JURISDICTION	:	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	:	CORONERS ACT 1996
CORONER	:	Philip John Urquhart
HEARD	:	19 - 21 October 2020
DELIVERED	:	9 FEBRUARY 2021
FILE NO/S	:	CORC 726 of 2017
DECEASED	:	BABY H

Catchwords:

Nil

Legislation:

Coroners Act 1996 (WA)
Children and Community Services Act 2004 (WA)

Counsel Appearing:

Ms S Tyler appeared to assist the Coroner
Mr B Nelson and Ms A Miller appeared on behalf of the Department of Communities and WA Country Health Services
Ms R Young appeared on behalf of Dr Isaac Adewumi

Case(s) referred to in decision(s):

Inquest into the death of PT [2020] WACOR 26

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

I, Philip John Urquhart, Coroner, having investigated the death of ***Baby H*** *with an inquest held at Perth Coroners Court, Central Law Courts, Court 85, 501 Hay Street, Perth, on 19 - 21 October 2020, find that the death of* ***Baby H*** *occurred on 28 May 2017 at Princess Margaret Hospital, from head and neck injuries in the following circumstances:*

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WARNING:

The contents of this finding may be distressing to readers as the contents refer to inflicted injuries suffered by a baby

SUPPRESSION ORDER:

Suppression of the deceased's name from publication and any evidence likely to lead to her identification. The deceased is to be referred to as 'Baby H'.

INTRODUCTION

1. Baby H died on 28 May 2017 from head and neck injuries. She was 4 months and 9 days old. Two days before her death, Baby H had been placed into the care of the Chief Executive Officer (CEO) of the Department of Child Protection and Family Support (the Department).[1]

2. Accordingly, immediately before her death, Baby H was a "*person held in care*" within the meaning of the *Coroners Act 1996* (WA) and her death was therefore a "*reportable death*".[2]

3. In such circumstances, a coronial inquest is mandatory.[3] Where, as here, the death is of a person held in care, I am required to comment on the quality of the supervision, treatment and care the person received from the Department while in that care.[4]

[1] Now the Department of Communities
[2] Section 3, *Coroners Act 1996* (WA)
[3] Section 22(1)(a), *Coroners Act 1996* (WA)
[4] Section 25(3), *Coroners Act 1996* (WA)

4. I held an inquest into Baby H's death at Perth on 19 - 21 October 2020. The following witnesses gave oral evidence:[5]

   i. Baby H's maternal grandmother;
   ii. Sergeant Simon Bowen, detective with the Homicide squad;
   iii. Maria Barry, team leader with the Department;
   iv. Nicole Mitchell, team leader with the Department;
   v. Tara Tomsett (nee Clement), child protection worker with the Department;
   vi. Suzanne Smith, registered nurse at the Bunbury Regional Hospital (BRH);
   vii. Dr Helen Truong, resident medical officer in the emergency department of BRH;
   viii. Dr Isaac Adewumi, consultant medical officer in the emergency department of BRH;
   ix. Glenn Mace, executive director in the Community Services division of the Department;
   x. Dr Louise Houliston, forensic paediatrician, Child Protection Unit at Princess Margaret Hospital (PMH); and
   xi. Sharlene Abbott, acting director of Population Health at the WA Country Health Service (WACHS) - South West.

5. The documentary evidence at the inquest comprised of two volumes that were tendered as exhibit 1 at the commencement of the inquest and a further four exhibits (exhibits 2-5) that were tendered during the inquest. Four exhibits were provided after the inquest (exhibits 6 - 9).

6. My primary function has been to investigate Baby H's death. It is a fact-finding function. I must find, if possible, how Baby H's death occurred and the cause of her death.[6]

7. I may also comment on any matters connected with Baby H's death, including public health or safety or the administration of justice.[7] This is an ancillary function of a coroner and I have used this function to make three recommendations.

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[5] With the exception of Mr Mace and Ms Abbott, the stated positions of these witnesses were as at March 2017.
[6] Section 25(1)(b) and (c), *Coroners Act 1996* (WA)
[7] Section 25(2), *Coroners Act 1996* (WA)

8. The inquest focused on the involvement of the Department in Baby H's life, examinations of Baby H by nurses at a child health centre from 3 February to 4 May 2017 and treatment of Baby H by medical staff at the emergency department of BRH on the evening of 10 May 2017.

9. On the basis that it would be contrary to the public interest, I made a suppression order with respect to Baby H's name on 19 October 2020, pursuant to section 49(1) of the *Coroners Act 1996* (WA). The terms of that order are set out on page three.

10. Where I have made any comment in this finding that may be construed as negative in nature towards any person or entity, it is to be clearly understood that none of the conduct referred to caused or contributed to the death of Baby H. It was solely the conduct of Baby H's mother (the mother) that was responsible for Baby H's tragic death.

11. At the end of the inquest, I invited Ms Young, counsel for Dr Isaac Adewumi, to provide written submissions whether her client's assessment that the bruise he noted on Baby H's right cheek on 10 May 2017 was an accidental injury should be the subject of an adverse comment in this finding. Those submissions were filed on 30 October 2020, together with a supplementary statement from Dr Adewumi of the same date[8] that addressed the evidence from Dr Louise Houliston regarding the type of injury that would arise if the face of a 4-month-old baby was pressed against the railing of a cot.

12. In making my findings I have applied the standard of proof as set out in *Briginshaw v Briginshaw* (1938) 60 CLR 336 per Dixon J at 361-362 which requires a consideration of the nature and gravity of the conduct when deciding whether a matter has been proved on the balance of probabilities.

[8] Exhibit 6

THE MOTHER'S PREGNANCY AND BABY H'S EARLY MONTHS

Relevant events during the mother's pregnancy [9]

13. Baby H was the only child of her parents. There were two occasions when the Department had contact with Baby H's parents during the pregnancy.

14. The first record of contact with the Department was a Family and Domestic Violence Incidence Report (FDVIR) received from WA Police on 2 November 2016. At that time, Baby H's parents shared a house with the brother of Baby H's father (the brother). It was reported that the mother and the brother had an argument during which the brother took hold of a kitchen knife and placed it near the mother's neck. He then picked up a kettle and held it over her head. Police attended and were advised that Baby H's parents would now be staying with Baby H's maternal grandmother (the grandmother). It was assessed that no further action was required by police or the Department and that follow up would be undertaken by the Co-ordinated Response Service (CRS).

15. On 29 December 2016, a further FDVIR was received by the Department in relation to a verbal argument between the mother and the brother. A 24-hour Police Order was issued to the brother and it was assessed that no further action was required by the police or the Department after the brother said he would not be returning to the house where Baby H's parents were living. Again, it was determined that follow up would be undertaken by the CRS.

Baby H's birth [10]

16. On 19 January 2017, Baby H was born at Busselton District Hospital (BDH). She was 39 weeks plus 5 days which was considered to be term. Her birth weight was 3,520 grams. A referral was made to the Department by a midwife who stated that although she did not have any concerns for the parents or Baby H, the grandmother had advised BDH staff that there was a recent domestic violence incident involving a

[9] Exhibit 1, Vol. 1, Tab 17, Department of Child Protection - Child Death Notification dated 30 May 2017; Exhibit 1, Vol. 1, Tab 18A, Department of Communities Report to the Coroner dated 14 January 2020
[10] Exhibit 1, Vol. 1, Tab 17, Department of Child Protection - Child Death Notification dated 30 May 2017; Exhibit 7, Baby H's Child Health Records

knife.[11] Referrals were also made to BDH's social worker and Child Health Services. As there were no child protection concerns identified and Baby H and the mother were due to be discharged to the grandmother's home, no further action was taken by the Department.

Baby H's contact with the Child Health Centre [12]

17. The mother had appointments with a child health nurse from the local child health centre (the centre) on five occasions between 3 February and 4 May 2017. Kathleen McKeogh was the nurse who saw Baby H, except for the appointment on 3 March 2017 when she was on leave and another nurse saw Baby H.[13] Ms McKeogh was a qualified registered nurse and, prior to her retirement in 2018, she had worked as a child health nurse for about 32 years. In 2017, she was working three days per fortnight at the centre.[14]

18. The first appointment was a home visit by Ms McKeogh on 3 February 2017 when Baby H was 15 days old. From her notes in Baby H's Child Health Record (the Record), it was evident Ms McKeogh was aware of the incidents the subject matter of the FDVIRs. The details completed by Ms McKeogh in the Record did not identify any concerns regarding the areas of parent/child relationship or Baby H's physical assessment. The mother/child relationship was described as "*Breast feeding, appropriate responses to baby's cues observed.*" In her statement, Ms McKeogh noted that the mother seemed to be managing Baby H well and she did not seem to have any particular problems.[15]

19. The second appointment took place at the centre on 16 February 2017 when Baby H was four weeks old. Again, Ms McKeogh noted on the Record there were no concerns with the parents' relationship towards Baby H or Baby H's physical assessment. The mother/child relationship was described as "*Breast feeding, both parents appropriate responses to baby's cues observed. Parents report baby smiling.*"

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[11] This was the incident the subject of the FDVIR on 2 November 2016.
[12] Exhibit 7, Baby H's Child Health Records
[13] Exhibit 8, Statement – Kathleen McKeogh, p 3
[14] Exhibit 8, Statement – Kathleen McKeogh, pp 1-2
[15] Exhibit 8, Statement – Kathleen McKeogh, p 2

20. The third appointment scheduled for the morning of 3 March 2017 at the centre was missed and Baby H's parents were late for the rescheduled afternoon appointment. Baby H was six weeks old. No concerns were noted in the Record with respect to the parents' relationship towards Baby H or Baby H's physical assessment. The parents' relationship with Baby H was described as warm and attentive with mutual gazes and smiles. However, the parents were "*stressed today*" due to tensions with the grandmother.

21. Baby H was not taken to her next scheduled appointment on 10 March 2017. A call by the nurse who saw Baby H on 3 March 2017 to the mother's mobile phone was unanswered and a message was left. A text was then sent to both parents' mobile phones requesting that another appointment be made.

22. That appointment at the centre took place on 24 March 2017. Baby H was nine weeks old. Ms McKeogh had returned from leave and saw Baby H. On this occasion Ms McKeogh sighted a slight bruise along Baby H's left cheek after the mother had pointed it out to her.[16] Ms McKeogh described the bruise as "*a small line, like a piece of string and about the length of a fingernail.*"[17] Ms McKeogh wrote in the Record at the section marked "*Indicators of Need in the Child*" that Baby H had a very slight bruise on her cheek area near her temple and that the mother reported she had "*banged cheek along cot rail.*" Ms McKeogh's progress notes in the Record stated "*main issue today* - [the mother] *pointed out very slight bruise along baby's (L) cheek - around temple area* '[Baby H] *banged face against cot rail' a couple of days ago.*" Ms McKeogh did not contact the Department regarding the bruise or discuss the matter with her manager.

23. The next appointment was made for 28 April 2017, however Baby H was not taken to it. Ms McKeogh rang the mother's mobile phone but it simply rang out and she was unable to leave a message. Ms McKeogh then spoke to the grandmother who said that the mother had been unwell and that she had actually cared for Baby H on the night of 23 April 2017.

[16] Exhibit 8, Statement – Kathleen McKeogh, p 3
[17] Exhibit 8, Statement – Kathleen McKeogh, p 3

The grandmother reported that Baby H was "*well*". That afternoon Ms McKeogh received a phone call from the mother apologising for missing the appointment, which was rescheduled for 4 May 2017.

24. The mother attended with Baby H for the appointment on 4 May 2017 at the centre. Baby H was 15 weeks old. Ms McKeogh's entry in the progress notes included the following:

> … other main issue [Baby H] still continues to bang head against side of cot as ?bruise to temple. M[other] reports as previous. I challenged her but [the mother] insists [Baby H] moves to side of cot. Suggest she change [Baby H's] position to other side. ?Change cot. I expressed my concern to [the mother] that not happy with the explanation. Appt arranged for 12 May at 3 pm to review. Advised [the mother] to see GP re baby's four mth vaccinations.

25. When Ms McKeogh told the mother that she should report the bruise to the Department, the mother asked her not to and repeated that it was the cot that had caused the bruise. There was a discussion about obtaining a different cot.[18] Ms McKeogh did not report the bruise she had observed to the Department or discuss the matter with her manager.

26. Baby H was not taken to her appointment at the centre on 12 May 2017. When contacted by Ms McKeogh the mother said she had forgotten the appointment. The mother declined making another appointment at the centre, stating that she would attend another child health centre.

Observations of Baby H by the grandmother [19]

27. Prior to Baby H's birth, the relationship between the mother and the grandmother had not always been harmonious. The mother had mental health issues growing up and this adversely affected the relationships she had with the immediate members of her family.

28. Following the birth of Baby H, there was another breakdown in the relationship between the mother and the grandmother which was not

[18] Exhibit 8, Statement – Kathleen McKeogh, p 4
[19] Exhibit 1, Vol. 2, Tab 6, Statement dated 26 May 2017 – the grandmother; ts. 19.10.20 (grandmother), pp 10-18

reconciled until early March 2017. Shortly after that, the grandmother began visiting the mother and Baby H every couple of days at their house which was only a short distance from the grandmother's home.

29. Up until mid-April 2017, the grandmother's concerns related to the untidy state of the mother's house and the effect that could have on Baby H. She was also worried that Baby H was not getting the nutrition she needed. By this stage, the grandmother had not yet seen any injuries to Baby H.

30. However, on a visit to the house shortly before the grandmother's birthday (which was 20 April 2017), she noticed bruises to Baby H's face on her cheekbone under her eye, on her forehead above her eye and a third bruise just under her chin. Although these bruises were noticeable, they were not large. When queried, the mother told the grandmother that the bruising was caused by Baby H bumping her head on the cot. The grandmother doubted that explanation; however she did not contact the Department as she wanted to give the mother the benefit of the doubt and she did not want to jeopardise the recently healed, but still fragile, relationship she had with Baby H's parents.

31. The next time the grandmother saw bruising to Baby H's face was on 4 May 2017. There was a bruise on her left cheek and there was an older, yellow coloured bruise above her left eye. When the grandmother asked Baby H's parents about the bruising she was again told that Baby H was hitting her head on the wooden bars of her cot. The mother also said that the nurse at the centre had seen the bruises and had told her she was obligated to report them because the explanation given did not sound right.

32. The grandmother next saw Baby H when she visited the mother's house on 10 May 2017. The house was in a very untidy state and she also noticed that Baby H had a friction burn on her neck and another bruise on her face. She was also very hungry and smelt like she had not had a bath for several days. Her nappy was also overflowing.

33. Later that day, the grandmother decided to contact the Department to express her concerns about Baby H.

THE DEPARTMENT'S INVOLVEMENT ON 10 MAY 2017

34. When the grandmother contacted the Department she spoke to Tara Clement,[20] a child protection worker responsible for taking child referrals at the Department's Bunbury office. The grandmother reported that she was worried about bruising she had noted on Baby H's face, including the initial bruises she had observed. The grandmother also told Ms Clement about the state of the house and her concerns regarding Baby H's nutrition.[21] She also mentioned that the mother had said the child health nurse had told her she was going to make a referral to the Department because of the bruising the nurse had cited.[22] The grandmother also relayed her concerns about the mother's mental health.[23]

35. After that conversation, Ms Clement rang the centre to speak to the nurse who had been seeing Baby H. She was not able to get through and left a message asking the nurse to call the Bunbury office.[24] Ms McKeogh returned Ms Clement's telephone call two days later and confirmed she had cited bruising on Baby H's face.[25] Ms Clement's recollection was that Ms McKeogh had spoken to another child protection worker in this call.[26]

36. After conferring with her team leader, Nicole Mitchell, Ms Clement and Amanda Meney (another child protection worker) decided to make a priority 1 unannounced visit to the house of Baby H's parents for the purposes of citing the bruising, ascertaining the family's reasoning for the bruising and checking on the home environment.[27]

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[20] As this witness has been referred to by the surname, Clement, in Exhibit 1, I shall use that surname instead of Tomsett.
[21] ts. 19.10.20 (grandmother), p 19
[22] Exhibit 1, Vol. 2, Tab 11A, Tara Clement, p 1
[23] ts. 19.10.20 (grandmother), p 19; Exhibit 1, Vol. 2, Tab 11A, Statement - Tara Clement, pp 2-3
[24] Exhibit 1, Vol. 2, Tab 11A, Statement - Tara Clement, p 4
[25] Exhibit 1, Vol. 2, Tab 11A, Statement - Tara Clement, p 4
[26] Exhibit 1, Vol. 2, Tab 11A, Statement - Tara Clement, p 4. However, the progress notes in the Record completed by Ms McKeogh has an entry dated 12 May 2017 which details a telephone call from Ms Clement with respect to a report that had been made to the Department regarding concerns about bruising to Baby H: Exhibit 7, Baby H's Child Health Records
[27] Exhibit 1, Vol. 2, Tab 11A, Statement - Tara Clement, p 4

37. When the child protection workers arrived at the house and introduced themselves, Baby H's parents said they were not surprised to see them as they believed a report had been submitted to the Department by the child health nurse.[28] No such report had been made by Ms McKeogh and this mistaken belief is likely to be the reason why the mother had advised Ms McKeogh on 12 May 2017 that she would be taking Baby H to another child health centre.[29]

38. Ms Clement saw that the inside of the house was very dark, cluttered and quite dirty. Ms Clement not only saw a bruise on Baby H's face but also a mark on her neck, a mark on her chin and scratches to her temple. Baby H's parents explained that the bruise was from Baby H hitting her head on the cot, the mark on her neck was from milk when she was drinking, the mark on her chin was from the zipper of her clothing and the scratches on her temple were from when she scratched herself.[30]

39. Although Ms Clement found the explanation for the mark on Baby H's chin as reasonable[31] and the explanation regarding Baby H scratching herself as plausible,[32] she was less certain regarding the explanation for the bruising.[33]

40. Ms Clement provided advice to Baby H's parents regarding the cleaning of the house, their cannabis consumption and using the support of the grandmother. She also took eight photographs of Baby H's face and advised Baby H's parents she would be raising what she had seen with her team leader and that the Department would be making further contact.[34]

41. After returning to the office, Ms Clement spoke to Ms Mitchell about what she had observed. Ms Mitchell was not satisfied with the explanation given for the bruising and it was decided Baby H should be

[28] Exhibit 1, Vol. 2, Tab 11A, Statement - Tara Clement, p 4
[29] Understandably, the Department does not disclose to a child's parents the identity of the person who has made the notifcation.
[30] Exhibit 1, Vol. 2, Tab 11A, Statement - Tara Clement, p 5
[31] ts. 19.10.20 (Tomsett), p 120
[32] Exhibit 1, Vol. 2, Tab 11A, Statement - Tara Clement, p 6
[33] ts. 19.10.20 (Tomsett), p 120
[34] Exhibit 1, Vol. 2, Tab 11A, Statement - Tara Clement, pp 7-8

medically examined that day.[35] It was arranged that the grandmother would take the mother and Baby H to BRH that evening and Ms Clement provided the grandmother with Ms Mitchell's mobile phone number if she had any issues.[36] The Department did not contact BRH of the impending attendance of Baby H.

BABY H'S ATTENDANCE AT BRH ON 10 MAY 2017

42. At about 8.20 pm on 10 May 2017, the mother and the grandmother attended the emergency department of BRH with Baby H. The first medical staff member they spoke to was Suzanne Smith who was the triage nurse that evening. After being told the reason for Baby H's attendance, Ms Smith commenced a "*head to toe*" assessment of her. Ms Smith noted a bruise to the right-hand side of Baby H's face. Although Ms Smith's statement says this bruise was on the left-hand side of Baby H's face,[37] Ms Smith clarified in her evidence that it was on the right-hand side.[38] When Ms Smith asked the mother how Baby H got the bruise she was told that Baby H was rolling over, pulling herself up in the cot and head-butting the cot.[39]

43. The mother also told Ms Smith that Baby H was attempting to crawl and stand.[40] When Ms Smith expressed her surprise at a 4-month-old being able to do that, the mother said that she had observed Baby H doing these actions. The balance of Ms Smith's assessment indicated a full range of movement with no distress from Baby H and nothing to suggest there were any issues apart from the bruise.[41] At the completion of her assessment Ms Smith gave a triage category of 4 to Baby H.[42]

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[35] Exhibit 1, Vol. 2, Tab 11A, Statement - Tara Clement, p 8
[36] ts. 19.10.20 (Tomsett), p 122
[37] Exhibit 1, Vol. 2, Tab 17, Statement – Suzanne Smith, p 2
[38] ts. 20.10.20 (Smith), p 144
[39] Exhibit 1, Vol. 1, Tab 21, Copy of Digital Medical Record - Emergency Department Notification; ts. 20.10.20 (Smith), pp 148-149
[40] Exhibit 1, Vol. 2, Tab 17, Statement – Suzanne Smith, p 2
[41] Exhibit 1, Vol. 2, Tab 17, Statement – Suzanne Smith, p 3
[42] The triage categories are 1 through to 5, with 1 being the highest priority. Category 4 has an expectation that the patient would be seen within 60 minutes.

44. Ms Smith was of the view that even if Baby H could pull herself up on her cot and make contact with the rails then she would have expected more bruising to the bony prominences such as the forehead, nose and a higher part of the cheekbones then where the bruise was.[43]

45. Baby H had a secondary assessment completed by a registered nurse before she was assessed by a doctor.[44]

46. The first doctor who examined Baby H was Dr Helen Truong. She had graduated from James Cook University with a Bachelor of Medicine and Bachelor of Surgery in 2014. Dr Truong had commenced at BRH in January 2017 as a resident medical officer working in the emergency department. As a resident she did not make any final decisions in relation to a patient but instead referred it to the emergency department's consultant doctor.[45]

47. Dr Truong observed the bruise on Baby H's cheek which the mother said happened when Baby H was in her cot and had pushed herself up against the bar of her cot, hitting her cheek. Dr Truong did not see any other injuries or bruises and observed that Baby H was not in any obvious pain and was moving all of her limbs. As described by Dr Truong, Baby H "*was a happy baby and was not screaming or crying and had a normal examination aside from the bruise from her cheek*".[46] Although Dr Truong would always get concerned when there was a bruise on a baby who does not walk, her view was that if a 4-month-old baby was quite active and moved around in their cot such a bruise was feasible. She therefore found the explanation plausible.[47] Dr Truong then asked Dr Adewumi to review Baby H.

48. Dr Adewumi completed a Bachelor of Medicine and Bachelor of Surgery in 2003. He was employed at BRH as the consultant in the emergency department on a six month contract commencing on 21 February 2017.

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[43] ts. 20.10.20 (Smith), pp 149-150
[44] ts. 20.10.20 (Smith), p 153
[45] Exhibit 1, Vol. 2, Tab 22, Statement – Dr Helen Truong, p 2
[46] Exhibit 1, Vol. 2, Tab 22, Statement – Dr Helen Truong, p 4
[47] Exhibit 1, Vol. 2, Tab 22, Statement – Dr Helen Truong, p 4

49. Dr Adewumi completed a full examination of Baby H. He noted she was an active baby who was alert and moving all four limbs spontaneously. Dr Adewumi observed a minor bruise to the soft tissue of Baby H's right lateral cheek. He did not note any other bruises on Baby H's body. He also observed a tiny scratch mark to Baby H's lateral upper right cheek and a rash on her neck and a similar rash in the nappy area.[48] Dr Adewumi was satisfied with the explanations given by the mother regarding the scratch and the two areas of rash. He also formed the belief that the bruise had occurred as explained and that Baby H had likely rolled around in her cot and hit her face against the cot bars causing a bruise. Dr Adewumi did not believe it was abnormal for a baby to be able to roll over at around 3 to 4 months of age.[49]

50. Dr Adewumi was therefore satisfied the bruise to Baby H's face was consistent with an accidental injury and, as there were no concerns over it being a non-accidental injury, Baby H was discharged home to the care of the mother and grandmother.[50]

51. Dr Truong prepared a letter addressed to Baby H's doctor which recorded the finding that the bruise was an "*accidental injury*".[51]

THE DEPARTMENT'S INVOLVEMENT FROM 11 MAY 2017

52. On 11 May 2017, the grandmother forwarded a copy of the letter prepared by Dr Truong to Ms Clement. After receiving the letter, Ms Clement and Ms Mitchell decided that a short term safety plan was necessary for Baby H until the matter was allocated to a child protection worker. The safety plan was for the grandmother to check Baby H on a daily basis and report to the Department if she had any concerns. The grandmother agreed to that arrangement.[52]

[48] Exhibit 1, Vol. 2, Tab 21, Statement – Dr Isaac Adewumi, pp 3-4
[49] Exhibit 1, Vol. 2, Tab 21, Statement – Dr Isaac Adewumi, p 5
[50] Exhibit 1, Vol. 2, Tab 21, Statement – Dr Isaac Adewumi, p 5
[51] Exhibit 1, Vol. 2, Tab 22B, Letter from Dr Truong to Dr Herbert Lau
[52] ts. 19.10.20 (grandmother), p 28

53. On the same day, Ms Clement purchased a cot bumper and attended the address of Baby H's parents with another child protection worker, Michelle Quinn. At the house, the two child protection workers spoke to Baby H's parents who expressed appreciation for the cot bumper and said they would put it in the cot straight away.[53]

54. Ms Clement also explained the safety plan that had been arranged with the grandmother and Baby H's parents said they were happy for that to occur.[54] Ms Quinn observed Baby H on this occasion as she slept in a baby swing in front of the television. Ms Quinn noted that there did not appear to be any marks on Baby H. She did note, however, that the inside of the house was very messy.[55]

55. On 12 May 2017, Baby H's matter within the Department's Bunbury office was transferred from the Duty Team to the Child Safety Assessment Team.[56]

56. On 17 May 2017, the grandmother had Baby H at her house. She noted that Baby H was wearing the same clothes as the night before and that she had not been cleaned. Baby H was also very hungry and appeared constipated and dehydrated.[57] At 2.34 pm, the grandmother sent a text to Ms Clement on the SMS service connected to Ms Clement's work computer.[58] In that text the grandmother asked whether Ms Clement had an extension number to call and that it was regarding Baby H. At 3.48 pm, Ms Clement responded with the text message: "*I have intaked the case and it is currently sitting with the Team Leader, Nicole Mitchell, until it is allocated to a case manager. If you need to report anything, please call and ask for her; she will be able to assist you*".[59]

57. Ms Mitchell finished work at about 4.00 pm on 17 May 2017. She received no telephone calls or messages from the grandmother on that

[53] Exhibit 1, Vol. 2, Tab 11A, Statement – Tara Clement, p 10
[54] Exhibit 1, Vol. 2, Tab 11A, Statement – Tara Clement, p 10
[55] Exhibit 1, Vol. 2, Tab 13, Statement – Michelle Quinn, pp 3-4
[56] Exhibit 1, Vol. 2, Tab 14, Statement – Nicole Mitchell, p 5
[57] Exhibit 1, Vol. 2, Tab 6, Statement dated 26 May 2017 – the grandmother, pp 30-31
[58] As the mobile phone number was set up in that way it would not ring if it was called: ts. 19.10.20 (Tomsett), p 129
[59] Exhibit 1, Vol. 2, Tab 11B, Photograph of text messages

day.[60] Nor did she receive any telephone calls or messages from the grandmother when she was at work on 18 May 2017. Ms Mitchell then went on leave which commenced on Friday, 19 May 2017 and she returned to work on Friday, 26 May 2017.[61] She went to Singapore for the duration of her leave, returning to Perth late in the evening of 25 May 2017.[62]

58. Maria Barry, a team leader from the Department's Collie office, filled in for Ms Mitchell at the Department's Bunbury office whilst Ms Mitchell was away. Before she went on leave, Ms Mitchell left a note on Baby H's case plan asking Ms Barry to perform the following two tasks: contact the grandmother and have child protection workers make an unannounced visit to the home of Baby H's parents.[63] Baby H's case plan was left with the case plans for other children on Ms Mitchell's desk in priority order. Ms Mitchell thought that Baby H's matter was the second highest priority.[64]

59. On Saturday, 20 May 2017, the grandmother was looking after Baby H when she noticed bruises around her neck which looked like finger marks.[65] Concerned by this, the grandmother made up an excuse to the mother for Baby H to stay the night at the grandmother's house. During the night, Baby H was very restless and kept waking up every two hours.[66]

60. Given what she observed, the grandmother called Ms Mitchell's mobile phone on 20 May 2017. Ms Mitchell was in Singapore at that time and had her mobile phone turned off.[67] The grandmother left a message on Ms Mitchell's mobile phone advising that she had Baby H with her and had some concerns and wanted to talk to Ms Mitchell before Baby H was

[60] ts. 19.10.20 (Mitchell), p 97
[61] Although there was contrasting evidence at the inquest as to whether Ms Mitchell's last day at work before she commenced her leave was 17 or 18 May 2017, her Timesheet for 5 May 2017 – 1 June 2017 confirms it was Thursday, 18 May 2017: see Exhibit 9
[62] ts. 19.10.20 (Mitchell), p 99
[63] ts. 19.10.20 (Mitchell), p 99
[64] ts. 19.10.20 (Mitchell), pp 98-99
[65] Exhibit 1, Vol. 2, Tab 6, Statement dated 26 May 2017 – the grandmother, p 32
[66] Exhibit 1, Vol. 2, Tab 6, Statement dated 26 May 2017 – the grandmother, p 32
[67] ts. 19.10.20 (Mitchell), p 100

returned to her parents.[68] Ms Mitchell only listened to that message after she came back from Singapore.[69]

61. The grandmother returned Baby H to the mother on 21 May 2017. She questioned the mother about the bruises on Baby H's neck and said that Baby H should be taken to a hospital. Instead, the mother told the grandmother she would make an appointment for Baby H to see a doctor the next day.[70] That did not happen.

62. After reviewing Baby H's file, Ms Barry called the grandmother's mobile phone once on Tuesday, 23 May 2017, again on Wednesday, 24 May 2017 and for a third time on Thursday, 25 May 2017. On each occasion her call was unanswered and she left a voicemail message for the grandmother to contact her.[71]

63. From 22 - 24 May 2017 the grandmother did not see Baby H as she was busy completing university assignments. She did call the mother's mobile phone several times during those days but the calls went straight to message bank.[72]

64. At about 10.00 am on 25 May 2017, Ms Barry made arrangements for child protection workers to conduct an unannounced visit at Baby H's home at 4.00 pm that day. Due to other commitments, those child protection workers were unable to make the visit. It was arranged that the visit would take place as a priority the following morning.[73]

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[68] Exhibit 1, Vol. 2, Tab 14, Statement – Nicole Mitchell, p 7
[69] ts. 19.10.20 (Mitchell), p 100
[70] ts. 19.10.20 (Mitchell), p 33; Exhibit 1, Vol. 2, Statement dated 26 May 2017 – the grandmother
[71] Exhibit 1, Vol. 2, Tab 15, Statement – Maria Barry, p 6. The grandmother's evidence at the inquest was that she did not receive messages to call someone from the Department on any of these dates: ts. 19.10.20 (grandmother), p 35. However, electronic material from the Department's database supports Ms Barry's account that she did make attempts to contact the grandmother during this period: Exhibit 1, Vol. 2, Tab 15B, Case notes of Maria Barry dated 23-25 May 2017; Exhibit 4, Extract from objective database relating to creation of case notes by Ms Barry with time and date of 25/05/2017 01:01:33 pm. Accordingly, I have concluded that Ms Barry did make these calls. However, I am unable to determine whether the grandmother listened to any messages that may have been left.
[72] Exhibit 1, Vol. 2, Statement dated 26 May 2017 – the grandmother, p 33
[73] Exhibit 1, Vol. 2, Tab 15, Statement – Maria Barry, pp 4-5

65. At about 6.00 pm on 25 May 2017, the grandmother visited the home of Baby H's parents to see Baby H. This was the first time she had seen Baby H since 21 May 2017. The mother told her that Baby H had been grumpy for the last couple of days. As she held Baby H, the grandmother noticed that she was crying in pain whenever she was moved. It appeared that the pain was in Baby H's back and her ankle.[74] The mother declined to take Baby H to hospital.[75] When she returned home that evening the grandmother decided she would call the Department's Bunbury office at 8.00 am the next day.[76]

66. Just after 6.30 am on 26 May 2017, Baby H's father (the father) changed Baby H's nappy and then gave her a bottle of formula milk before placing her back in her cot which was located in the mother's and his bedroom. He then went and had a shower for approximately 30 minutes. As the father was in the shower, the mother took hold of Baby H and vigorously shook her causing immediate and critical injuries to her head, brain, eyes and spine.[77] She then placed Baby H back into her cot. The father was unaware of what had taken place.

67. After the father's shower, the mother asked him to get Baby H out of the cot so that she could give her a kiss. As the father lifted Baby H out of the cot he noticed she was not breathing. An ambulance was called and the father attempted to resuscitate Baby H by performing CPR which was taken over by the grandmother who had been contacted by the mother. Attending paramedics took over CPR and attached defibrillator pads and provided ventilation with a bag-valve mask. The paramedics' cardiac monitor showed a mostly asystole (cardiac flat line) reading. Baby H was then taken to the ambulance where paramedics suctioned her airway and inserted a laryngeal mask to keep her airway open. Baby H remained unresponsive enroute to the emergency department of BRH.[78]

[74] ts. 19.10.20 (grandmother), p 37
[75] ts. 19.10.20 (grandmother), p 37
[76] ts. 19.10.20 (grandmother), p 38
[77] Exhibit 1, Vol. 1, Tab 11, Perth Supreme Court sentencing remarks, p 11
[78] Exhibit 1, Vol. 1, Tab 22, St John Ambulance WA Patient Care Records

68. The on-call paediatrician at BRH examined Baby H and formed the view that her injuries were highly suspicious of being deliberately inflicted.[79] At about 10.00 am, BRH advised the Department's Bunbury office of Baby H's admission to the emergency department and the suspicious nature of her injuries. The Department immediately had Baby H taken into the CEO's provisional protection and care pursuant to section 37 of the *Children and Community Services Act 2004* (WA) on the grounds that there was an immediate and substantial risk to Baby H's wellbeing. At about 10.30 am, the Department advised BRH of that action.[80]

69. Although Baby H had a delayed return of spontaneous circulation at BRH, her condition remained very critical and she was transferred by the Royal Flying Doctor Service to PMH later that morning.

70. Despite the very best efforts by ambulance paramedics and health practitioners at BRH and PMH, Baby H was declared deceased at 11.37 am on 28 May 2017.[81]

ISSUES RAISED BY THE EVIDENCE

Observations of bruising by the child health nurse

71. As outlined above, Ms McKeogh noted bruising to Baby H's face on 24 March 2017 and again on 4 May 2017. Although the mother had assumed that Ms McKeogh had made a report to the Department regarding this bruising, no such report was made.

72. When examining the conduct of Ms McKeogh in not making a report to the Department on either of the occasions she saw bruising to Baby H's face, I need to be mindful not to insert hindsight bias into my assessment of her conduct.[82]

73. Ms McKeogh did not contact the Department on the first occasion because she believed the mother's explanation, finding her to be

[79] Exhibit 1, Vol. 1, Tab 21, Copy of Digital Medical Record – ED Progress Notes dated 26 May 2017
[80] Exhibit 1, Vol. 1, Tab 18A, Department of Communities Report to the Coroner dated 14 January 2020, p 15
[81] Exhibit 1, Vol. 1, Tab 4, Princess Margaret Hospital Death Notification
[82] Hindsight bias is the tendency after the event to assume that events are more predictable or foreseeable than they really were: *The Australasian Coroner's Manual*, Hugh Dillon and Marie Hadley, 2015, p 10

"*sincere*" and "*not defensive or guarded*". When she was with Ms McKeogh, the mother "*always came across as friendly and open*".[83]

74. I make no criticism of Ms McKeogh's decision not to report this bruise to the Department. It was only a slight bruise and there were no other injuries to Baby H that would indicate it was a non-accidental injury. Significantly, it was the mother who had pointed out the bruise to Ms McKeogh, who otherwise would not have noticed it.[84] Ms McKeogh had also observed that the mother engaged appropriately with Baby H and always came across as a mother who loved and cared for her baby.[85] In those circumstances, it is understandable why Ms McKeogh did not make a report.

75. I also note that Ms McKeogh was not the only health practitioner who accepted the mother's account of how the bruising occurred. It is evident the mother was very adept at providing a convincing, albeit fabricated, explanation for the bruising to Baby H's face.

76. As to the second occasion, Ms McKeogh had intended to report the matter to the Department and conduct an unannounced home visit when she was back at work in the centre the following week. She did neither because she had received a telephone call from Ms Clement[86] which superseded her planned home visit.[87]

77. Although it was unfortunate that Ms McKeogh did not report the second bruise to the Department prior to her telephone call with Ms Clement on 12 May 2017, I do not make a finding adverse in nature that she should have done so. If I was to do that I would be inserting hindsight bias in my finding. I must take into account that Ms McKeogh was only working three days a fortnight at the centre the mother was attending and that the second bruise was, again, an isolated injury and similar in size to the previous bruise that the mother had brought to Ms McKeogh's attention.[88]

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[83] Exhibit 8, Statement – Kathleen McKeogh, p 3
[84] Exhibit 8, Statement – Kathleen McKeogh, p 3
[85] Exhibit 8, Statement – Kathleen McKeogh, p 5
[86] This telephone call was on 12 May 2017: see Exhibit 7, Baby H's Child Health Records
[87] Exhibit 8, Statement – Kathleen McKeogh, p 4
[88] Exhibit 8, Statement – Kathleen McKeogh, p 4

The Department's contact number given to the grandmother

78. As I referred to above, on 10 May 2017 the grandmother was provided with Ms Mitchell's personal mobile phone number as a contact for the Department if she had any concerns. This number was provided to her by Ms Clement on instructions from Ms Mitchell.

79. The evidence at the inquest was that occasionally Department staff did provide their personal mobile phone numbers for work-related matters.[89]

80. In her statement, Ms Mitchell said she provided her personal mobile phone number so that the grandmother could contact her directly with any concerns for Baby H.[90] In her evidence, Ms Mitchell clarified that the grandmother was only to use her personal mobile phone number if she had any concerns during the evening of 10 May 2017. When asked whether she said to Ms Clement that the grandmother was only to call her personal mobile phone number for that particular evening, Ms Mitchell stated:[91]

> My words to Tara, from memory, were, "You can give her my number. I'm on call if there are any issues tonight with the baby being assessed at the hospital or the parents staying at the hospital." Those were my words.

81. Ms Mitchell further explained that her reasoning behind using this number as the contact was because Baby H's attendance at the hospital was going to be after-hours. As Ms Mitchell was on-call that evening, if the grandmother needed to contact the Department it would circumvent the Crisis Care Unit (CCU)[92] becoming involved as she was already aware of the case.[93]

82. Ms Clement's evidence was that she had no recollection of Ms Mitchell saying her mobile phone number was only to be used by the grandmother after-hours on 10 May 2017.[94] Her evidence was that she

[89] ts. 19.10.20 (Barry), p 72
[90] Exhibit 1, Vol. 2, Tab 14, Statement – Nicole Mitchell, p 3
[91] ts. 19.10.20 (Mitchell), p 102
[92] The CCU is the after-hours service provided by the Department
[93] ts. 19.10.20 (Mitchell), pp 91-93
[94] ts. 19.10.20 (Tomsett), pp 122-123

told the grandmother this number was to be used if she had any concerns. Ms Clement accepted that it would have been entirely reasonable for the grandmother to have believed this was the contact number for the Department if she had any future concerns regarding Baby H.[95] That was exactly the belief the grandmother had. Her understanding was that Ms Mitchell's personal mobile phone number "*was the mobile number that I was to call any time, not just in business hours, that it would be available for me to call at any time.*"[96] It was therefore not surprising that the grandmother called Ms Mitchell's personal mobile phone number when she had concerns about Baby H's welfare on Saturday, 20 May 2017.

83. It was unfortunate that the grandmother was left with the impression that Ms Mitchell's personal mobile phone number was to be her point of contact with the Department. I attribute this to a misunderstanding between Ms Mitchell and Ms Clement as to when the grandmother was to use this number. It did, however, lead to the untimely circumstance of the grandmother calling Ms Mitchell's personal mobile phone when Ms Mitchell was overseas and had it turned off. Unfortunately, the grandmother was not aware of the CCU's number.[97] This number would have obviously been the appropriate one to call on a weekend.

No notification by the Department to BRH of Baby H's impending visit

84. The evidence before me is that BRH had no prior notification from the Department that Baby H would be attending for an examination on the evening of 10 May 2017.

85. Ms Mitchell gave evidence that she not only asked Ms Clement to arrange for the grandmother to take Baby H to the emergency department of BRH but also that Ms Clement was to telephone the nursing co-ordinator in the emergency department and notify her of the impending assessment.[98]

[95] ts. 19.10.20 (Tomsett), p 123
[96] ts. 19.10.20 (grandmother), p 34
[97] ts. 19.10.20 (grandmother), p 32
[98] ts. 19.10.20 (Ms Mitchell), pp 89-90

86. Ms Clement's evidence was that she did not recall having a conversation with Ms Mitchell about her having to contact BRH. Although Ms Clement agreed it was possible the conversation did occur, she added: "*but I feel that every request that was made by Ms Mitchell I followed through with, so I figured it unusual for me to have a request that I didn't comply with at that time.*" [99] Ms Clement accepted that she did not contact BRH, adding that as she had only been at the Bunbury office for three weeks at that point she did not know it was the usual practice.[100]

87. Ms Mitchell also gave evidence that, at the time, it was not a policy the hospital be notified by the Department's Bunbury office that a child was attending for a specific reason and that "*it was just general practice within the office.*"[101]

88. I am not able to find, on the balance of probabilities, that Ms Clement was told by Ms Mitchell to contact the nursing co-ordinator at BRH. I also note that Ms Mitchell's statement does not refer to any conversation to Ms Clement in regards to notifying the hospital.[102]

89. Glenn Mace, the executive director in the Community Services division of the Department, accepted it would have been good practice for the Department to notify BRH of Baby H's impending attendance.[103] However, the lack of notification was not particularly critical in this instance. Medical staff at BRH were aware that the Department had requested Baby H's attendance at the emergency department for a review prior to the examinations by Dr Truong and Dr Adewumi.[104]

Findings of accidental injury by Dr Truong and Dr Adewumi

90. From all the evidence before me, I find that the bruise to the right cheek of Baby H that was visible on 10 May 2017 was not an accidental injury. In light of the mother's conviction of Baby H's murder, it is open for me

[99] ts. 19.10.20 (Tomsett), p 123
[100] ts. 19.10.20 (Tomsett), p 123
[101] ts. 19.10.20 (Mitchell), p 93
[102] Exhibit 1, Vol. 2, Tab 14, Statement – Nicole Mitchell, p 3
[103] ts. 21.10.20 (Mace), p 247
[104] Exhibit 1, Vol. 1, Tab 21, Copy of Digital Medical Record - Emergency Department Notification

to find the mother had inflicted this bruise. Applying the necessary standard of proof I am satisfied, on the balance of probabilities, that the mother did inflict this injury. However, it does not automatically follow that a finding adverse in nature should be made against either of the doctors for their conclusions that the bruise was consistent with the mother's fabricated explanation and, therefore, accidental. That assessment must depend on the information the doctors had at the time they examined Baby H.

91. The triage nurse, Ms Smith, was the first person at BRH who assessed Baby H. I am satisfied that Ms Smith undertook a comprehensive examination of Baby H for the purpose of triaging her. After noticing the bruise to Baby H's right cheek she asked the mother how Baby H got the bruise. The mother told her that Baby H had begun rolling over and had just started pulling herself up in the cot and was attempting to crawl and stand. Ms Smith questioned the plausibility of that explanation and after completing her assessment (which did not reveal any other issues), she again asked the mother to describe how Baby H had received the bruise. The mother repeated that Baby H had been pulling herself up in her cot and that she had observed her doing that.[105] Ms Smith then "*felt a 'Red Flag', a feeling that something was just not right.*"[106]

92. After speaking to another nurse regarding her observations and the explanations given by the mother, Ms Smith advised the nursing co-ordinator.[107] The nursing co-ordinator told Ms Smith that she would make the treating doctor aware of the situation. Ms Smith therefore had a legitimate expectation this information would be given to the treating doctor or the emergency department consultant.[108]

93. Ms Smith made the following notation under the heading "Clinical Synopsis" in the Emergency Department Notification records for Baby H:[109]

[105] Exhibit 1, Vol. 2, Tab 17A, Statement – Suzanne Smith, pp 2-3
[106] Exhibit 1, Vol. 2, Tab 17A, Statement – Suzanne Smith, p 4
[107] Exhibit 1, Vol. 2, Tab 17A, Statement – Suzanne Smith, p 5
[108] ts. 20.10.20 (Smith), p 152
[109] Exhibit 1, Vol. 1, Tab 21, Copy of Digital Medical Record - Emergency Department Notification

> HISTORY:
> Child Presents With Bruising To R) Cheek Above Lip. Child Interactive At Triage. Observed Nan Feeding Child. Nil Other Obvious Injuries. Child Health Nurse Alledgedly [sic] Reported Injury To Face To Dcp And Dcp Have Requested Child To Present To Ed For Review. Mother States That Child Received Injury Due To Becoming Active And Rolling Over In Cot And Hitting Head Onto Rails.

94. In addition to completing the above entry, Ms Smith also made a note of her findings in a personal diary. That note included:[110]

> Bruising evident to cheek & lip; mother asked how this came about she stated "child has begun rolling over & crawling & she has been head banging in her cot"
> ...
> Something feels off.

95. Although the history in the Clinical Synopsis did not contain the explanation given by the mother that Baby H had been pulling herself up in the cot and attempting to crawl and stand, I make no criticism of Ms Smith for not including that detail. Her initiative in conferring with another nurse and then advising her co-ordinator of her concerns is deserving of high commendation. She did more than what would be expected of a busy triage nurse.

96. Baby H had a secondary assessment by another nurse at 9.20 pm. That nurse recorded the following in Baby H's medical records:[111]

> Brought in by Mother and [the grandmother]: with bruising to R cheek, chin & red mark around crease of neck. Active, GCS 15, alert interested in surroundings, BO x "normal" today. Reporting babe "well settled" this pm. Drinking well - reported. Has had vaccinations (4 months) today with no change in condition from normal. T: 37.1, HR 140-150 bpm. PR 60-80 rpm with Sp02 100% RA. Nil WOB, [without] grunting. Chest sound clear. Awaiting R/V [review]

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[110] Exhibit 1, Vol. 2, Tab 17C, Suzanne Smith's personal notes dated 10 May 2017
[111] Exhibit 1, Vol. 1, Tab 21, Copy of Digital Medical Record - Emergency Department Secondary Assessment

97. Dr Truong examined Baby H after the above assessment. Her role as a resident medical officer was to present the case to someone more senior who would make the final decision.[112] Dr Truong had access to the Clinical Synopsis notes by Ms Smith and the notes of the nurse making the secondary assessment. She did not recall having a conversation with any health staff who raised concerns prior to her assessment of Baby H.[113]

98. Dr Truong accepted that evidence of bruising on a non-ambulant baby was "*definitely a red flag*".[114] She only recalled speaking to the mother regarding the bruising. The mother told her Baby H had been lying in her cot and had pushed up against the bar of the cot, hitting her cheek.[115] Dr Truong did not recall speaking to the grandmother who did not provide any additional information. The mother and grandmother were always together during Dr Truong's examination of Baby H.[116] Dr Truong noted that the mother was attentive to Baby H's needs and co-operated fully with her questioning.[117]

99. Like Dr Truong, Dr Adewumi had access to the Clinical Synopsis notes and the secondary assessment notes. At the inquest he accepted that if it happened in the way described by the mother (with Baby H rolling over and her head making contact with the cot's rails) there would be bruising either around the bony prominences of Baby H's face or just below the bony prominences. The mild bruise that he observed was consistent with that part of Baby H's face being pressed up against a hard spot for some time. Dr Adewumi accepted that the bruise was in an unusual spot but he was nevertheless of the view it was still consistent with Baby H being stuck against a rail of the cot.[118]

100. Unfortunately neither Dr Truong nor Dr Adewumi had a full history of the bruises observed on Baby H's face. The hospital did not have access to Baby H's child health records. Dr Truong said she certainly would

[112] ts. 20.10.20 (Dr Truong), p 180
[113] ts. 20.10.20 (Dr Truong), pp 182-183
[114] ts. 20.10.20 (Dr Truong), p 182
[115] Exhibit 1, Vol. 2, Tab 22, Statement – Dr Helen Truong, p 3
[116] Exhibit 1, Vol. 2, Tab 22, Statement – Dr Helen Truong, p 3
[117] ts. 20.10.20 (Dr Truong), p 204
[118] ts. 20.10.20 (Dr Adewumi), pp 228-229

have been assisted if she had such access.[119] I find that access to Baby H's child health records would have been valuable as it would have established there were previous occasions when bruising had been seen on Baby H's face. One of those occasions happened when Baby H was just nine weeks old which would have cast more doubt on the mother's explanation.

101. Neither doctor was aware that the grandmother had notified the Department of Baby H's bruising. Had Dr Truong and Dr Adewumi known that, each would have taken the grandmother aside and spoken to her separately from the mother.[120] Again, that would have established there were previous sightings of bruising to Baby H's face and neck.

102. Furthermore, both doctors gave evidence that if they were aware of the mother's explanation that Baby H was pulling herself up and banging her face against the side of the cot that would have created a greater suspicion as a baby of her age would not be able to do that.[121]

103. Dr Houliston, a consultant and forensic paediatrician at the Perth Children's Hospital, was of the view that a diagnosis of accidental injury on 10 May 2017 regarding Baby H's bruise was not a reasonable conclusion to draw.[122] As stated in Dr Houliston's report:[123]

> The bruising is all highly suspicious for inflicted injury due to [Baby H's] young age and lack of mobility. The explanations offered of hitting her head on the edge of the cot … do not account for the pattern of injury seen. If [Baby H] had developed sufficient muscle control to move her head sufficient to "knock" it on the cot, the impact would be very soft and insufficient to cause bruising. In addition, frontal impacts by mobile children often result in forehead bruising which is the most prominent part of the face … Bruising located over the angle of the jaw and over the soft tissues of the face in infants has been shown to be strongly associated with inflicted injury. These are not areas accidentally injured in infants.

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[119] ts 20.10.20 (Dr Truong), p 198
[120] ts. 20.10.20 (Dr Truong), p 202; ts. 20.10.20 (Dr Adewumi), p 231
[121] ts. 20.10.20 (Dr Truong), pp 206-207; ts. 20.10.20 (Dr Adewumi), p 233
[122] ts 21.10.20 (Dr Houliston), p 274
[123] Exhibit 1, Vol. 1, Tab 10B, Report of Dr Louise Houliston, pp 7-8

104. At the inquest, Ms Young, counsel for Dr Adewumi, tendered an article from the journal *Paediatrics in Review.*[124] That article contained a table titled "*Developmental Milestones*" which are achieved, on average, by infants at the 50th percentile for age. Under the heading "*Gross Motor*" a baby at age three months "*rolls to side*" and at four months "*rolls front to back*". At five months, a baby "*rolls back to front*".

105. After putting those milestones to Dr Houliston, Ms Young asked the following questions:[125]

> Just prior to four months, a baby might be able to roll to the side? - - - Possibly.
>
> If a baby were [sic] instead, rather than rolling around in a cot prone to supine, supine to prone, was instead reported as being able to roll to the side and making contact with the side of the cot railing, is that something which might be consistent with a soft tissue injury on the cheek? - - - No. I don't believe that a young baby will generate enough force in that roll to cause themselves any harm, particularly to cause bruising.
>
> ...
>
> If the baby instead rolled to the side and pressed the cheek against the cot for an extended period of time, that is because they couldn't roll necessarily prone to supine, supine to prone back to remove themselves from the cot railing. Is that something which conceivably could cause some soft tissue injury? - - - That would cause a pressure injury. So if you were in contact with something for an extended period of time and unable to move, then you can develop redness and you can develop blistering and breakdown of the skin. You don't see bruising ...
>
> And pressure injuries begin out as a red mark, is that accurate? - - - Area of redness, yes.

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[124] *Developmental Milestones: Motor Development*, Dr R. Jason Gerber, Dr Timothy Wilks and Dr Christine Erdie - Lalena, 7 July 2010

[125] ts. 21.10.20 (Dr Houliston), pp 283-284

106. The photographs taken of Baby H's face by Ms Clement on the afternoon of 10 May 2017 were not of the best quality.[126] It is therefore difficult to determine the precise colour of the bruise to Baby H's right cheek from those photographs. Although it does not appear red in the photographs, Dr Adewumi's evidence was that on the evening of 10 May 2017 he observed an area of redness to Baby H's right cheek which he considered to be a mild bruise.[127] No doubt with that evidence in mind, Ms Young asked the follow question of Dr Houliston:[128]

> And so therefore, in that context[129], would you expect a doctor to be able to make the distinction between the cause of a bruise rather than the cause of a pressure injury? - - - If the area was just red, it can be difficult, because bruising can be red in colour. Usually over time it will evolve and change colour over, sort of, the days.

107. I find that Dr Truong's examination of Baby H on the night of 10 May 2017 was of an appropriate standard. Although she accepted the mother's fabricated explanation for how the bruising occurred, I make no adverse finding against Dr Truong regarding that. In reaching that decision I take into account her position as a junior resident medical officer at BRH who had little experience in child safety issues, the limited history she had received and that she sought a review from the more experienced Dr Adewumi.

108. In light of all the circumstances, I find that Dr Adewumi's examination of Baby H on the night of 10 May 2017 was also of an appropriate standard. I therefore make no adverse finding against Dr Adewumi regarding his assessment that the bruising to Baby H's right cheek was consistent with an accidental injury as described by the mother. In reaching that decision, I have considered Dr Adewumi's supplementary statement dated 30 October 2020[130] and his written submissions through his counsel of the same date. It was relevantly submitted to me that:

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[126] Exhibit 1, Vol. 2, Tab 11C, Photographs of Baby H
[127] ts. 20.10.20 (Dr Adewumi), pp 222-223
[128] ts. 21.10.20 (Dr Houliston), p 286
[129] The context being an explanation that Baby H had pushed her head against the side of the cot, rather than pulling herself up and head-butting the cot.
[130] Exhibit 6

a. Dr Adewumi's observations were consistent with a pressure injury caused by accidental injury;

b. The relevance of the history provided to Dr Adewumi, namely the explanation by the mother of Baby H rolling to the side and pushing her face against the railings of the cot was consistent with Dr Adewumi's knowledge and experience that a 3-4 month old baby could roll to the side;

c. The clinical judgement of a well experienced, specially trained doctor in paediatrics, whose role is to examine cases in hindsight, and who has examined multiple cases of non-accidental injury in infants is not the standard by which an emergency department doctor, who has completed about three to four child welfare assessments in his 17 year career, working a busy night shift at a regional hospital should be compared; and

d. All relevant factors were not available to Dr Adewumi which did not assist him to best exercise his clinical judgement.

The Department's missed opportunities on 17 and 20 May 2017

109. As outlined above, the grandmother sent a text to Ms Clement on the afternoon of 17 May 2017 requesting an extension number to call Ms Clement. Ms Clement responded by saying that the grandmother should contact Ms Mitchell.[131] Twelve minutes after Ms Clement sent that text message, Ms Mitchell finished work for the day and although she attended work the following day, she went on leave for a week after that.

110. Ms Clement's evidence was that she did not think she was aware that Ms Mitchell was going on leave.[132]

111. Ms Clement accepted, with the benefit of hindsight, that she should have provided the office number to the grandmother and, given the time of day, a further message that if the grandmother could not get through then

[131] Exhibit 1, Vol. 2, Tab 11B, Photograph of text messages
[132] ts. 19.10.20 (Tomsett), p 129

to call the CCU and also provide her with that number as well.[133] Again, with the benefit of hindsight, Ms Clement said that in order to make sure that the grandmother had someone to speak to she could have placed the text message correspondence onto the case file and sent Ms Mitchell a link to that case file note, together with an email advising Ms Mitchell that the grandmother attempted to make contact with her and that she gave the grandmother the office number. As an alternative, Ms Clement accepted she could have also simply gone into Ms Mitchell's office and suggested that Ms Mitchell call the grandmother.[134]

112. Mr Mace was of the view[135] that more should have been done in the communication with the grandmother on this occasion and that it was "*pretty minimal*".[136]

113. A further missed opportunity presented itself on Saturday, 20 May 2017 when the grandmother attempted, without success, to call Ms Mitchell on her mobile phone number. Ms Mitchell agreed that, with the benefit of hindsight, the grandmother should have been provided with the CCU's telephone number and/or the Bunbury office's landline number.[137]

114. I do not make any criticism of the conduct of Ms Clement and Ms Mitchell with respect to these matters. An unfortunate series of circumstances led to the Department not being aware of the grandmother's concerns for Baby H on 17 and 20 May 2017. It was only later that this non-contact assumed a much greater significance. I am also satisfied from hearing their evidence at the inquest that Ms Clement and Ms Mitchell have made improvements to their practices since the death of Baby H.

[133] ts. 19.10.20 (Tomsett), pp 129-130
[134] ts. 19.10.20 (Tomsett), p 131
[135] A view that had the considerable advantage of hindsight.
[136] ts. 21.10.20 (Mace), p 250
[137] ts. 19.10.20 (Mitchell), p 103

The length of the safety plan

115. The safety plan for Baby H came into effect on 11 May 2017. It was still in effect and without change when Baby H was taken by ambulance to BRH on the morning of 26 May 2017.

116. Ms Mitchell agreed that the safety plan was only to be a short term measure and that once the case was allocated to a child protection worker, a wider safety network would have been explored with the holding of a Signs of Safety meeting where the safety plan would be strengthened if required.[138] Ms Mitchell gave evidence that the safety plan should have been in place for no more than 10 days.[139]

117. Ms Clement's evidence was that the safety plan regarding the daily visits by the grandmother was adequate as it was only an interim plan. She was of the view that a child protection worker would have been allocated within a shorter period of time.[140] No such allocation had been made as of 26 May 2017. Ms Clement also agreed, when referring to the grandmother, that with the benefit of hindsight "*it was completely unreasonable to put such a high expectation on one person.*"[141] Ms Barry also acknowledged that having one person responsible for reporting any concerns "*certainly isn't ideal, partly because it's placing a lot of responsibility on one person.*"[142]

118. Mr Mace testified that an initial safety plan for a vulnerable infant should only be in place for a few days and as a week approaches the Department should know the prospects of bringing other people in to form a safety network. He accepted that the period of 16 days in Baby H's case was "*far too long*".[143]

119. The shortcomings of a safety plan going beyond an interim measure was revealed at the inquest. The grandmother did not advise the Department she would not be following the safety plan from 22 - 24 May 2017

[138] ts. 19.10.20 (Mitchell), pp 95-96
[139] ts. 19.10.20 (Mitchell), p 96
[140] ts. 19.10.20 (Tomsett), p 126
[141] ts. 19.10.20 (Tomsett), p 127
[142] ts. 19.10.20 (Barry), p 61
[143] ts. 21.10.20 (Mace), p 248

because she was "*not under the impression that I had to.*"[144] The grandmother was of the view it was simply "*a casual agreement*" and that she was never told she had to call the Department if she was not able to see Baby H on a particular day.[145]

120. Ms Barry gave evidence that she was not concerned the grandmother had not returned her calls on 22, 23 and 24 May 2017 as she assumed that if the grandmother was really worried about Baby H then she would have contacted the Department.[146] Ms Barry accepted that her assumption did not take into account other plausible reasons why the grandmother had not contacted her; such as not being able to answer her calls, being ill or away on holidays.[147]

121. The reason why the safety plan went beyond 10 days was due to Ms Mitchell's leave from 19 - 25 May 2017.[148] Ms Mitchell agreed that had she not been on leave, Baby H's matter may well have reached the stage of being allocated to a child protection worker.[149]

122. Mr Mace expected that a relieving team leader would be given the task of conducting whatever matters were necessary for a case, including a Signs of Safety meeting if that was due. He was concerned that arrangements for such a meeting in Baby H's case were delayed until Ms Mitchell returned from leave.[150] Mr Mace agreed that "*in an ideal world*" more should have been planned from 19 - 25 May 2017 (days 9 - 15 of the safety plan) than contacting the grandmother and scheduling an unannounced visit to the home of Baby H's parents.[151] Sadly, despite Ms Barry's efforts, no contact was made with the grandmother and no unannounced visit was made.

123. The timing of Ms Mitchell's leave was, with the benefit of hindsight, most unfortunate. It meant that there was going to be a delay well

[144] ts. 19.10.20 (grandmother), p 34
[145] ts. 19.10.20 (grandmother), p 35
[146] ts. 19.10.20 (Barry), p 70
[147] ts. 19.10.20 (Barry) pp 70-71
[148] ts. 19.10.20 (Mitchell), p 111
[149] ts. 19.10.20 (Mitchell), p 112
[150] ts. 21.10.20 (Mace), pp 251-252
[151] ts. 21.10.20 (Mace), p 252

beyond 10 days to have a child protection worker allocated to Baby H's matter and for a Signs of Safety meeting to be convened. It also meant that the Department did not receive information regarding the further concerns the grandmother had for Baby H's wellbeing on 20 May 2017, which included the presence of bruising to Baby H's neck that looked like finger marks.[152] Had the Department received that information then it is expected an urgent re-evaluation of the current arrangements would have been prioritised. If the Department had deemed it necessary, it would have had the resources to conduct a welfare check during the weekend of 20 and 21 May 2017.[153]

CAUSE AND MANNER OF DEATH [154, 155, 156, 157]

Cause of death

124. Dr Judith McCreath, a forensic pathologist, conducted a post mortem examination on Baby H's body on 29 May 2017.

125. That examination noted the presence of bleeding over the surface of the brain (right subdural haemorrhage over the cerebral hemisphere and diffuse subarachnoid haemorrhage), swelling of the brain, bruising to the left jawline, bruising to the left arm and bruising to the front of the neck. Following her examination, Dr McCreath did not express an opinion as to the cause of death as further investigations were pending.

126. Subsequent microscopic examination of Baby H's tissues showed bronchopneumonia in the lungs and stress related changes in the thymus (a gland in the top part of the chest). Microscopic examination also confirmed the previous macroscopically observed fresh bruising to Baby H's arm, neck and jawline.

[152] Exhibit 1, Vol. 2, Tab 6, Statement dated 26 May 2017 – the grandmother, p 32
[153] ts. 21.10.20 (Mace), p 264
[154] Exhibit 1, Vol. 1, Tab 6A-F and Exhibit 3, Post Mortem Reports of Dr Judith McCreath dated 29 May 2017, 18 October 2017 and 26 March 2019
[155] Exhibit 1, Vol. 1, Tab 8A-B, Reports of Dr Vicki Fabian dated 14 June 2017 and 22 June 2017
[156] Exhibit 1, Vol. 1, Tab 7, Report of Dr Andrew Baker dated 24 March 2019
[157] Exhibit 1, Vol. 1, Tab 10B, Report of Dr Louise Houliston dated 7 June 2017

127. In June 2017, an examination of Baby H's brain was undertaken by a neuropathologist, Dr Vicki Fabian. This examination showed traumatic brain injury, traumatic spinal cord injury (with massive haemorrhaging to the vertebral column of the left and right dorsal route) and changes to the cervical spinal cord parenchyma (the functional part of the spinal cord) in keeping with recent ischaemia (inadequate blood flow). Neuropathological examination of Baby H's eyes showed extensive recent retinal haemorrhage.

128. The post mortem findings of Dr McCreath and the neuropathological findings of Dr Fabian were reviewed by Dr Houliston. Based on her review, Dr Houliston concluded that Baby H sustained multiple traumatic injuries to her soft tissues, bones, brain, eyes and spine. Dr Houliston further concluded that the combination of those injuries was diagnostic for inflicted (non-accidental) injury.

129. On 18 October 2017, after reviewing the findings of Dr Fabian and Dr Houliston, Dr McCreath expressed the opinion that the cause of Baby H's death was "*head and neck injuries*".

130. In March 2019, a radiological review of computerised tomography (CT) scans and x-rays taken of Baby H was made by Dr Andrew Baker, a forensic pathologist based in the United States. Dr Baker's review revealed that Baby H at the time of her death had the following injuries:

    a. A right femoral distal (thighbone) metaphyseal corner fracture which showed signs of early healing;

    b. Bucket-handle fractures of both the proximal and distal metaphyseal regions of the right tibia (the larger of the two bones that make up the lower leg) which showed signs of early healing;

    c. Bucket-handle fractures of the left distal femur (thighbone above the knee);

    d. Bucket-handle fractures of the proximal and distal metaphyseal regions of the left tibia with the fracture to the distal region showing signs of early healing;

e. Bucket-handle fracture of the distal aspect of the left fibula (the smaller of the two bones that make up the lower leg) showing early signs of healing and probably the distal aspect of the right fibula, with possible proximal fibula metaphyseal fractures bilaterally;

f. Possible subtle fractures at the posteromedial aspect of the right second and third ribs, and a subtle cortical buckle of the right second rib on CT but no abnormality discernible on CT of the third rib; and

g. Soft tissue swelling around the left elbow without discernible associated fracture.

131. Dr Baker concluded that it was unlikely the signs of early healing he observed in the fractures had occurred in the two days prior to Baby H's death. He therefore regarded these fractures as having pre-dated 26 May 2017.

132. I accept and adopt the conclusion expressed by Dr McCreath. I find that the cause of Baby H's death was head and neck injuries.

Manner of death

133. Prior to the inquest, the mother was convicted on her guilty plea of the murder of Baby H in the Perth Supreme Court and sentenced to life imprisonment.

134. I have considered the outcome of the above criminal proceedings and had regard to section 53(2) of the *Coroners Act 1996* (WA), which requires that my finding not be inconsistent with the result of any earlier proceedings where a person has been charged on indictment in which the question whether the accused caused the death is in issue.

135. I find that the manner of Baby H's death is unlawful homicide.

QUALITY OF SUPERVISION, TREATMENT AND CARE

By the Department and the hospitals from 26 - 28 May 2017

136. Immediately before her death, Baby H was a person held in care by the Department and under section 25(3) of the *Coroners Act 1996* (WA) I must comment on the quality of her supervision, treatment and care while in that care.

137. After Baby H's hospitalisation on 26 May 2017, the Department acted appropriately and promptly to apply for the protection order that resulted in Baby H being brought into the CEO's provisional protection and care. That protection order was made very shortly after Baby H was admitted to BRH.

138. As Baby H was under the care of BRH and then PMH for the entire duration of the protection order and received medical care of the highest order, I am satisfied that these hospitals' and the Department's supervision, treatment and care of Baby H from 26 - 28 May 2017 was appropriate. I am also satisfied that the arrangements made by the Department through its CCU for family members to visit Baby H when she was in PMH were appropriate. This extends to the financial assistance provided by the Department for accommodation in Perth for these family members.[158] I have reached that conclusion notwithstanding the delays some family members experienced as they waited for the Department to approve their visits to Baby H when she was in PMH. As Mr Mace identified, there are processes that must be followed when dealing with a hospitalised and critically ill baby, including the management of visits with hospital staff.[159] The potential for delays in arranging visits would be, at times, unavoidable.

139. This finding is separate to the comments I have already made about the supervision and care of Baby H by the Department and BRH prior to her hospitalisation on 26 May 2017.

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[158] Exhibit 1, Vol. 1, Tab 18A, Department of Communities Report to the Coroner, pp 15-17
[159] ts. 21.10.20 (Mace), p 253

By the Department from 10 - 25 May 2017

140. In summary, I am satisfied with the initial response by the Department on 10 May 2017 when the grandmother reported her concerns for Baby H. It is evident that the Department commenced its investigations in an appropriately prompt manner. Ms Clement attempted to contact the relevant child health nurse, an unannounced home visit was quickly organised and, following that, arrangements were made for Baby H to attend BRH that evening. An interim safety plan was quickly introduced which had the grandmother visiting Baby H daily. On 11 May 2017, Baby H's parents agreed to the safety plan and had been provided with a cot barrier. There is no evidence before me that the safety plan was not operating effectively in its first week.

141. However, from 17 - 25 May 2017, there were deficiencies in the Department's handling of Baby H's case. At the inquest Mr Mace accepted that, based on today's standards, there were shortcomings in Baby H's matter which have since been addressed.[160] Those changes by the Department are outlined below.

By BRH on 10 May 2017

142. Doctors at BRH incorrectly identified the cause of the bruise to Baby H's right cheek that was visible on the night of 10 May 2017. In that regard, there was a deficiency in BRH's treatment of Baby H on this occasion. However, for reasons already outlined above, no blame is to be attributed to the two doctors who saw Baby H that evening. Through no fault of their own, neither doctor had the complete history of Baby H's bruising. In all the circumstances, it can be understood why a finding of accidental injury was made.

143. As the Department has done, WACHS has addressed ways in which improvements can be made to its policies and procedures. These are also outlined below.

[160] ts. 21.10.20 (Mace), p 254

IMPROVEMENTS SINCE BABY H'S DEATH

144. As would be expected of all governmental departments, the Department is on a pathway of continual improvement.

Consistent intake procedures [161]

145. In June 2017, the Department implemented a Central Intake Model to improve the consistency of decision-making in relation to the assessment of notifications of concerns. Incorporated into this model was a new decision-making tool known as the "Interaction Tool". This was introduced in July 2017 and is used to assess all child protection contacts at the point of initial referral to determine whether further action by the Department is required. The use of this tool requires consideration of stated relevant risk factors. These factors include prior history with the Department, history and recency of reporting family and domestic violence, the age of the child, drug use within the child's household, stability of accommodation, parental mental health and history of abuse. A "Risk Score" of 5 or above will result in a recommendation to intake the case.

146. As there is now a set of questions that must be asked of the notifying person, and with the threshold score now in place, the Department has achieved a greater consistency in determining whether a matter should be an intake or not.[162]

147. A Central Intake Team (the Team) also came into operation in July 2017. The Team processes all notifications of concern for children in the metropolitan area. Referrals of concern for children in regional and remote areas are processed by regionally based intake officers. The Team and these regional intake officers are required to assess notifications of concerns for children utilising the standardised practice guidance as set out in the Department's Case Practice Manual. This has also enhanced consistency in the decision-making process.

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[161] Exhibit 1, Vol. 1, Tab 18D, Report of Lindsay Hale dated 29 September 2020
[162] ts. 21.10.20 (Mace), p 254

The High Risk Infant Policy [163, 164]

148. The High Risk Infant Policy (the Policy) was introduced in November 2018 and provides information and practice guidance to Department staff on responding to abuse and neglect of high-risk infants. A high-risk infant is an unborn infant or a child between zero and two years of age who is considered to be at an increased likelihood of significant harm or death due to the presence of identified risk factors.

149. It is noted that the Policy relevantly refers to the following processes to be followed. Pursuant to the Policy, child protection workers:

    a. must assess all infants and unborn infants referred to the Department to determine whether there are significant risk factors present;

    b. must, when completing an Interaction or Initial Inquiry which includes information about an unborn infant or child aged between zero and two years of age, refer to the resource "Determining risk factors for an infant" in addition to the Interaction Tool to assess whether the matter needs to progress to a Child Safety Investigation (CSI);

    c. must, where a child is identified as a high-risk infant, commence a CSI within 24 hours as a priority 1;

    d. must refer all high-risk infants to Best Beginnings Plus;

    e. must give parents verbal information on the effects of shaking an infant and the risks associated with co-sleeping; and

    f. must actively case manage all high-risk infants until the risk factors have been addressed and there is sufficient safety to close the case. As such, high-risk infants must not be placed on the monitored list.

[163] Exhibit 1, Vol. 1, Tab 18A, Department of Communities Report to the Coroner, Annexure 1.
[164] Exhibit 1, Vol. 1, Tab 18D, Report of Lindsay Hale dated 29 September 2020

150. There is further specific advice in the Policy about bruising which alerts the reader about the research in regard to infants:

    a. Bruising in non-mobile infants is unusual and highly suggestive of non-accidental injuries;

    b. Non-mobile babies rarely cause injuries to themselves and therefore must be considered at high risk of abuse;

    c. Infant deaths from non-accidental injuries often have a history of minor injuries prior to hospital admission; and

    d. In connection to patterns of bruising suggestive of physical child abuse, information is given about a high risk in connection with bruises that are away from bony prominences and bruises to the face.

151. At to what must be done if bruising is noted, the Policy states:

    a. Any bruising or symptom of injury located on a non-mobile infant must be further assessed by a paediatrician, preferably with child protection experience, and the child protection worker should accompany the infant to the appointment;

    b. In relation to regional and remote areas, when a paediatrician may not be available on the same day, arrangements must be made for the infant to attend either the local medical service (GP or hospital) in the company of a child protection worker who is to request that the examining doctor consult with the on-call paediatrician;

    c. The child protection worker must seek clarification from the paediatrician as to whether the injury had been deemed to be accidental or non-accidental; and

    d. Any non-accidental or suspicious injury to an infant must be referred to WA Police.

Training

152. After May 2017, the Department developed and introduced a two day, face-to-face training course titled "Responding to High-Risk Infants". This course focuses on infant, child and family mental wellbeing in a way that is culturally responsive and trauma informed.

153. Since 2017, the training has been reviewed on a regular basis, which has included consultation with professionals in the perinatal and infant mental health field. The training has stressed the importance of ensuring that any infant with a bruise is assessed by a paediatrician, preferably with child protection experience, on the same day, or for regional remote areas by a medical service which is to consult with a paediatrician on the same day. This consultation should not cause any difficulty as Perth Children's Hospital's Child Protection Unit has an on-call service that can provide around the clock advice.[165]

Changes by WACHS [166]

154. At the inquest, Sharlene Abbott, the acting director of Population Health at WACHS - South West, outlined the changes that have been made by WACHS since Baby H's death. Ms Abbott stated that a review after Baby H's death had led to multiple recommendations and improvements being implemented across the state. I will highlight two of those changes.

155. One improvement that was introduced in October 2018 was the implementation of a Community Health Information System (CHIS). There is now no longer a physical medical record for a child attending a child health centre but rather CHIS electronic records which are visible to all community health clinicians.

156. Another improvement was introduced in December 2018 when WACHS and Child and Adolescent Health Service implemented a protocol titled "Clients of Concern Management". This is designed to safeguard infants where there are concerns for their health, wellbeing and/or safety. Once an infant has been identified with certain identified risk factors then the responsible child health nurse has a monthly review with a senior staff member.

[165] ts. 21.10.20 (Dr Houliston), p 277
[166] Exhibit 1, Vol.2, Tab 23, Report of Sharlene Abbott dated 6 October 2020

157. Ms Abbott testified that the awareness and follow up for infants at risk has significantly improved since Baby H's death; although she acknowledged there is always a continual need for improvement.[167]

158. WACHS is to be commended for the changes that have taken place since Baby H's death. However, what caused me some concern was Ms Abbott's evidence that hospital emergency departments still do not have access to CHIS electronic records.[168] Ms Abbott is aware of that deficiency and has been making efforts to ensure hospital staff can have access to these records. It was anticipated that this process would be completed within six months of October 2020.[169]

159. In light of that progress, I do not propose making a recommendation that a hospital that is treating a child have access to the child's CHIS electronic records. I will simply record that I strongly encourage the efforts being made by WACHS to have this access put in place as soon as possible.

RECOMMENDATIONS

Mandatory reporting of injury to non-ambulant infants

160. This inquest highlighted the risks of injury to non-ambulant infants. I am able to consider how similar incidents can be prevented in the future. An appropriate recommendation would be one that reduces the risk of an earlier missed opportunity to intervene.

161. The four witnesses called at the inquest who worked for the Department, the two doctors from BRH and Dr Houliston all supported the mandatory reporting of injuries in a non-ambulant child.[170] As Dr Houliston noted[171] "*this is one of many cases that we've been involved in where earlier intervention may have changed the outcome.*"

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[167] ts. 21.10.20 (Abbott), p 313
[168] ts. 21.10.20 (Abbott), p 299
[169] ts. 21.10.20 (Abbott), pp 299-301
[170] ts. 19.10.20 (Barry), p 76; ts. 19.10.20 (Mitchell) p 104; ts. 19.10.20 (Tomsett); ts. 20.10.20 (Dr Truong), p 200; ts 20.10.20 (Dr Adewumi), p 233; ts. 21.10.20 (Mace), p 261; ts 21.10.20 (Dr Houliston), p 279
[171] ts. 21.10.20 (Dr Houliston), p 279

162. Ms Abbott also supported mandatory reporting, only raising the concern that parents may be deterred from taking their child to a child health nurse if they knew they were going to get reported.[172]

163. One of the benefits of mandatory reporting is that it would lead to health practitioners being more comfortable in disclosing evidence of physical abuse in non-ambulant children as at present there could be concerns around privacy, confidentiality and losing their relationship with the family.[173] Significantly, mandatory reporting would reduce the potential prospect of the infliction of more serious injuries if earlier injuries are reported.

164. The case of Baby H is very similar to the matter of PT which was heard before the State Coroner from 9 - 11 September 2019.[174] In delivering her findings on 23 September 2020, the State Coroner made the recommendation that consideration be given to the mandatory reporting of any injuries in a non-ambulant child in similar terms to the mandatory reporting of child sexual abuse that has been in place for 12 years.[175]

165. I am firmly of the view that the death of Baby H highlights the need for this recommendation to be carefully considered by the Western Australian Government. It is for that reason I will make the same recommendation again in this finding. There is no need to make any amendments to it as the circumstances of Baby H's harm, her age and the opportunities to report the bruising fall within the parameters of the State Coroner's recommendation.

[172] ts. 21.10.20 (Abbott), p 314
[173] Inquest into the death of PT [2020] WACOR 26, p 50
[174] Inquest into the death of PT [2020] WACOR 26
[175] Inquest into the death of PT [2020] WACOR 26, p 52

Recommendation No.1

I recommend that the Western Australian Government considers the undertaking of a regulatory impact review and if appropriate, introduces:

(a) an amendment to the *Children and Community Services Act* 2004 (WA) to include a duty to report any injuries in a non-ambulant child, in similar terms to the reporting structure for the reporting of sexual abuse of children requirements contained in Division 9A of Part 4 of the *Children and Community Services Act 2004* (WA); and

(b) an extension to the current mandatory training program jointly provided by the Department of Communities and the Department of Health – Child and Adolescent Health Services regarding the reporting of sexual abuse of children requirement contained in Division 9A of Part 4 of the *Children and Community Services Act 2004* (WA) to include education on the duty to report any injuries in a non-ambulant child.

Absence of Department contact details in the High Risk Infant Policy

166. During the course of his evidence Mr Mace noted that the Policy has no instructions regarding after-hours communications with the Department. He was of the view that "*there's probably an opportunity here in our operating instructions to make that explicit.*" [176]

167. In light of the failed attempt by the grandmother to contact the Department on 20 May 2017 and the confusion as to when she was supposed to use Ms Mitchell's mobile phone number, I am of the same view as Mr Mace. The Policy should set out the appropriate lines of communications between the Department's staff and third parties, particularly those who have notified the Department of their concerns for a child and those participating in a safety plan. These lines of communications should include contact details during office hours and after-hours. The provision of the private mobile phone number of a

[176] ts. 21.10.20 (Mace), p 260

Department's employee should only be given as a contact number in exceptional circumstances.

Recommendation No.2

In order to improve communications between its staff and third parties, the Department should include information regarding the appropriate contact details for its staff (including after-hours) in its High Risk Infant Policy.

Creation of a Department policy for grieving family members

168. Through counsel assisting, the family of Baby H asked Mr Mace this question during the inquest: [177]

> [A]fter Baby H's death and obviously there was a lengthy criminal process, they feel that they, and particularly the father of Baby H, were left with really no information or contact from the department following that. So no discussion about the changes that have been made very much primarily due to Baby H's case, no debriefing really about what occurred or any support offered to them with respect to counselling about what they went through in terms of Baby H's tragic death. I'm curious as to whether the department has a policy about these types of tragic incidences and how they relate with the family after that or whether that's considered inappropriate entirely by the department? --- No. We – we don't have a policy on how to manage those circumstances, but I can certainly understand why the extended family would feel the way they do about what happened and how these things can play out after the event.

169. Mr Mace later said there was no plan to create such a policy and he did not take issue with the family's perception that there was a significant gap in their involvement with the Department after Baby H's death.[178]

170. In his closing submissions Mr Nelson, counsel for the Department, confirmed that there was no policy presently in place in relation to services or counselling being offered to families in circumstances where

[177] ts. 21.10.20 (Mace), p 253
[178] ts. 21.10.20 (Mace), p 269

a child in the Department's care has died. Mr Nelson did clarify that this did not mean these matters did not occur but simply that there is no policy.[179]

171. I am of the view that a policy which addresses contact with the family following the death of a child in the Department's care would be appropriate. In much the same way that the Central Intake Model improved consistency in the decision-making process in relation to the assessment of notifications of concerns, a policy that sets out the practices and procedures to be followed with grieving family members would provide a consistent approach. It would also avoid the situation that arose following Baby H's death.

172. I am concerned that the father, after the terrible loss of his daughter at the hands of his then partner, felt let down by the Department following his daughter's death. There would be considerable merit in a policy, for example, that offers counselling for those family members wishing to avail themselves of that service. The policy could also have a procedure which provides the opportunity for the family to be advised of the changes that the Department has made in light of the child's death. As to this last matter, although family members always have the opportunity of hearing evidence about those changes at the inquest or reading about them in the Coroner's finding, there can be a considerable delay before an inquest takes place.

Recommendation No. 3

In order to provide an appropriate level of support to family members, the Department should prepare a policy document that sets out the practices and procedures to be followed in relation to family members after the death of a child who was in the Department's care.

[179] ts. 21.10.20 (closing submissions of Mr Nelson), p 323

CONCLUSION

173. Baby H brought much happiness to her father and grandparents during her short life. She was a much loved infant.

174. Baby H was placed into the care and protection of the Department on 26 May 2017, shortly after she suffered horrific inflicted injuries. Regrettably, the potential care and protection that the Department could offer under the protection order was too late and Baby H died two days later.

175. The evidence at the inquest showed there were missed opportunities that may have enabled the Department to intervene earlier than it did. Inquests will often identify opportunities that were not acted upon which may have prevented the death that is the subject of the inquest. However, simply being involved in an opportunity missed does not mean a person or entity should be the subject of criticism, let alone be held responsible for a subsequent death. As I made clear at the outset of this finding, the person responsible for Baby H's death was the mother. I have also made clear that those involved in the missed opportunities are not to have adverse findings made against them.

176. The identification of missed opportunities does, however, allow for an analysis to be done and for improvements to be made. The Department quickly acknowledged the shortcomings that arose in Baby H's case and implemented changes to address them.

177. The Department is to be commended for its introduction of the new intake procedures, the High Risk Infant Policy and other changes that it has made. Mr Mace testified that there is "*rigorous implementation of these new practice guides and rules.*"[180] If that is maintained then the missed opportunities identified in the tragic death of Baby H should never be repeated.

178. Similarly, WACHS is to be applauded for the changes it has made to its practices and procedures.

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[180] ts. 21.10.20 (Mace), p 268

179. I have made three recommendations aimed at addressing the further issues I have identified during the inquest. It is my hope that these recommendations, and the changes already made by the governmental departments following Baby H's death, may provide some consolation to her family for their heart-rending loss.

P J Urquhart
Coroner
9 February 2021