it was '*very*

[149] Transcript, pages 410-412
[150] Transcript, pages 831-833
[151] Transcript, page 572
[152] Exhibit C35a
[153] Exhibit C35a
[154] Exhibit C35a

unusual'[155] for something to be sitting with him for CNA approval in 2018 and he had no explanation for why that approval was not actioned within seven days.[156]

12.12. Mr Kinnear's evidence was that once Ms Walles filled the position of supervisor of the Assessment and Support Team; she would have actioned any notifications that came in for the Port Pirie office. Yet the notification of 20 November 2018 was actioned by Ms Jan Hutchinson of the Kadina office, despite the fact that Ms Walles was employed as the supervisor of the Assessment and Support Team in the Port Pirie office at that time.[157]

12.13. Mr Kinnear's evidence was that between October 2018 and December 2018 there were still occasions when the supervisor of the Kadina office would action the notifications for Port Pirie if Ms Walles was on leave or absent from the office for some reason.[158] It is curious to note that, following baby Caleb's death on 30 November 2018, Ms Longman is referred to as the supervisor in the case notes that follow, rather than Ms Walles. This might suggest Ms Walles was inactive as the supervisor of the Assessment and Support Team at the time the notification came in, and in the weeks that followed.

12.14. Ms Longman gave evidence that throughout 2018 the Port Pirie office was under a direction from Manager Patrick Kinnear to 'close no action' all notifications that came in as '*within 10 day*' responses. This was due to a lack of capacity which was primarily a consequence of the persistent staffing shortages.[159]

12.15. Mr Kinnear's evidence was that each Monday morning a meeting would take place of the leadership team of the Port Pirie and Kadina offices (which included Ms Longman) at which it would be discussed whether the Port Pirie office had capacity to assess '*within 10 day*' notifications that week or not. If not, the instruction was that all '*within 10 day*' notifications that week would be 'closed no action'.[160]

12.16. Mr Kinnear said it was his understanding from conversations with the supervisors, and in particular Ms Dianne Longman, that there was no capacity for the Port Pirie office to deal with any of the '*within 10 day*' notifications and that situation existed for some

[155] Transcript, page 819
[156] Transcript, page 820
[157] Exhibit C35a
[158] Transcript, page 847
[159] Transcript, page 414
[160] Transcript, page 813

period in 2018.[161] Mr Kinnear's evidence was that strategy of dealing with all '*within 10 day*' notifications as CNA was more of an agreement among the leadership team than a direction that he gave,[162] but agreed that as the Manager of the Port Pirie and Kadina Office, he was accountable for any strategy put in place.[163] Mr Kinnear's evidence was that '*That was the horrible reality we were faced with, and as the Manager I was responsible for that*'.[164]

12.17. Despite Mr Kinnear agreeing with a proposition that the effect of his evidence is that during the weeks when there was an agreement led by him that these cases would be closed without review, those decisions were contrary to the relevant policy.[165] Ms Macdonald's evidence was that if Mr Kinnear had given a direction to his office to close all '*within 10 day*' notifications with no action, that was something that he was permitted to do within the bounds of this particular policy.[166] Her evidence was that:

> 'It wasn't an agency position, but I agree that it was something that was open to him within the bounds of this guideline.'[167]

12.18. According to Counsel for DCP, Ms Macdonald's evidence is best understood as recognising that the interpretation of the policy put by Counsel Assisting was possible, but not the proper interpretation of the policy. It was submitted that the policy requires the manager to be the '*person responsible*' for approving the closure. Whilst the manager is to rely on the professional assessment of the supervisor, the manager's role in endorsing the recommendation requires them to give active consideration to whether the supervisor's assessment is appropriate. The policy requires the supervisor to consider the intakes to assess the seriousness of them and the threat to child safety or risk of harm. In the context of a persistent unmet demand, the manager is placed in a challenging position but, as the responsible person in the office, is expected to be exercising their judgment when endorsing decisions.

12.19. Regardless of whether it was or was not within the bounds of a written policy the DCP had in place at the time, it was abundantly clear that Mr Kinnear, and staff undertaking the work of the Port Pirie office, had little choice but to close a large number of notifications in the face of chronic and persistent understaffing.

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[161] Transcript, page 813
[162] Transcript, page 824
[163] Transcript, page 824
[164] Transcript, page 813
[165] Exhibit C36A
[166] Transcript, page 658
[167] Transcript, page 658

12.20. Once Ms Walles commenced in the supervisor role, the Monday meetings still continued to consider a number of issues, including if the office was short staffed and how that would be managed.[168] It is unclear from the evidence whether the 20 November 2018 notification came in during a week when a direction to CNA all '*within 10 day*' notifications was in place or not. Mr Kinnear's evidence was that if this notification of 20 November 2018 came in at a time where there was no capacity in the Port Pirie office other than to action urgent matters, his expectation would have been that the staff member assessing this notification would have recorded it as CNA without review.[169] Despite the fact it was a direction given '*more often than not*' throughout 2018,[170] by 20 November 2018 there was a supervisor of the Assessment and Support Team, Ms Walles. Yet, regardless of whether this notification was 'closed no action' due to a blanket direction to CNA all '*within 10 day*' notifications that week, or because, despite no blanket direction to CNA, there were still no resources to assess and investigate this notification, it is clear that this notification was not actioned by DCP, and was marked for closure with no action due to a lack of capacity in the Port Pirie office at the time. According to Mr Kinnear:

> 'The situation was managed up to the Director of Northern DCP, Supervision in the minutes of the monthly formal leadership meeting, requests for support that we were in this very challenging situation and we only have limited capacity to do the work that we're meant to be doing under the legislation.'[171]

Though Mr Kinnear could not recall whether he explicitly told anyone more senior to him that he had directed his staff to CNA all '*within 10 day*' notifications more often than not throughout 2018, regardless of whether he did or not, those more senior than him in the DCP must have known that the consequence of chronic understaffing in the Port Pirie office was that a large number of notifications were not being appropriately dealt with.

12.21. Counsel for the DCP submitted that DCP supported the office whilst it carried vacant positions, including undertaking three recruitment processes for the supervisor role; providing short term support for periods of time; and support from the Court Liaison Team. It was also submitted that the recruitment of skilled staff to regional areas is a

[168] Transcript, page 848
[169] Transcript, page 823
[170] Transcript, page 823
[171] Transcript, page 814

challenging issue for all Australian states and territories and continues to be a focus for ongoing improvement.

12.22. Given the state of the home as observed by police on 30 November 2018, it is highly likely that had DCP actioned this notification and entered the home sometime between 20 and 29 November 2018, they would have located baby Caleb and his siblings living in squalor. Ms Macdonald's evidence was that if the children had been observed in that home between 20 and 30 November 2018 in the state it was on 30 November 2018, there would have been a safety plan put in place for the children to be somewhere else and they would not have been left in that home.[172]

12.23. Accordingly, I find that the failure to take action in response to this notification was a significant failure in ensuring the safety of baby Caleb in the days before his death. Had this notification been actioned, it is highly likely that baby Caleb would not have been sleeping in an unsafe sleeping environment in a squalid home on the evening of 29 November and the morning of 30 November 2018.

12.24. In making this finding I am not critical of the DCP staff members in the office that marked this notification as a CNA. It is clear they faced chronic and persistent understaffing and the inability to respond to many notifications for an extended period of time; there was little option but for a large number of notifications to be dealt with as a CNA. I also acknowledge the difficulties I am told exist with recruiting and retaining staff in regional DCP offices. Yet it is an inescapable fact that the inability of DCP to properly staff the Port Pirie office for an extended duration of time had dire consequences for baby Caleb.

13. <u>The use of CNA/Not proceeding in relation to notifications made about baby Caleb</u>

13.1. The notification of 20 November 2018 was one of a number of notifications made in relation to baby Caleb and his siblings that was 'closed no action'. CNA indicates that a matter was screened-in for a response by the CARL centre following the screening of the notification using the SDM Screening and Response Priority Tool,[173] but was not actioned due to workload demands facing the office.

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[172] Transcript, page 690

[173] Exhibit C36, SM2, page 30 - Mr David Armour gave evidence that the SDM Screening and Priority Assessment Tool is the tool used by the CARL call centre in relation to each notification in order to make a decision whether or not the notification should be screened-in, and if so, the response priority

13.2. The practice of DCP closing notifications as CNA under the Children's Protection Act has been the subject of criticism by the Nyland Royal Commission, the State Ombudsman,[174] and by this Court in the inquests into the deaths of Chloe Valentine, Ebony Napier, and Amber Rigney and Korey Mitchell.

13.3. The Life They Deserve, published in August 2016, states:

> 'The current use of CNA and other closure codes sends a message to children, parents, notifiers and the broader community that some concerns are not worthy of response and, by extension, that some children are not worthy of protection. The opportunity to intervene early is lost. In many cases, the opportunity to gather evidence of abuse or neglect is also lost, meaning from an evidentiary perspective—though surely not from the child's perspective—it is as though the event never happened.' [175]

13.4. The Life They Deserve also states that:

> 'Once a concern has been screened-in, the agency has accepted that the information reveals a genuine child protection issue that requires a response. Any inaction on the basis of an overwhelming workload is patently unacceptable, and leaves many children living in risky and unsafe conditions.' [176]

13.5. Recommendation 62 of The Life They Deserve was to:

> 'Phase out the closure of intakes and files due to lack of resources. This should occur over a period of no more than five years from the date of this report. In the interim practitioners should be provided with clear guidelines as to the circumstances in which such closures are appropriate. There should be quarterly reports to the public on the rate of closures that are due to lack of resources.'

13.6. Deputy State Coroner Schapel addressed the practice of '*closing no action*' in his published finding into the deaths of Amber Rigney and Korey Mitchell:

> 'While the CNA procedure could not apply to Tier 1 notifications, the notion that Tier 2 notifications, which could nevertheless involve serious allegations of abuse or neglect, and/or involve the creation of a suspicion on reasonable grounds that a child was at risk, might be accorded no response whatsoever, was actively embedded in the Department's own internal procedures. There was certainly no statutory imprimatur for such a procedure. On the contrary, such a procedure flew in the face of the mandatory statutory duties of the Department to conduct an investigation in certain circumstances. Needless to say, an internally documented procedure such as the CNA could not supplant the legal obligations and responsibilities mandated by the Act. Insofar as these devices were deployed to close off an assessment of or an investigation into a matter that the Act

[174] SA Ombudsman report entitled 'Department for Child Protection - Wrongful failure to share information concerning the care and protection of two deceased children (2018/02813), https://wwwombudsmansagovau/publications/investigation-reports/2019-investigation-decisions
[175] Transcript, page 198
[176] The Life They Deserve, page 197

> stipulated must be so assessed or investigated, such processes were contrary to law. This was so regardless of resource considerations. The devices amounted to an egregious and sustained institutionalised flouting of the statutory requirements relating to child protection. The failure of the Department to carry out its statutory obligations had been the subject of criticism in the findings of this Court in both the Valentine and Napier inquests.' [177]

13.7. When the *Children and Young People (Safety) Bill* was introduced into the House of Assembly on Tuesday 14 February 2017, it was announced by then Attorney-General the Honourable John Rau that:

> 'Part 2 sets out the nature of the assessment to be done with respect to reports received pursuant to clause 28 or by other means. Of note is that clause 29[178] confirms that an assessment must be done on each and every report.' [179]

13.8. During further debate in the House of Assembly on 11 April 2017, it was stated, with reference to clause 29:

> 'This amendment is moved in response to feedback received by the government. The amendment will make it clear that the chief executive must assess and take action in relation to either a report received by the department under clause 28 of the bill or by any other means … The most significant aspect of this is subclause (3), which sets out what options are available to the chief executive once an assessment has been completed. Specifically, the amendment states that at least one of a following list of actions must be undertaken. It is also important to note that the government has imposed transparency measures in this amendment by means of a mandatory requirement on the chief executive to maintain a formal record in relation to each action undertaken. Secondly, the amendment requires the annual report from the department to include statistical information relating to clause 28 of the bill. In terms of the concerns that have been raised in consultation, people were concerned that there might be a matter raised and the department would simply not even turn its mind to it. We accept that is not okay; that is what the government is saying. The government is saying, 'Yes, that is unacceptable'. However, what we do think is that what is done about the particular matter once it is assessed is not a matter for the parliament to dictate. It is a matter for the people on the ground, who have intimate knowledge of the circumstances and facts pertinent to the particular case, to make a judgement, and we have given them a menu of options from which they can make a selection. So, the government has listened to the feedback about where these complaints are made they should be the subject of some consideration by the department; they cannot simply not be actioned.' [180]

13.9. Counsel Assisting has submitted that the second reading and debate made it clear that the intention of introducing Section 32 (which was introduced and debated as clause 29

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[177] Inquest 07/2021, Amber Rose Rigney and Korey Lee Mitchell, Finding delivered 21 April 2022
[178] Clause 29 of the Bill became Section 32 in its current form in the Act
[179] What was introduced into the House of Assembly as Clause 28 and Clause 29 became Section 31 and Section 32 in the Act once passed
[180] Clause 29 of the Bill became Section 32 in its current form in the Act

of the Bill) was to eradicate the practice of CNA, and that DCP has an obligation in accordance with Section 32(3) of the *Children and Young People (Safety) Act* in relation to every notification it receives to action it in at least one of the following four ways:

1) an investigation into the circumstances of the child must be carried out under Section 34;[181]

2) if the Chief Executive is satisfied that an investigation under Section 34 is unnecessary, having regard to such of the circumstances of the child as may already be known to the Chief Executive, an alternative response that, in the opinion of the Chief Executive, more appropriately addresses the risk to the child or young person must be implemented;[182]

3) the matter must be referred to an appropriate State authority under Section 33;[183]

4) if the Chief Executive is satisfied that—

   i. the matter has previously been dealt with under this or any other Act and there is no reason to re-examine the matter;[184] or

   ii. the matter is trivial, vexatious or frivolous;[185] or

   iii. there is good reason why no action should be taken in respect of the matter,[186]

   the Chief Executive may decline to take further action.

13.10. Ms Macdonald agreed that the only basis upon which a CNA could fall within the current legislative requirements would be if it came under Section 32(3)(d)(iii), and stated that it does not, because the DCP does not consider a lack of resources to be a '*good reason*' why no action is taken in respect of a matter.

13.11. Counsel for DCP has submitted that this Court must be cautious as a fact finder in making findings of law as to the operation of legislative provisions, particularly where such legal findings are not necessary to the fact-finding obligations. In this submission, counsel is asking me to be cautious about stating the obvious, which has been stated in the report of a Royal Commission, in Parliament in debate about the provisions of the

[181] Section 32(3)(a) CYPSA
[182] Section 32(3)(b) CYPSA
[183] Section 32(3)(c) CYPSA
[184] Section 32(3)(d)(i) CYPSA
[185] Section 32(3)(d)(ii) CYPSA
[186] Section 32(3)(d)(iii) CYPSA

CYPSA, and in findings of this Court, namely that to close a screened-in case with no action for reasons of lack of resourcing does not fall within the range of options provided by legislation governing that action. Given that several notifications made in relation to baby Caleb and his siblings that were screened-in for a child protection response were closed with no action for reasons of lack of resourcing, I consider it part of my fact-finding obligations to consider whether that was done in accordance with legislative provisions or not. Furthermore, Ms Macdonald conceded that anything that is 'closed no action' due to resourcing issues is not being dealt with in accordance with DCP's statutory obligations[187] and the finding is plainly open on her evidence.

13.12. Closing a screened-in matter as a CNA was not an option available to the DCP to deal with a screened-in notification under the Children's Protection Act. It is still not permitted in accordance with the Children and Young People (Safety) Act 2017.[188] Yet a number of notifications made in relation to baby Caleb and his siblings that were screened-in for a child protection response were 'closed no action' for reasons of lack of resourcing.

13.13. In 2019/2020 the CNA code was altered to an outcome of '*not proceeding*' but is effectively the same; the '*Outcomes Codes Procedure*'[189] indicates that the '*not proceeding*' code can be used where it has been determined that the office does not have capacity to assess the matter.[190] Despite the fact the name of the code was altered to an outcome of '*not proceeding*',[191] the practice is the same. The Outcome Codes Procedure, by allowing for an outcome code of '*not proceeding*' to be used where it has been determined that the office does not have capacity to assess the matter, continues to enshrine into DCP's internal procedures the practice of not proceeding due to a lack of resources, contrary to its legislative obligations.

13.14. The practice of DCP inaction in relation to a notification due to a lack of resources, contrary to statutory requirements under previous and current legislation, persists. This is despite Recommendation 62 from The Life They Deserve that the closure of intakes and files due to lack of resources should be phased out no later than August 2021.

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[187] Transcript, page 637
[188] Transcript, page 637 - Ms Macdonald conceded that there is no legislative ability for the DCP to CNA
[189] Exhibit C36c
[190] Exhibit C36c, page 14
[191] The 'Outcomes Codes Procedure', Exhibit C35a, indicates that the 'not proceeding' code can be used where it has been determined that the office do not have capacity to assess the matter

13.15. DCP's publicly available document purporting to be an update on the status of recommendations arising out of the Royal Commission, indicates that DCP is '*implementing*' Recommendation 62.[192] Ms Macdonald's view is that DCP is '*implementing*' Recommendation 62 because:

> 'I don't think we've completed it, but I do think there's been significant efforts made to phase out the closure of intakes due to lack of resources, you'll see that in the data that's been provided.' [193]

13.16. However, Recommendation 62 also stipulated that in the interim practitioners should be provided with clear guidelines as to the circumstances in which such closures are appropriate and there should be quarterly reports to the public on the rate of closures that are due to lack of resources. Ms Macdonald conceded that there are no clear guidelines as to the circumstances in which such closures are appropriate (with the only guidelines being the brief mention of '*not proceeding*' in the Outcome Codes Procedure and the Manual of Practice Intake and Assessment),[194] and that the quarterly reporting is not happening.[195] Ms Macdonald conceded that use of the word '*implementing*' in relation to that recommendation may be misleading to a reader.[196]

13.17. The data to which Ms Macdonald referred to support her assertion that there have been significant efforts made to phase out the use of CNA, was the table tendered as Exhibit C36d. The table, on its face, indicates that the number of matters closed as CNA (or its current equivalent '*not proceeding*') has steadily declined each year since The Life They Deserve. Despite that, the table indicates that 18.9% of all screened-in notifications to that time in the financial year have been 'closed no action'. This means that, as at the time the evidence was heard in December 2022, there had been 1,890 notifications made since July 2022 where an assessment was made that there was a reasonable cause to suspect the children are at risk that were 'closed no action'.[197] Ms Macdonald explained that the significant increase in screened-in notifications each year has made it impossible for DCP to achieve Recommendation 62 of The Life They Deserve to have completely phased out the practice of closing files with no action by August 2021. The statistics indicate DCP is a long way from achieving that.

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[192] Exhibit C36f
[193] Transcript, page 649
[194] Transcript, page 673
[195] Transcript, page 648
[196] Transcript, page 676
[197] Transcript, pages 639-640

13.18. Counsel Assisting has submitted that the statistics produced for the purpose of the inquest as Exhibit C36d do not help in assessing progress towards phasing out closures without action. In particular, attention was drawn to the fact that a calculation of the percentage of screened-in notifications of total notifications from the data presented in Exhibit C36d reveals that the percentage of all notifications that are screened-in is declining since 2019 (in the 2019-20 financial year, 52% of notifications were screened-in, compared to 43% in the 21-22 financial year).

13.19. Although the proportion of notifications that have been screened-in from 2019/2020 to date has been declining, the evidence does not permit the significance of that to be assessed. Screened out notifications comprise a number of outcome codes which include, but are not limited to, notifier concerns, extra familial notification, adolescent at risk and general practice. The Manual of Practice for the Call Centre[198] also includes the following outcome codes which are screened out: Divert Notifier Action; No Grounds for Intervention; and Care Concerns. Without more information I cannot draw conclusions as to why the number of CNA/not proceeding matters is declining as the statistics produced to the Court suggest. I am not required to make any findings about this.

13.20. It also emerged during this inquest that, despite a legislative obligation to include statistical information relating to the action taken under Section 32 in the annual report,[199] the 2021-2022 Annual Report[200] does not include any information on how many notifications have been dealt with under the category of '*decline to take action*'. Ms Macdonald said she does not know why.[201]

13.21. I observe the submission made by Counsel for DCP that having regard to Section 25(3) of the Coroners Act, it is inappropriate for the Court to be making findings as to DCP's compliance or otherwise with the provisions of the CYPSA. However, as previously mentioned, the question of DCP's compliance with legislative obligations is not arising for the first time in this inquest. I note the following observations and recommendations

[198] Exhibit C42

[199] Section 32 (4) states: The Chief Executive must, in accordance with any requirements set out in the regulations—
(a) cause a record of each action taken under this Section, and the reasons for the action, to be kept in relation to each report or notification made to the Department; and
(b) include statistical information relating to action taken under this Section to be included in the annual report of the Chief Executive under the Public Sector Act 2009

[200] Exhibit C41

[201] Transcript, page 642

made by Deputy State Coroner Schapel in relation to the deaths of Amber Rigney and Korey Mitchell:

> 'What this inquest has highlighted, however, is the folly of governments ignoring coronial and other recommendations. I speak again of the course of the continuation of unlawful practices within the child protection authority despite coronial findings in the Valentine and Napier Inquests that identified those practices. In my opinion what is required is a broad review of all coronial and other recommendations including recommendations of the Ombudsman and of the Royal Commission relating to child protection. I recommend that the Premier of South Australia, the Minister for Child Protection and the Chief Executive of Child Protection cause a review of all coronial and other recommendations relating to child protection in the State of South Australia ***with a view to the implementation of the same***.' *(emphasis added)*

A further recommendation was:

> 'I recommend that a complete review be conducted in relation to all of the statutory obligations contained within the Children and Young People (Safety) Act 2017 ***so as to ensure that practices within the Department align with those statutory obligations***. Such a review should consist of an examination of all documented and undocumented internal Departmental procedures so as to ensure that they comply with all statutory obligations contained within child protection legislation. I also recommend that on completion of such review, an assessment be made ***to ensure that the carrying out of all statutory obligations under the Children and Young People (Safety) Act 2017 are fully resourced to enable those duties and obligations to be carried out without exception***.' *(emphasis added)* [202]

13.22. Ms Kate Alexander was engaged by the SA Government to undertake a review of the coronial and other recommendations relating to child protection as recommended by the Deputy State Coroner following that inquest.[203] Ms Alexander is the Executive Director of the Office of the Senior Practitioner for the NSW Department of Communities and Justice. She has been awarded a Churchill Fellowship to research child protection systems in the UK, US and Norway and is completing her PHD at Melbourne University with research in child protection decision making. She is an eminent and independent expert in the design and implementation of child protection systems.

13.23. The terms of reference of Ms Alexander's report were to review (1) all coronial and other recommendations relating to child protection in the State of South Australia since 2010 and the implementation of the same, and (2) all statutory obligations contained within the CYPSA and the extent to which practices within the DCP, and other State

[202] Inquest 07/2021, Amber Rose Rigney and Korey Lee Mitchell, Finding delivered 21 April 2022
[203] Exhibit C36, SM10, page 193

government agencies as may be appropriate, align with those statutory obligations. According to Ms Alexander's report:

> 'The second term of reference, which is about the alignment of practice with statutory obligations, is broad and far-reaching. It has been addressed in the most pragmatic ways possible, noting the full review of the legislation currently underway. Aspects of the Children and Young People (Safety) Act 2017 have been reviewed, yet its application by the workforce and the great majority of challenges in practice and service provision were understood more as reflections of practice culture than use of legislative powers.'

13.24. The report deals with the persisting practice of the DCP closing files with no action under Section 32 by noting:

> 'Two recommendations made by the Nyland report are still at the implementation stage. These are about ensuring DCP responds to all notifications, either directly, or by appropriate referral (Recommendation 61) and to phase out the closure of intakes and files due to a lack of resources (Recommendation 62). The difficult reality of child protection work is that demand will always exceed supply and these recommendations while hopeful, are not likely to be achieved in the foreseeable future.'[204]

13.25. Given the terms of reference for Ms Alexander's review, if it were to be accepted that that is all which needs to be said regarding Section 32 and the extent to which the practice of CNA complies with it, that would effectively amount to a rejection of Recommendation 62 of The Life They Deserve and an acknowledgement that it is not being and will not be implemented.

13.26. On this issue, a comprehensive analysis is required before such a step could properly be contemplated.

13.27. This would fly in the face of DCP statements that Recommendations 61 and 62 are being implemented and, furthermore, would amount to a rejection of the statutory framework in Section 32 found in the CYPSA, governing the range of responses available in the case of a screened-in notification. Rejecting a statutory framework is not a response which is open, except by Parliament legislating to change that framework.

13.28. It is apposite to repeat the observation of Deputy State Coroner Schapel in the Rigney and Mitchell inquest:

> 'For the most part the issue in this inquest concerned the nonadherence to statutory obligations imposed on the child protection authority due to alleged resource deficiencies.

[204] Trust in Culture, A review of child protection in South Australia, Kate Alexander, November 2022, page 11

> It is manifest that such a situation should never be allowed to develop and be tolerated ever again.' [205]

14. Notifications in relation to baby Caleb's siblings post his death

14.1. Section 13 of the Coroners Act states that '*the jurisdiction of the Coroner's Court is to hold inquests in order to ascertain the cause or circumstances of the events prescribed by or under this Act or any other Act*'. Section 3(3) states that a reference to the circumstances of an event '*may be taken to include matters related to or arising out of the event or its aftermath*'. In accordance with this provision, the inquest considered the response of DCP to the predicament of baby Caleb's siblings following baby Caleb's death.

14.2. On the day of baby Caleb's death, a notification was made by SAPOL to DCP in relation to his (then) two surviving siblings.[206] The notification was prioritised as a '*within 24 hour*' response. The details given by the notifier included the following:

- Baby Caleb had died at 10 weeks and 5 days old;
- A coronial investigation reported some injuries to baby Caleb's body, specifically an injury to his face. The notifier was unsure whether this injury contributed to his death;
- The house is one of the worst the notifier has seen in 20 years;
- Cats have urinated and defecated throughout the home, there was cat faeces smeared on the sofa, there were birds in a dirty cage and significant clutter throughout the house;
- The smell in the house was putrid, it smelled like rotting food, cat faeces and urine. There were mouldy baby bottles in the kitchen. There was no edible food in the house.

14.3. At 3:30pm on the day of baby Caleb's death, two DCP caseworkers went to Ms Evans' mother's home, where they spoke to her and her partner, and also Ms Evans. According to the case note from the visit:

> 'The mother informed them that the two older children were staying with the (step) father of Dawn, David, and will be there for a couple of days. The family advised that they thought this was appropriate, so workers did not question the decision.' [207]

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[205] Inquest 07/2021, Amber Rose Rigney and Korey Lee Mitchell, Finding delivered 21 April 2022
[206] Exhibit C19, page 66; Exhibit C26, page 257
[207] Exhibit C26, page 262

The DCP workers did not sight the children during this visit. Numerous reports had been made to DCP about Dawn's stepfather, Mr David Stewart, in the years preceding baby Caleb's death. In particular, a notification was made that Mr Stewart had threatened to kill Ms Evans,[208] there were a number of notifications made about him being a drug user,[209] and a drug screen once ordered by DCP indicated he had cannabis in his system.[210] Despite that, DCP workers seemed to accept that the children were safe with him, without having a conversation with him, and without sighting the children.

14.4. According to Detective Mayger, he had a conversation with Ms Longman at 4:42pm on the day of baby Caleb's death in which he advised her that DCP needed to sight baby Caleb's siblings to make a proper assessment of their safety.[211] Ms Longman agreed that DCP had purportedly satisfied themselves of the siblings safety that day, without sighting the children, and agreed it was Detective Mayger's suggestion that the siblings were sighted to make a proper assessment of their safety.[212] It is difficult to comprehend how one might make a proper assessment of the safety of a child who had been living in those circumstances without seeing them. Even when the children were seen, DCP staff were apparently satisfied that they were safe based on watching them play in the front yard.[213] There was apparently no information obtained about if and when they might return to the squalid home.[214]

14.5. Furthermore, DCP apparently did not consider whether and if so, how the squalid state of the home may have affected the health of Dawn and Eva. Ms Longman, who was the supervisor of those who made the assessment of Dawn and Eva's safety on 30 November 2018, conceded that in hindsight it would have been appropriate for Dawn and Eva to undergo a health assessment at that time.[215] Ms Macdonald agreed that it would have been appropriate at that time for the children to undergo a medical assessment.[216] There is no indication that anyone from DCP turned their mind to the need for Dawn and Eva to have a medical assessment, despite DCP staff having seen

[208] Exhibit C26, page 60
[209] Exhibit C26, page 60
[210] Exhibit C26, page 82
[211] Transcript, page 126
[212] Transcript, page 507
[213] Exhibit C19, page 86
[214] Transcript, pages 512, 529
[215] Transcript, page 515
[216] Transcript, page 734

first-hand the home in which they were living, and being armed with details from SAPOL about the squalid state of the home.

14.6. The notification made in relation to Dawn and Eva following baby Caleb's death was investigated by DCP by way of an investigation in accordance with Section 32(3), and then closed on 17 January 2019,[217] less than eight weeks after baby Caleb's death. The case closure note includes the following of particular relevance:

- NO5 inadequate basic care was substantiated;
- The death of baby Caleb was still being investigated by SAPOL;
- DCP workers visited the property as part of the investigation and assessed that the mother had not been managing the care of her home for quite some time;
- In its initial findings it appears to be a SIDS incident;
- There are concerns relating to the mother's mental health and how she is able to manage on a daily basis;
- That baby Caleb's death was not due to child protection concerns;
- That there are no current child protection concerns and therefore no current role for DCP.

14.7. According to Ms Macdonald's affidavit:

> 'In hindsight, it was open to DCP staff to undertake a more thorough assessment of Dawn and Eva's circumstances after baby Caleb's death.' [218]

14.8. I consider that the assessment of Dawn and Eva's circumstances following baby Caleb's death, in the context of the information known to the DCP, was entirely inadequate. I conclude that after baby Caleb died there ought to have been a more thorough assessment of his siblings' circumstances.

14.9. There have been other notifications made in relation to Dawn and Eva in the years following baby Caleb's death which Counsel Assisting submitted were also

[217] Exhibit C19, page 96-97
[218] Exhibit C36 at paragraphs 57 – 58

inappropriately addressed by DCP.[219] In particular, a notification was made on 30 June 2022,[220] in which the notifier raised the following concerns:

- Ms Evans had disengaged with services;
- Ms Evans was on autopilot and had no time to engage supports for herself;
- The notifier had been unable to contact Ms Evans between March and June;
- A previous NO5 inadequate basic care was substantiated.

14.10. Despite Ms Evans' history, this notification was assessed as a notifier concern (NC), the current equivalent of the former NOC, and screened out. Given Ms Evans' history with DCP and the circumstances in which baby Caleb died, it would be reasonable to expect that applying the SDM Screening and Response Priority Tool would not result in this notification being screened out as not requiring a child protection response. Ms Macdonald agreed that this notification should not have been assessed as a NC.[221]

14.11. I note Ms Macdonald's evidence in relation to another significant notification that was screened out as a NC (the notification of 14 September 2018) that:

> 'I consider that it is likely that the changes to the practice would mean that currently (in 2022) this notification would have been likely screened-in for a response'.[222]

The screening out of the notification of 30 June 2022 does not inspire confidence that, in future, cases which should require a response from DCP will not be screened out as NC/NOC.

14.12. For the DCP it was contended that the important contextual factor is that although there was risk that they would suffer harm as a consequence of their family history, there is insufficient evidence to support a finding that the two older siblings, or the child born to Ms Evans since, suffered harm as a result of Ms Evans' parenting or DCP's conduct. It was highlighted that following baby Caleb's death Ms Evans has engaged with UCSA on a self-referral and the evidence suggested that the siblings are attending school (where age appropriate) and there are no reported concerns about their development or wellbeing. I accept that. However, that does not alleviate concerns about how some notifications made about these children post baby Caleb's death were addressed.

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[219] Exhibit C26, page 708 notification made on 6 July 2022; page 725 notification made on 30 June 2022 and page 715 notification made on 20 June 2022
[220] Exhibit C26, page 726
[221] Transcript, page 710
[222] Exhibit C36, paragraph 54

15. DCP Adverse Events Review

15.1. The adverse events report completed by DCP in relation to baby Caleb's death was not completed until July 2020, almost two years after baby Caleb's death. Ms Macdonald's evidence was that it was a concern from DCP's perspective that it took so long for it to be produced, and she stated that:

> 'The best Adverse Events Reviews are always done as close as possible to the death or serious injury of a child… we have done a lot of work to reduce that backlog and to ensure that such reviews are done as close as possible to the incident.' [223]

15.2. Also of concern is that the adverse events review did not consider the notification made on 20 November 2018, the last notification before baby Caleb's death and the one which features in my conclusions about preventability of baby Caleb's death. Ms Macdonald described the failure of the review to consider that particular notification as an oversight.[224] Given the significance of the notification, and its proximity to baby Caleb's death, it is difficult to understand how it could have been overlooked. It was a fundamental issue requiring consideration and it should have been dealt with.

15.3. Furthermore, the adverse events review did not make any recommendations. Counsel Assisting submitted that it would have been an entirely appropriate recommendation that an assessment of the capacity of Ms Evans to keep her surviving children safe was undertaken as a matter of urgency. Ms Macdonald agreed that it '*was possible*' that a recommendation could have been made that DCP undertake a better assessment of her capacity to keep her children safe.[225] The adverse events review did not consider why there had never been a parenting capacity assessment undertaken. It would have been useful for the review to have sought to understand or ascertain why not. It also would have been appropriate for the adverse events review to consider why DCP seemingly did not undertake medical assessment of the welfare of the two surviving siblings, post baby Caleb's death, once DCP was aware of the squalor in which they had been living.

15.4. Ms Macdonald conceded that:

- the adverse events review took too long to be produced;
- it did not consider the last notification made before baby Caleb's death;
- it mentioned a thematic review that did not exist;[226]

[223] Transcript, page 716
[224] Transcript, page 715
[225] Transcript, page 715
[226] Exhibit C36, paragraph 19

- it made no recommendations where there were recommendations that could have been made; and
- it was not a thorough review of the circumstances of baby Caleb's death.

15.5. However, Counsel for DCP has urged me in their submissions to recognise the context that:

- there was a significant backlog in the adverse events reviews which has now been caught up so that they will be undertaken closer to the events;
- the adverse events review process has been considered and improved since this review was undertaken.

15.6. On that basis, it is reasonable to expect that in future, upon review, there will be effective processes of self-reflection and analysis, rather than the delayed and ineffective one which followed the death of baby Caleb.

16. Criminal charges

16.1. Following the death of baby Caleb, Ms Evans was charged with three counts of failure to provide food, clothing and accommodation to baby Caleb and his two older siblings contrary to Section 14A of the *Criminal Law Consolidation Act 1935* (CLCA).

16.2. It was submitted and accepted for the purposes of those criminal proceedings that there was no connection between that offending and baby Caleb's death.[227]

16.3. Ms Evans was reported for these offences on 25 March 2021.

16.4. On that date, Detective Mayger emailed Ms Dianne Longman and Ms Elizabeth Kinnear to advise them that Ms Evans had been charged. He indicated the purpose of this was:

> 'To keep them updated about the investigation and to share information with them, I suppose, so they're aware of what arose, what came about of my investigation.'[228]

16.5. Ms Macdonald was advised via email on 6 May 2022 from the Significant Incident Reporting Unit that Ms Evans had been charged with offences of failing to provide food, accommodation and shelter.[229] She was also advised in that email that there had been no involvement by DCP with the family since baby Caleb's death. She conceded

[227] Exhibit C26b and C26c
[228] Transcript, page 135
[229] Exhibit C19, page 102

that DCP should have gathered further information about the current situation for Ms Evans' two other children at that time. That did not occur.[230]

16.6. Ms Evans pleaded guilty to these three offences in June of 2022.[231]

16.7. Ms Longman was due to be a witness at the trial but was then advised Ms Evans had pleaded guilty. Her evidence was that she did not take any action in relation to the information that Ms Evans had pleaded guilty.[232] She explained that:

> 'All I was informed was that I needed to be a witness for the court. I got a telephone call probably a day or two before saying that I was no longer required and that she had pleaded guilty. No further information was provided to me. I don't even know what she pled guilty for. I don't know what her outcome was or is. I still don't know.'[233]

16.8. An offence against Section 14A of the *Criminal Law Consolidation Act* is not a '*qualifying offence*' as defined in Section 44 of the *Children and Young People (Safety) Act*. Although it is not clear why that is the case, it may be that this is because Section 14A of the CLCA was not introduced until after the CYPSA had been assented to on 18 July 2017. It may also be that each qualifying offence involves an intention to cause harm or reckless indifference to causing harm to the child of the offender, whereas an offence against Section 14A of the CLCA is a lesser quality offence. It requires only that a person without lawful excuse fails to provide necessary food, clothing or accommodation to a child or vulnerable adult, to whom they are liable to make provision. There is no element of causing harm. There is no mental element with respect to causing harm.

16.9. The implications of an offence being a qualifying offence are that the CYPSA contains provisions requiring the Chief Executive of DCP to issue a temporary instrument of guardianship if the Chief Executive becomes aware of a child residing with a parent who has been found guilty of a qualifying offence: Section 45 CYPSA. Following the temporary instrument of guardianship, the Chief Executive must apply for an order under Section 53: Section 50(1) CYPSA. Orders pursuant to Section 53 include but are not limited to guardianship of the child. The requirement to apply for orders is not based on any assessment of risk to the child. The Court is obliged to notify the Chief

[230] Transcript, page 700
[231] Exhibit C26b and Exhibit C26c
[232] Transcript, page 522
[233] Transcript, page 523

Executive of DCP of the prescribed information relating to the finding of guilt as soon as practicable after the person is found guilty: Section 48 CYPSA.

16.10. If Section 14A was a qualifying offence, there would have been an obligation on the Court to advise the Chief Executive of DCP of the finding of guilt in June 2022, in accordance with Section 48 of the CYPSA. Ms Macdonald's evidence was that, had she known at the time of Ms Evans' guilty plea in June 2022:

> 'I probably would have taken the same action that I took in preparation for the Coroner's matters, which was to ask the Director of the North to follow up on the circumstances for the children.' [234]

16.11. Ms Macdonald's evidence was that she was not aware Ms Evans pleaded guilty to these offences until, in September 2022, she became aware baby Caleb's death was to be the subject of an inquest.[235]

16.12. Counsel Assisting has submitted that it is unsatisfactory that a parent can be found guilty of multiple charges of Section 14A of the CLCA, including charges relating to children still in their care, and there is no process in place for DCP to be formally notified, and no process in place for DCP to follow if that occurs.

16.13. Counsel for DCP has submitted that the fact of a conviction or finding of guilt of an offence against Section 14A of the CLCA is a matter relevant to DCP's assessment of risk to children in the care of a parent. It was submitted that the fact of criminal liability is less relevant than the fact of the underlying conduct, which usually occurs some significant time before the finding of guilt; in this case, a delay from November 2018 to June 2022. The absence of any automatic notification to DCP regarding a finding of guilt against Section 14A of the CLCA is submitted to be less significant in the context of a significant delay between the offending (at which time DCP will receive a mandatory notification pursuant to Section 31 of the CYPSA) and the time of the finding of guilt.

16.14. Whilst I acknowledge that the critical time for DCP to become aware is the time at which the offending is said to have occurred, I do think it is important for DCP to be informed of the fact of a finding of guilt, regardless of the time delay between the alleged offending and that finding. It may be that notification of a finding of guilt is a

[234] Transcript, page 704
[235] Transcript, page 704

trigger for DCP to check in with that family – in this instance, had there been such a notification, a check in would have occurred in June 2022 rather than September 2022, once DCP became aware of the impending inquest.

17. CaFHS' involvement with baby Caleb

17.1. CaFHS is a state-wide primary and preventative health service. CaFHS key role is to improve the health, development and wellbeing outcomes of infants and children, from the antenatal period to five years old.

17.2. CaFHS delivers free health services to all families living in South Australia following the birth of a baby. This includes the provision of immediate and ongoing support and advice in relation to health and development, adjustment to parenting and sleep and settling. CaFHS does not provide mandatory services. Engagement with the service is based on the consent of the parents/caregiver.

17.3. CaFHS staff are mandatory notifiers pursuant to the *Children and Young People (Safety) Act 2017*. CaFHS staff make a CARL notification if they suspect on reasonable grounds that a child may be at risk. There is no formal referral process to DCP, but a CaFHS employee can contact the local DCP officer in their region if a child receiving CaFHS services was also known to DCP and the CaFHS staff member considered it may assist in overall service provided to the family.[236]

17.4. In 2018 all CaFHS care components were undertaken through one initial contact visit only which was called a Universal Contact Visit (UCV). The CaFHS care components addressed during that visit included a newborn history overview, a genogram of the family structure and supports, health promotion messaging to support family health, psychological health assessment of the mother, safe sleep education and information, and a screening for domestic violence if required.[237]

17.5. At the time of baby Caleb's birth in September 2018, in order to access CaFHS services a parent/caregiver was required to complete a Consent to Contact form which was provided by the birthing hospital to the parent/caregiver for completion. This was a two-page document and required the parent/caregiver to either consent or not consent to be contacted by CaFHS.

[236] Exhibit C37
[237] Exhibit C37

17.6. The Consent to Contact form completed by Ms Evans in relation to the birth of baby Caleb[238] indicates that Ms Evans did not consent to CaFHS contacting her except for the hearing test.

17.7. There was also a Priority Information Form (PIF) completed by hospital staff in relation to baby Caleb's birth,[239] which is to be completed by staff at the birthing hospital when they consider it appropriate to inform CaFHS about any specific concerns that required a priority assessment.[240] The PIF to CaFHS dated 23 September 2018 indicated that baby Caleb was a priority information referral to CaFHS. The concerns noted were that baby Caleb had a tongue-tie awaiting review by the lactation consultant, had a young mother with minimal supports, and required an Automated Auditory Brainstem Response test (AABR).

17.8. Due to Ms Evans only providing consent to contact in relation to the hearing screen, the only direct contact CaFHS had with baby Caleb and Ms Evans was a visit on 4 October 2018 when they attended for an AABR. Ms Evans and baby Caleb attended along with Ms Evans' mother Tamara Evans.

17.9. Ms Josephine Probin, the CaFHS nurse who conducted this AABR, provided an affidavit stating that during this appointment Ms Evans confirmed that she only wanted a hearing test for baby Caleb.[241] Ms Evans had explained that she felt that she had '*had enough*' in the two days prior with baby Caleb having had a tongue-tie snip the day before that took 2½ hours. Ms Probin noted that Ms Evans appeared '*sullen*' and not interested in being at the clinic.

17.10. Ms Probin completed the paperwork that is usually utilised for the UCV, even though that was technically not the purpose of baby Caleb's visit, explaining that:

> 'This form would not ordinarily be used for a simple hearing assessment visit. I used this form as a convenient and available location to record information from the clinic discussion.' [242]

17.11. That record indicated that the safe sleep education component of the UCV, which involved a discussion around sleeping the baby safely and an assessment as outlined in the Sleeping Baby Safely Form, was not completed on baby Caleb's file. According to

[238] Exhibit C18, page 11
[239] Exhibit C18, page 13
[240] Exhibit C37
[241] Exhibit C37
[242] Exhibits C37 and C18, pages 16-19

the affidavit of Ms Kurtzer, this was not completed as Ms Evans did not consent to any of the routine universal visit services, however Ms Kurtzer's evidence was that the lack of consent was not a barrier to providing safe sleeping information to Ms Evans during this visit.[243] This was a perfect opportunity to provide and discuss safe sleeping information with Ms Evans, however given this was her third child, it would have been reasonable to assume she would have been educated on safe sleeping practices in relation to her previous children and, from Ms Probin's account of Ms Evans' presentation during this visit, she was unlikely to be receptive to that education during this visit in any case.

17.12. Ms Probin stated:

> 'Even though (Ms Evans) was not attending for a UCV, I tried to obtain a history from (Ms Evans) and assess baby Caleb's wellbeing during the hearing test because I knew baby Caleb was a priority referral and (Ms Evans) did not want to participate in any other CaFHS services.
>
> I enquired into (Ms Evans') wellbeing and I documented the information offered by (Ms Evans) and her mother in baby Caleb's notes. I noted that (Ms Evans) felt that she had enough professional support at home, was breastfeeding well, had a close relationship with her mother, was coping well, was living on her own and that (Ms Evans') siblings had input into helping with her two other children. I also noted my impression that baby Caleb's grandmother was very ('++') supportive.
>
> …
>
> I recall that I considered that (Ms Evans) had the supports she required based on the history provided to me. However, I suspect that I referred (Ms Evans) for further consideration of her CaFHS pathway because I knew I was a casual relief nurse in the region, baby Caleb was a priority referral and (Ms Evans) had not engaged in a UCV.' [244]

17.13. The referral Ms Probin is referring to for further consideration of her CaFHS pathway was the Case Review process.[245] A Case Review was one of the CaFHS processes to determine CaFHS service pathways, actions required by the nurse or any other agency referrals required. Ms Evans' medical record contained a Case Review Record form that Ms Probin completed, a standard CaFHS procedure to seek a Case Review. Case Review with Kathy Sumner (CaFHS Nurse Consultant) was undertaken on 4 October 2022. Ms Probin has noted the reason she presented this case for review was because Ms Evans was a single young mother aged 17 years with mental health issues. She noted that Ms Evans had a past history of mental health issues and had refused

[243] Transcript, page 768
[244] Exhibit C37
[245] Exhibit C17, page 126

questionnaires at this time. Ms Probin also noted that DCP had closed its case for Ms Evans' first child and noted that there was no present DCP case.[246] The action from the Case Review was to follow up with Ms Evans in two weeks after midwifery led care had finished.[247]

17.14. On 17 October 2018 Ms Probin called Ms Evans but she did not answer so she sent a text message inviting Ms Evans to connect with CaFHS, as noted in baby Caleb's record. There was no reply to that text. Ms Probin contacted Lynda McDowall (CaFHS Nurse Consultant, Country North) later that day, noting that '*It was my standard practice to raise any concerns or queries about next pathway steps with the relevant Nurse Consultant*'. Ms Probin's notes indicated that the concluded pathway was for '*Ms Evans' further contact with CaFHS to be for her to use CaFHS services as she decided*'.[248]

17.15. Ms Probin noted that:

> 'At the time of my consultation with (Ms Evans) and baby Caleb I was aware of my obligations to make a mandatory notification if I considered that baby Caleb was at risk. I did not have sufficient information to form the view that baby Caleb was at risk of harm given the other services and supports in place for (Ms Evans) at the time.'

17.16. CaFHS did not inform DCP that Ms Evans had opted out of CaFHS involvement. Ms Macdonald agreed that CaFHS involvement could have been a protective factor in baby Caleb's life and that it is important that the DCP is made aware when a family with a child protection history has opted out of CaFHS involvement with a subsequent child. Her evidence was that, in baby Caleb's case, if DCP had become aware that Ms Evans had opted out of CaFHS involvement with him, that would definitely have raised a concern.[249]

17.17. Nevertheless, Counsel Assisting submitted CaFHS should not be criticised for failing to inform DCP that Ms Evans had opted out of CaFHS involvement following baby Caleb's birth, as it seems the information CaFHS had about the current status of child protection concerns relating to Ms Evans' children was inadequate. The Case Review

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[246] Exhibit C17, page 126

[247] Exhibit C17 pages 3-6 indicate that Midwife Lena Boxall undertook 5 post-natal visits with Ms Evans and baby Caleb, with the last visit taking place on 13 October 2018. The notes do not indicate where the visits were occurring Ms Boxall had made a notification about the state of the family home to DCP prior to baby Caleb's birth, that being the notification that was made on 14 September 2018 that was screened out as a NOC.

[248] Exhibit C37

[249] Transcript, page 725

Record[250] indicated that DCP closed their case on Ms Evans' first child on 10 July 2017 and there was no present case with DCP. That was clearly inaccurate; there had been an investigation in relation to Dawn and Eva that was not closed until July 2018. In addition, there had been three UCCs raised in relation to baby Caleb in recent months, and an additional notification that was screened out as a NOC.

17.18. Ms Kurtzer's evidence was that if CaFHS was aware there had been three UCCs raised in relation to baby Caleb, the expectation would have been that DCP would have been notified by CaFHS that Ms Evans had opted out of CaFHS involvement.[251] According to Ms Kurtzer, '*…all we had to go on was that contact that Josie had with (Ms Evans)*'.[252]

17.19. Counsel Assisting submitted it is open to me to find DCP should have taken steps to ensure that Ms Evans had CaFHS involvement given her recent history with the DCP, the number of UCCs raised in relation to baby Caleb, which had not been actioned in any way prior to his birth, and the notification made on 14 September 2018 that she was likely to require support once baby Caleb was born. DCP had ample reason to be concerned – even before baby Caleb was born – that he may not be safe in his home environment. I do find that DCP should have actively engaged with Ms Evans and CaFHS to ensure Ms Evans was getting the benefit of CaFHS assistance when baby Caleb was born. CaFHS involvement may have been a protective factor for baby Caleb.

17.20. I am told that it is currently not part of CaFHS internal policies and procedures that DCP should be notified whenever a family with a DCP history opts out of CaFHS involvement. Counsel Assisting suggested that opting out could be relevant or important for families who had a child protection history. Counsel for DCP said that this submission begs the question, what is a child protection history, how is CaFHS to be notified of that history, and how should CaFHS interpret information received about notifications and what action should they take as a result. It was further submitted that it is unclear whether sharing a family's decision to opt out of CaFHS when that family has a child protection history (without any more risk factors) provides any information which is helpful in managing any risk to the children.

[250] Exhibit C17, page 126
[251] Transcript, page 780
[252] Transcript, page 780

17.21. It was submitted that whilst it may have been relevant for DCP to be advised that Ms Evans had opted out of CaFHS involvement with baby Caleb, it is not clear that this provides any information about how the child protection system ought to be structured, and whether this supports a finding that there is a broader concern about the operation of the system. Counsel for DCP pointed out that it cannot be found that opting out of CaFHS is a sufficient basis to suspect that a child is at risk of harm. Whilst I accept that, it is important for DCP to be aware if a family with any child protection history opts out of CaFHS involvement, so that DCP can then make an informed judgment about whether there is a reason to suspect that a child is at risk of harm. In baby Caleb's case, had DCP been notified that Ms Evans had opted out of CaFHS involvement, that should have raised suspicion that baby Caleb was at risk of harm.

18. CaFHS involvement with Kalima

18.1. Kalima was born 18 months after the death of baby Caleb.[253] Given the circumstances of baby Caleb's death, one would expect that DCP and CaFHS would have paid particular attention to the subsequent child born to Ms Evans, and the environment in which that infant was to be living and sleeping. However, DCP was apparently unaware of Kalima's birth until the first notification made about her on 30 June 2022.[254]

18.2. CaFHS involvement with Kalima was again very limited. This was so despite Ms Evans consenting to CaFHS contact following Kalima's birth.[255] A PIF was completed by the birthing hospital and forwarded to CaFHS.[256] It was noted on the form that '*last baby Caleb deceased ?SIDS @ 11/52 age*'. The document notes: '*referral done due to outcome of last baby and maternal anxiety around this*'. There is no mention on the PIF provided to CaFHS of the family having a history with DCP.

18.3. Ms Evans attended for a CaFHS appointment with Kalima on 10 June 2020. However, due to an administrative error, that appointment did not take place and was rescheduled. According to Ms Kurtzer, if that appointment had taken place as scheduled, one hour would have been allocated for that purpose, and:

> 'Given that a PIF had been submitted in respect of Kalima which clearly identified previous Sudden Unexplained Death of baby Caleb, this placed the family at greater risk

[253] 28 May 2020
[254] Exhibit C25
[255] Exhibit C25, page 13
[256] Exhibit C25, page 16

and CaFHS could have offered support services to assist (Ms Evans), to deal with any trauma associated with the death of baby Caleb and the care of Kalima'.[257]

Ms Evans' attendance at the clinic on this day suggested a willingness to engage with CaFHS at that point in time however, following the administrative error by CaFHS, and the rescheduling of the appointment, the appointment never took place despite multiple attempts by CaFHS to follow that up.[258] None of the paperwork relevant to the UCV was completed, including the paperwork relating to safe sleeping. On 1 July 2020, CaFHS sent Ms Evans a letter detailing that they had been unable to contact her and inviting her to get in contact.[259] That did not occur.

18.4. No Case Review was completed in relation to Kalima. Ms Kurtzer's evidence was that if the CaFHS nurse overseeing the management of Kalima had been aware of Ms Evans' DCP history, she would have expected a Case Review to have taken place. Ms Kurtzer said the CaFHS nurse involved with Kalima would have had access to the notes relating to Ms Evans' other children and through perusing those should have gleaned information about the family's DCP history, which should have caused a Case Review to take place. As stated previously, the information CaFHS had about DCP involvement with the Evans children in recent years was inaccurate in any case.

18.5. Ms Kurtzer's evidence about what involvement CaFHS should have had with Kalima was as follows:

'Q: … if CaFHS had identified the child protection history, but more particularly the circumstances in which baby Caleb had died, what do you think should have happened in relation to Kalima, what CaFHS involvement.

A. A home visit should have occurred so we could see the sleeping environment.

Q. So a home visit to assess the sleeping environment, other than just that one home visit to assess the sleeping environment what other involvement do you think CaFHS should have had with Kalima.

A. We could have referred her to our social work services and also we've got psychology as well, but social work in particular to support her in her housing, because it looks like from reading this that she had issues with housing and just to support her with parenting and, you know, constantly weighing the baby and supporting her with her grief as well. That's what social work would have helped, assisted with after the death of her baby, but in particular I think the most important thing that's missing here is the safe sleep and giving her that information and just asking her where the

[257] Exhibit C38
[258] Exhibit C25, paragraphs 23-24
[259] Exhibit C25, page 33

> baby sleeps and then - I mean, she could have done that this nurse but it's not documented there that she did ask that.' [260]

18.6. The evidence suggested that Kalima's case was never discussed by the '*high risk infant group*'.[261] The high-risk infant group was put forward at the inquest as a positive change since baby Caleb's birth, which should mean that high risk infants like baby Caleb and Kalima receive a collaborative response from the relevant agencies. According to Ms Kurtzer:

> 'The high risk infant meeting was brought in many years ago to support agencies all coming together antenatally so that the birthing hospitals when they have a mother coming in from 20 weeks on antenatally, if she was identified as high risk, that would be documented as an unborn child concern, and that information would go to the high risk infant meeting. So, CaFHS and DCP, if the system works correctly, would all have that information and we make up a case file for that mother antenatally, and marry that information up when we get the consent to contact, so we have got that previous information for that infant.' [262]

18.7. Counsel Assisting submitted, given the circumstances in which baby Caleb died, Kalima was clearly a high-risk infant. Ms Macdonald agreed that given the circumstances in which baby Caleb died, and DCP's lack of involvement with the family since January 2019, had the DCP known about Kalima she should have been considered a high-risk infant until satisfied otherwise.[263]

18.8. Counsel Assisting submitted that the fact that Kalima did not come to the group's attention is an indication that the existence of this group has not solved the problem of children slipping through the gaps. Counsel for DCP submitted that given the high-risk infant meeting in Port Pirie was not fully operational until sometime in 2020, it can be understood why this forum did not recognise that Kalima was a high-risk infant and communicate that information to CaFHS. I am of the view that Kalima clearly was a high-risk infant and should have come to the attention of the high-risk infant meeting if this forum was operational prior to Kalima's birth.

18.9. Ms Macdonald's explanation for why DCP were not aware of Ms Evans' pregnancy was that no notifications had been made to DCP about the fact that Ms Evans was pregnant again. Ms Macdonald supposed that the lack of notifications about Ms Evans

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[260] Transcript, page 794
[261] Ms Macdonald's evidence was that if she was discussed at the high-risk infant group, there would be a record of that on C3MS, Transcript, page 722
[262] Transcript, page 764
[263] Transcript, page 722

being pregnant with Kalima, or relating to Kalima post birth, meant that '*the professionals involved with Ms Evans at the time were not concerned about her capacity to parent Kalima*',[264] but conceded the lack of notifications could also have been the result of mandated notifiers having a lack of information about Ms Evans' child protection history.[265]

18.10. Ms Macdonald's evidence was that DCP is able to direct CaFHS to take certain actions in relation to a family, but that did not occur in relation to Kalima, because DCP did not have an open case in relation to her when she was born.[266]

18.11. Counsel Assisting submitted that if DCP had engaged with and monitored the family for a longer period of time following baby Caleb's death, then DCP would have become aware of Ms Evans' pregnancy with Kalima. Had that occurred, DCP could have taken an active role in ensuring Ms Evans had CaFHS engagement regarding Kalima.

18.12. While counsel for the DCP conceded that had DCP engaged with Ms Evans for a longer period of time following baby Caleb's death then they would have become aware of Ms Evans' pregnancy with Kalima, it was submitted that it is impossible for DCP to have ongoing monitoring of all families with a child protection history. It was submitted that the fact of child protection history does not, of itself, sufficiently differentiate the family from those other families where there is a reasonable basis to suspect that a child is at risk of harm, so as to justify the ongoing deployment of finite resources.

18.13. Whilst I accept that to be the case, given the circumstances in which baby Caleb died (in a squalid home, in an unsafe sleeping environment), and the repeated pattern of notifications about Ms Evans' inability to maintain a safe home for her children and cope with her parental responsibilities, I do not consider that some element of ongoing monitoring for a longer period of time post baby Caleb's death would have been unduly onerous on DCP and its finite resources. Ms Evans was pregnant with Kalima within ten months of baby Caleb's death. Had DCP seen fit, for example, to do a quarterly check in with the Evans family following baby Caleb's death to monitor the living circumstances of his siblings, they would have become aware of Ms Evans' pregnancy

[264] Exhibit C36, paragraph 60
[265] Transcript, page 724
[266] Transcript, page 728

with Kalima and been in a position to take steps to mitigate the risks potentially faced by Kalima as a high risk infant, including ensuring CaFHS involvement.

18.14. Counsel Assisting submitted that the fact that Ms Evans had another infant 18 months after baby Caleb's death, failed to engage properly or utilise the supports offered by CaFHS, and the DCP was unaware of Kalima's existence, was a significant failure to ensure Kalima's safety. DCP had ample reason to be concerned about the safety of any subsequent child born to Ms Evans after baby Caleb, and yet took no proactive measures to ensure that, if Ms Evans did have another infant, they would not only be aware, but also involved until assured of the infant's safety.

18.15. I accept that there is no evidence that the risk materialised to cause any harm to Kalima, but I do not accept that it cannot be said that there was a failure to ensure Kalima's safety. DCP ought to have taken steps to ensure that if Ms Evans was to have another infant within a short time after baby Caleb's death, it came to DCP's attention so proactive steps, which may have included directing CaFHS involvement, could be taken to ensure the safety of that infant.

19. Preventability

19.1. One of the matters considered upon inquest was whether baby Caleb's death may have been prevented. That including considering whether, had DCP acted differently in response to any of the notifications it received in relation to baby Caleb, his death may have been prevented. According to Dr Starr:

> 'I think that if he had been put to bed in a cot like any other baby without anything in the cot and it was an appropriate mattress and the area was clean and he was clean and the mother didn't smoke and she didn't co-sleep then this death would not have happened; they're all preventative things.'[267]

He went on to stay that in his view, baby Caleb's death could have been prevented had he been in clean, well set up cot.[268]

19.2. Of course, it was open to his mother, being his primary caregiver, to ensure he was put to sleep in a clean, well set up cot. However, baby Caleb's mother had consistently demonstrated over a number of years that she struggled to meet her parenting

[267] Transcript, page 245
[268] Transcript, page 247

responsibilities. Concerns about the way in which she parented were frequently brought to the attention of the DCP.

19.3. DCP submitted that the evidence supports a finding that DCP could not have prevented baby Caleb's death; nor had DCP caused or contributed to the death. I disagree. It is clear that there were opportunities for DCP to have intervened in a manner which would have prevented baby Caleb from living and sleeping in the environment he was in at the time of his death. It was accepted on behalf of DCP that it is reasonable to conclude that, if DCP had taken action in response to the notification of 20 November 2018, rather than closing it with no action, then baby Caleb would have been removed from that squalid home environment.[269]

19.4. Had baby Caleb been removed from that environment, he would have been sleeping in a clean, well set up cot, rather than in an unsafe sleeping environment, and this may have prevented his death.

20. Summary of findings

20.1. In the weeks leading up to his death, baby Caleb had been unwell with a respiratory tract infection.

20.2. On the evening of 29 November 2018, baby Caleb was placed to sleep in an unsafe sleeping environment.

20.3. On 30 November 2018 at approximately 3:45am, baby Caleb was located by his mother deceased.

20.4. Baby Caleb's cause of death is '*unascertained, in an unsafe sleeping environment on a background of respiratory tract infection*'.

20.5. Baby Caleb was living in squalor at the time that he died, and for the months prior to his death.

20.6. The home in which baby Caleb lived placed him at risk of both physical and psychological harm and was not adequate for optimal child health and wellbeing.

[269] Transcript, page 689

20.7. A number of notifications had been made to DCP about baby Caleb before and after his birth.

20.8. DCP engagement following the notification in May 2018 was not adequate to ensure Ms Evans had made sustained changes to the living environment.

20.9. CaFHS involvement with baby Caleb may have been a protective factor.

20.10. CaFHS should have been made aware by DCP of all of the unborn child concerns relating to baby Caleb.

20.11. The notification made to DCP on 20 November 2018 should have attracted a child protection response including a visit from DCP to the family home.

20.12. Had DCP visited the family home in response to the notification of 20 November 2018, it is likely baby Caleb would not have been sleeping in an unsafe environment on the evening of 29 November/morning of 30 November 2018.

20.13. Had baby Caleb not been sleeping in that environment, but rather sleeping in a safe sleeping environment, his death may have been prevented.

20.14. DCP's response to ensure the safety of baby Caleb's siblings in the immediate aftermath of baby Caleb's death was inadequate.

20.15. DCP's lack of knowledge of the birth of Kalima was unsatisfactory given that Kalima was clearly a high-risk infant and may have benefited from CaFHS or DCP involvement.

21. Recommendations

21.1. 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.

21.2. I am informed that in the four years between baby Caleb's date of death and the date the inquest was heard, DCP made significant changes to its practice and if baby Caleb's case was dealt with by DCP today, the response would have been different and likely have resulted in better engagement with Ms Evans. Ms Macdonald's affidavit and oral

evidence described a number of measures that have been implemented since the events with which this inquest is concerned. The scope of this inquest did not extend to conducting a detailed examination of how each those measures are working in practice.

21.3. Nevertheless, I consider there are recommendations to be made.

21.3.1. Counsel Assisting has proposed a recommendation that the *Children and Young People (Safety) Act 2017* should be amended to include an offence against Section 14A of the *Criminal Law Consolidation Act 1935* of failing to provide food, clothing or accommodation to a child as a qualifying offence pursuant to Section 44 of the CYPSA. As previously discussed, the effect would be to require the Chief Executive of DCP to issue a temporary instrument of guardianship upon becoming aware of a child residing with a parent found guilty of such an offence, and then to apply for an order pursuant to Section 53 of the CYPSA. As pointed out by Counsel for the DCP, this would change the policy structure of the regime of qualifying offences and their mandatory consequences to extend beyond offences involving intentional harm or reckless indifference as to harm, to offences involving no such intention. I am not persuaded that the mandatory scheme should be extended in this way and so I shall not make the suggested recommendation.

21.3.2. However, I accept the alternative submission of Counsel Assisting, namely that if Section 14A is not a qualifying offence as defined in Section 44 of the CYPSA, the court making a finding of guilt must notify DCP whenever a parent is convicted of an offence against Section 14A (as the court must do when a parent is convicted of a qualifying offence). Such recommendation was not opposed by Counsel for DCP, although it was submitted that the fact that a parent has been convicted of a Section 14A offence is likely to be of limited utility given the time taken from the underlying events and the finding of guilt or conviction.

21.3.3. Counsel Assisting also urged a recommendation that DCP should notify CaFHS whenever a parent is convicted of a qualifying offence or an offence against Section 14A of the CYPSA. Counsel for DCP submitted that rather than DCP receiving information from courts and passing that information to CaFHS, it would be preferable for there to be one information source and that

any recommendation ought to require courts to provide the information to both DCP and CaFHS and that this would ensure that accurate and timely information passes from the source to agencies who can use the information. Accordingly, to the Minister for Child Protection and the Minister for Health and Wellbeing, I recommend that the CYPSA be amended to require a court which finds a parent of a child guilty of an offence against Section 14A of the CLCA to notify both DCP and CaFHS.

21.3.4. Counsel Assisting urged a recommendation that, where a parent is convicted of offences against Section 14A, and has other children remaining in their care, a mandatory court ordered parenting capacity assessment should be undertaken within a short timeframe after that conviction.

21.3.5. I take into account the submissions of counsel for the DCP arguing against a regime of mandatory court orders and pointing out that the most appropriate time for such a parenting assessment would be at the time of the events, not the time of a finding of criminal liability. I note that a conviction can only occur after finding of guilt by a court, which follows an admission of guilt or a trial. Until such time, the commission of the offence has not been proved and may be genuinely in dispute. I expect that it would be a relatively rare situation for a parent to be convicted of offences against Section 14A of the CLCA and still have children in their care, such that it would place any significant strain on finite specialist parenting capacity assessment resources. I bear in mind that I have not recommended that a Section 14A offence be a qualifying offence leading to mandatory temporary guardianship followed by an application for orders pursuant to Section 53. To the Minister for Child Protection, I recommend that that the CYPSA be amended to require the Minister or the Chief Executive (of the DCP) to apply to the Youth Court for an order that a parenting capacity assessment be undertaken when a parent who still has a child or children in their care has been found guilty of an offence against Section 14A of the CLCA.

21.3.6. Counsel Assisting urged a recommendation that a policy should be developed for CaFHS to notify DCP whenever a parent with a known child protection

history opts out of CaFHS involvement with a new infant.[270] Counsel for DCP submitted that this recommendation proposes a significant shift to the notification system which requires mandated notifiers to assess risk and report when they have the appropriate suspicion. It was submitted that the High-Risk Infant Meetings and the Child and Family Safety Networks now provide a way for service providers to discuss failures to engage and concerns about families (including where those concerns are less than required to make a mandatory notification). I see no drawback to requiring CaFHS to advise DCP whenever a family with any child protection history opts out of CaFHS involvement. It need not be done as a formal child protection notification. If armed with this information, then DCP can then make its own assessment as to whether that warrants any exploration by DCP or not. Accordingly, to the Minister for Child Protection and the Minister for Health and Wellbeing, I recommend that a policy or protocol be developed providing for CaFHS to notify DCP when a parent with a known child protection history opts out of CaFHS involvement with a new infant.

21.3.7. Counsel Assisting submitted that it would also be appropriate for a procedure to be established whereby any Unborn Child Concerns that DCP receive be shared with CaFHS. I agree that this would ensure CaFHS is armed with important information when they come into contact with that infant in the first days and weeks of its life. Accordingly, to the Minister for Child Protection and the Minister for Health and Wellbeing, I recommend that a policy or protocol be developed providing for Unborn Child Concern notifications to be shared by DCP with CaFHS.

21.3.8. Counsel Assisting submitted that the practice of DCP closing screened-in notifications without taking any action, which has persisted following the Recommendation 62 of the Royal Commission in 'The Life They Deserve' and subsequent coronial inquest findings and recommendations, must cease

[270] This recommendation was explored with Ms Kurtzer of CaFHS. Her evidence at transcript, page 785 was as follows:
Q Is it currently a practice of CaFHS that DCP need to be advised any time a client with DCP history has not consented to CaFHS involvement.
A No, that is not a policy currently.
Q Do you think that would be a beneficial policy.
A It could be a beneficial policy, or if we had a state-wide service like CPS. We've got CPS, there's child protection units in each of our local health networks but they are all separate, so if we had something centralised we could make referrals through that avenue and they could manage back out to DCP. But at the moment there's many different DCP offices, so you know it's a bit clunky and not a very straightforward process.

immediately. Despite the ongoing purported process of implementation of Recommendation 62, Ms Alexander described the recommendation as '*hopeful*' and '*not likely to be achieved in the foreseeable future*'. If these characterisations were to be accepted, then the process of implementation will be never-ending and illusory. Until this recommendation is fully implemented, experience allows it to be presumed that further potentially preventable deaths of children will occur when a screened-in notification has been 'closed no action' due to lack of resources. I agree that it is time for this practice to cease and for the statutory obligations in Section 32 of the Children and Young People (Safety) Act to be complied with. An issue arises, however, of the practicability of a recommendation that the practice cease immediately, where the necessary measures have not been undertaken. I shall make a recommendation designed to encourage an immediate focus on bringing the practice to an end and, if necessary, the allocation of financial and other resources as required. Accordingly, to the Minister for Child Protection and the Chief Executive of the Department for Child Protection, I recommend:

(1) that the phasing out of the closure of intakes and files due to lack of resources, as recommended in Recommendation 62 of The Life They Deserve, be completed within 18 months of the date of this finding; and

(2) that after nine months from the date of this finding, no intake be closed due to lack of resources without the specific approval in writing of the Chief Executive of the Department for Child Protection.

21.3.9. Counsel Assisting urged a recommendation that DCP should advise notifiers if the notification they make is subsequently 'closed no action'. This was first raised in The Life They Deserve where it was stated:

> '… if an Assessment and Support team decided to close a screened-in notification without assessment, providing feedback to notifiers would afford some accountability for that decision. The notifier is entitled to know both the response priority rating, if and when it is applied, and if the file were to be closed with no assessment. If the Agency cannot respond to the child, then it must at least advise the notifier and give them the opportunity to support the child and family in some other way, if possible.'

Recommendation 40 of The Life They Deserve was that DCP should provide automated electronic feedback to all notifiers, confirming receipt of their notification (in the case of eCARL) and, post-assessment, what screening and response priority assessments were made in relation to their notifications. The State Ombudsman noted in his report[271] in relation to Amber Rigney and Korey Mitchell that:

> 'The Nyland Commission has otherwise recommended that the agency "provide automated electronic feedback to all notifiers, confirming what screening and response priority assessments were made in relation to their notification".[272] The Agency has indicated its "in principle" acceptance of this recommendation; however, at time of writing the recommendation remains to be meaningfully implemented.'

The document updating the public on the current status of the Recommendations from The Life They Deserve still indicates that this Recommendation has been accepted '*in principle*'[273] but Ms Macdonald's evidence on the topic of whether DCP currently advised notifiers that their notification has been 'closed no action', provided no clarity.[274] Despite stating that '*It is appropriate to inform some categories of notifiers, and we do*',[275] she went on to say that she would not support a recommendation that when a State authority makes a notification, they should be advised of the outcome of that. She would not support a recommendation that when a not-for-profit engaged to work with a family makes a notification and it is closed by the DCP with no action, the not-for-profit should be notified, and she would not support a recommendation that a mandated notifier that makes a notification should be advised if DCP closes a notification with no action.[276] Counsel Assisting submitted, as long as the practice of CNA continues, any notifier whose notification is 'closed no action' should be advised as soon as that

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[271] SA Ombudsman report entitled 'Department for Child Protection - Wrongful failure to share information concerning the care and protection of two deceased children (2018/02813), Redacted Final Report (Ombudsman SA)

[272] Recommendation 40, The Life They Deserve

[273] Exhibit C36f

[274] Transcript, page 666 exchange was as follows:

Q So, is that something that DCP has actively considered whether it might be appropriate to tell the notifier if the notification has been closed with no action

A I'm actually just trying to weigh up that question, I'm not trying to not answer it, and I don't think that's the answer to the difficulties that we face, I think the difficulty is not being able to get to the notification, clearly, and trying to increase effort there

Q But I'm not asking you if it's the answer, I'm asking you if it is something that has been contemplated by the department whether or not it would be appropriate to inform some categories of notifiers that the notification has been closed with no action

A It is appropriate to inform some categories of notifiers, and we do

[275] Transcript, page 666

[276] Transcript, pages 667-668

occurs, for the reasons elucidated in The Life They Deserve as extracted above.

21.3.10. Counsel for the DCP noted that this recommendation has been made by a number of bodies on different occasions. It was submitted that it is unclear what, if anything, notifiers can and should do if DCP are not able to provide a child protection response. It was submitted that the escalation pathways embedded since the events of this inquest provide a new ability for service providers to work together to support families where DCP is not in a position to respond to a notification. Unintended consequences were referred to, for example in some circumstances, a notifier might be at risk of harm if there is a response to the fact of their notification (for example if family report domestic violence by a parent). It was submitted that the technology available to DCP is not presently able to facilitate automatic responses to notifiers and it is not clear whether investment in a response to notifiers (whether by diverting social workers or by acquiring new technology) provides a good return on investment in terms of ensuring child safety.

21.3.11. I note the opposition to this recommendation expressed on behalf of the DCP. That opposition, the reasons advanced for it, and the evidence of Ms Macdonald to which I have referred suggest that 'acceptance in principle' of Recommendation 40 of the report of the Child Protection Systems Royal Commission, 'The Life They Deserve' is subject, in the view of the Department for Child Protection and its guiding minds, to a wide range of exceptions.

21.3.12. I observe that if a notifier is not advised of closure without action of a notification, they may well be disinclined to make further reports in the case of ongoing concerns because they assume, wrongly, that the Department is taking action in response to their earlier notification. If, on the other hand, a notifier was advised that a notification had been 'closed no action' they may be more likely to be motivated to notify again if the situation which gave rise to the concern persisted or recurred. They will also have the opportunity to support the child and family in some other way, if possible.

21.3.13. To the Minister for Child Protection and the Chief Executive of the Department for Child Protection, I recommend that (if Recommendation 40 of 'The Life They Deserve' is not to be implemented) a policy be developed which identifies the circumstances in which a notifier is to be advised, or not advised, that a notification has been closed with no action.

Key Words: Department for Child Protection; Safe Sleeping Practices; Child Abuse

In witness whereof the said Coroner has hereunto set and subscribed his hand and Seal the 28th day of June, 2024.

State Coroner