JURISDICTION	**:**	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	**:**	CORONERS ACT 1996
CORONER	**:**	SARAH HELEN LINTON, DEPUTY STATE CORONER
HEARD	**:**	17 - 18 OCTOBER 2023
DELIVERED	**:**	4 APRIL 2024
FILE NO/S	**:**	CORC 2174 of 2021
DECEASED	**:**	Child LT

Catchwords:

Nil

Legislation:

Nil

Counsel Appearing:

Ms S Markham assisted the Coroner.
Ms R Hartley (SSO) appeared on behalf of the WA Police Force and the Department of Communities.

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

Nil

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

I, Sarah Helen Linton, Deputy State Coroner, having investigated the death of ***Child LT*** *with an inquest held at Perth Coroners Court, Central Law Courts, Court 85, 501 Hay Street, Perth, on 17 to 18 October 2023, find that the identity of the deceased person was* ***Child LT*** *and that death occurred on or about 18 August 2021 at 49 Avery Avenue, Dianella, from an unascertained cause in the following circumstances:*

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SUPPRESSION ORDER

Suppression of the deceased's name, the deceased's siblings and other family members from publication and any evidence likely to lead to their identification.
The deceased is to be referred to as Child LT.

INTRODUCTION

1. Child LT, whom I will refer to as the deceased in this finding, was born on 25 October 2009. After his birth, the deceased was diagnosed with a rare genetic developmental disorder that significantly affected his physical and mental development. At 11 years of age, the deceased had the appearance and abilities of a child much younger than his biological age and more like a toddler. He was able to crawl, sit upright and take some supported steps but generally mobilised in a wheelchair. He was non-verbal and primarily consumed baby formula as he had never transitioned to eating solids. The deceased required a high level of care and support.

2. At the time of his death, the deceased was living with his mother and his nine year old sister, LM, in a house in Dianella. His younger half-sister, SJ, was living with her paternal grandparents. The deceased was enrolled at the specialist Sir David Brand School, where he received the support he required to live a rich full life while accommodating his complex physical and mental needs.[1] Unfortunately, he only attended intermittently, despite encouragement from school staff. This meant it was not always clear whether his needs were being met, as other than school staff, the deceased had very limited contact with anyone outside his immediate family.

3. The Department of Communities had been involved with the deceased and his family since November 2018, but the first time Communities undertook a Child Safety Investigation in relation to the family was in July 2020. No neglect was substantiated at that time. More concerns were raised in 2021, which eventually led to another Child Safety Investigation commencing in May 2021. The concerns centred predominantly around the deceased's mother's ability to care for him.

4. After their mother suffered a health event, the deceased and his sister were cared for by their maternal great aunt, Ms G, in an informal arrangement between 21 July 2021 and 13 August 2021. The deceased was attending school regularly while in Ms G's care. He had also been suffering from a chronic skin condition and been losing weight, both of which began to resolve as a result of Ms G's attentive care.

5. However, on 13 August 2021, both children were returned to their mother's care as Ms G could no longer care for them and their mother's health event had resolved. A safety plan was put in place for a support person to provide monitoring over the weekend as the Child Safety Investigation was still ongoing at this time.

6. There were more signs of concern in the week commencing 16 August 2021, with both children not attending school. This prompted contact between Child Protection staff and the deceased's mother on the Monday, Tuesday and Wednesday. When questioned, the deceased's mother told Child Protection staff that she and the children were unwell.

7. On Tuesday, 17 August 2021, the deceased's sister became distressed by her mother's behaviour and asked their father to come and collect her. He collected her

[1] T 93.

that evening. There was some discussion about him returning to also collect the deceased, but in the end, the deceased remained at home alone in his mother's care.

8. On the evening of Wednesday, 18 August 2021, the deceased's mother was witnessed driving erratically. She was spoken to by ambulance and police officers, who suspected she was under the influence of drugs/alcohol and possibly suffering from a mental health condition. The deceased's mother was taken to Royal Perth Hospital (RPH) by ambulance, arriving at 10.36 pm. She had a very high blood alcohol concentration on admission and was behaving in a bizarre manner. The next day, she was assessed and admitted for treatment as an involuntary psychiatric patient under the *Mental Health Act 2014* (WA).

9. On the morning of Thursday, 19 August 2021, RPH staff contacted Child Protection staff to advise that the deceased's mother was in hospital and they had become aware that Communities had an open case in relation to two of her children. They advised the children were not with her. Child Protection staff began taking steps to confirm the location of the deceased and his sister by contacting family members, the mother's support person and the school. They located the deceased's sister but did not have any success in confirming the location of the deceased.

10. Ms G was contacted and she became concerned the deceased might have been left at home alone. She immediately went to his house, arriving at around 1.00 pm. Ms G entered the house through a closed but unlocked flyscreen door and found the deceased in a lifeless state on his bedroom floor. Police and ambulance officers quickly attended and observed signs of blood pooling and rigor mortis, suggesting he had died sometime earlier. A forensic pathologist attended the scene and then later conducted a post mortem examination. Despite extensive post mortem investigations, the forensic pathologist could not determine a definite cause of death. However, given his serious heart disease, the forensic pathologist did indicate that the deceased could have died suddenly at any time.

11. Police enquiries established that the deceased had last been seen alive by his father at about 5.00 pm on 17 August 2021 when he collected the deceased's sister. The house was in a state, the deceased was distressed and the deceased's mother was asleep. He said he woke up the deceased's mother and told her to take care of the deceased before he left. There is no confirmed sighting of the deceased alive after that night.

12. On her discharge from hospital, Homicide Detectives arrested the deceased's mother on suspicion of manslaughter. They interviewed her under caution on 2 September 2021. In brief, she said she had been heavily intoxicated and unwell on the night of Tuesday, 17 August 2021 and believed the deceased's father had taken both children that night. The next day, being the Wednesday, she believed the deceased was not at home and she spent the day drinking alcohol. Later that night, she went into the deceased's room and found he had died. She drank more alcohol and then drove away from the house, reportedly with a plan to kill herself. That is when she came into contact with the police and was taken to hospital. Following the interview, the deceased's mother was released without charge and no charges were ever laid against any person in relation to his death.

13. As the Department of Communities had an open case involving the deceased at the time he died, and the police had also been involved with the deceased's mother the night before he was found, the State Coroner determined that it was desirable to hold an inquest into the death pursuant to s 22(2) of the *Coroners Act 1996* (WA). I held an inquest on 17 to 18 October 2023. The inquest focussed on the involvement of Communities with the family leading up to the deceased's death, as well as the events surrounding his death. In particular, I considered whether the Department of Communities could have taken further steps to protect the deceased and/or support his mother and father in order to prevent his death, as well as the communication issues that meant that the deceased's body was not discovered in the house until the following day by his great aunt.

MEDICAL BACKGROUND

14. The deceased was born in Newcastle and later lived with his family in Queensland, before eventually relocating to Western Australia in 2012. He was born with Cornelia De Lange Syndrome, a rare genetic developmental disorder that affects many parts of the body and causes physical, health and learning challenges. He was diagnosed antenatally a couple of days after his birth. The deceased was also diagnosed with Tetralogy of Fallot, a combination of four congenital heart defects, that required surgical correction. While still in Queensland, the deceased underwent cardiac surgery to repair the Tetralogy of Fallot. He had a complex postoperative course, but eventually recovered.[2]

15. After moving to Perth, the deceased came under the care of a Consultant Cardiologist at Perth Children's Hospital (PCH). He was also seen by a Consultant Paediatrician at PCH, who referred him to the Disability Services Commission for ongoing support, given his longstanding difficulties with developmental delay, feeding difficulties and poor weight gain.[3]

16. In July 2014, the deceased was seen by another paediatrician in the General Paediatric Infant Monitoring Clinic. It was noted he was registered with the Disability Services Commission and was receiving Better Start Funding and his family were in receipt of a Carer's Allowance. The deceased continued to have problems with feeding and his sole source of nutrition at that time was a toddler formula. Any attempt to transition him to solids had been unsuccessful. Overall, his functioning at that time was assessed as at a 5 to 12 months level, although he was biologically almost five years of age. All his growth parameters were under the 3rd percentile for his age, which was in keeping with his genetic condition. It was noted he was dependent on his pram for mobility and his therapy priority at the time was his mobility. Active speech therapy was considered the next priority. The deceased needed assistance with all activities of daily living and he demonstrated some challenging behaviours at times. He could sometimes become distressed and aggressive towards others and was also prone to self-harm at these times. In terms of his cardiac function, it was noted he was under six monthly review by Cardiology

[2] Exhibit 2, Tab 2.
[3] Exhibit 2, Tab 2.

and his oxygen saturations were now generally good, although he did show some mild cyanosis. He was on no regular medications and had no known allergies.

17. At the end of the review, it was noted that the deceased would need to transition to another General Paediatric Clinic as he could not be managed in the Infant Monitoring Clinic on an ongoing basis, given his age. It was expected he would be reviewed in the General Paediatric Clinic in about three months' time. He was also referred to Orthopaedics for review in the Hip Surveillance Clinic, but there is a record that he did not attend an Orthopaedic Appointment on 2 December 2019. It does not appear from the medical records that the deceased was ever reviewed in the General Paediatric Clinic and he did not have a general paediatrician managing his overall care from that time.[4]

18. The deceased was meant to be reviewed on an annual basis after his last review in the Cardiology Clinic on 21 November 2019. There are records to indicate he did not attend an appointment on 25 February 2021, nor again on 27 February 2021. There is no record to indicate he ever received further Cardiology Review.[5]

19. The deceased was not on any regular medications and only saw a GP as needed. The only recent medical review on the file was a GP appointment on 26 February 2021 when the deceased was brought in for medical review due to repeated vomiting and diarrhoea. His mother was reportedly anxious for his oxygen levels. Samples were to be taken for faecal testing, he was given a medical certificate for non-attendance at school and his mother was told to take him to hospital if his vomiting increased. It doesn't appear there was any further follow-up and it seems it was just a brief gastrointestinal illness.[6]

INITIAL COMMUNITIES INVOLVEMENT – 2018 to 2019

20. The deceased's parents' relationship had ended in 2013 and he and LM lived with their mother from that time, with regular visits from their father. The deceased's mother had started a new relationship in 2013 and eventually she married her new partner. While the deceased's mother had reportedly experienced some mental health issues in about 2009 which led to ongoing anxiety and depression, she was said to have been relatively well and stable from 2013 to early 2020. The deceased's mother was said to use cannabis recreationally from time to time, but was not known to have any particular substance abuse issues.[7]

21. The evidence at the inquest generally suggested that the deceased's mother was a caring parent who had provided him with an appropriate standard of care for many years. His mother had initially been reluctant to enrol him at the Sir David Brand School, but with encouragement she had eventually enrolled him in July 2015. His mother withdrew him again in July 2018.[8]

[4] Exhibit 2, Tab 1.
[5] Exhibit 2. Tab 1.
[6] Exhibit 2, Tab 1.
[7] Exhibit 1, Tab 12.
[8] Exhibit 1, Tab 22.

22. The deceased's first contact with the WA Department of Communities was in November 2018. At the time, the deceased was nine years old and living with his mother, stepfather, younger sister LM and baby half-sister SJ in Embleton.[9] He was withdrawn from school at this time. The deceased's mother said he had found it distressing and he was self-harming, so she was home schooling him at that stage while on maternity leave with her youngest child.[10]

23. The deceased had been brought into the Princess Margaret Hospital (PMH) Emergency Department on 11 November 2018 with a tear to the underside of the foreskin of his penis. His mother and stepfather advised PMH staff that the deceased had three very large bowel movements that day and when his stepfather was cleaning him after the third event, he noticed blood on the deceased's penis. The deceased did not appear to be in pain but they decided to take him to hospital for medical treatment. Both parents were noted to be appropriately concerned about the injury and showed empathy and care for the deceased. They could not provide any explanation for the injury. The laceration to the deceased's penis was determined to be superficial and it was sutured with stitches in theatre on 12 November 2018.[11]

24. PMH staff contacted Communities to determine if there was any history of contact between the family and Communities, and were advised there was none. The case was referred to the PMH Child Protection Unit (CPU) as it was an unexplained injury in a vulnerable child. The deceased's family were interviewed by senior social workers from the CPU together and then the deceased's mother was spoken to separately. The deceased's mother denied any drug or alcohol misuse or mental health issues in the home and said her relationship with her current husband was good. It was noted that the deceased's only contact with a service outside the home at that time was the Ability Centre (now AbilityWA), given he wasn't attending school. CPU staff spoke to staff at the Ability Centre, who advised they had no concerns with the family and would be going out to the family home again in December. It was determined that there was no risk around the deceased and he was discharged home that night with his family.[12]

25. PMH made an unexplained injury report in relation to the unexplained penile injury but indicated it was more for the information of Communities than a referral, given the PMH staff had no concerns about the behaviour of the deceased's mother and stepfather and the doctors felt it was unlikely the injury was inflicted.[13] As the PCH staff reported no concerns, Communities did not take any further action at that time.[14]

26. On 10 May 2019, a Mediation Assessment Officer from Relationships Australia reported to Communities that in the course of speaking with the deceased's stepfather, he disclosed that the deceased's mother would leave the deceased in a cot

[9] Exhibit 2, Tab 2.
[10] Exhibit 2, Tab 2.
[11] Exhibit 2, Tab 2.
[12] Exhibit 2, Tab 2.
[13] Exhibit 2, Tab 2.
[14] Exhibit 1, Tab 19.3.

"while she quickly went to the shops."[15] It is recorded that Communities took no further action, although I understand that the concerns were investigated.[16]

SIR DAVID BRAND SCHOOL

27. As noted above, the deceased had been enrolled at Sir David Brand School in July 2015, after about six months of negotiations with the deceased's mother to reassure her that he was able to be cared for safely.

28. Ms Hilary Palmer, the Principal of Sir David Brand School, gave eloquent evidence about the deceased's abilities and his requirements in her statement and in her evidence at the inquest. It was largely through Ms Palmer that we gained a detailed understanding of who the deceased was as a person. He had a profound disability but with support, he was able to learn and engage with people and the world around him. He was a young boy who had complex needs but also the ability to feel happiness and curiosity and showed a desire to interact with his environment, particularly through sensory engagement. He had likes and dislikes; he liked sweets and his bottle and spinning things but didn't like savoury food. Ms Palmer described the deceased as happiest when he listening to music, exploring the world outside or enjoying hydrotherapy classes. He also enjoyed using the interactive whiteboard and liked to find a sunny spot to sit and view the world. [17]

29. I am satisfied from the evidence before me that a lot of his happiest times, at least in the last part of his life, were when he was at school with people who were focussed on ensuring he was safe and supported and able to use all of his different abilities to engage with the world. There was government funding to ensure that all his needs were met, and the school was willing to facilitate that occurring. However, it also seems his mother had stopped cooperating with the school at some stage, which made it difficult for them to provide the level of care they wanted to provide.

30. In July 2018 to May 2019 his mother took him out of school again and indicated she intended to homeschool him while she was on maternity leave with her youngest child. There is no evidence to indicate exactly what kind of homeschooling his mother was providing for him at this time, although other evidence suggests that the deceased was not receiving close support and attention over this period. Ms Palmer speculated that withdrawing him from school may have been a response to some pressure from the school to engage with their suggestions for increased support for the deceased. Ms Palmer wrote to the homeschool coordinators and the deceased's therapists to let them know she felt there needed to be somebody external to the family who still had "eyes on"[18] the deceased and his family to ensure his wellbeing, but it is unclear whether this occurred.[19]

31. The deceased was eventually re-enrolled at the Sir David Brand School in May 2019. During the deceased's period of home schooling, Ms Palmer had arranged for his

[15] Exhibit 1, Tab 19.3, p. 3.
[16] Exhibit 1, Tab 19.3.
[17] T 82 – 83; Exhibit 1, Tab 22.
[18] T 92.
[19] T 92.

mother to be sent resources to support his education, but when he was re-enrolled in May 2019, Ms Palmer noticed a regression in his abilities. His mobility had decreased quite dramatically and his level of engagement in his interests and curiosity had reduced. Ms Palmer commented that he appeared to be less inquisitive and "just seemed a lot flatter."[20]

32. There were ongoing concerns about his health and supports from that time. Ms Palmer explained that she had become concerned that the deceased's teeth were causing him to self-harm and she had attempted to get the deceased's mother to engage with a specialist dental service, but this proved difficult. He would also self-harm when bored, repeatedly poking his jawline and bending his fingers back. The school was responsible for conducting a needs assessment for the deceased and an Individual Education Plan was developed each year. His mother attended the meetings but there were ongoing difficulties maintaining her consistent engagement. Ms Palmer stated that she was worried about the deceased's mother's capacity to look after the deceased without proper support structures to assist her, due to her erratic levels of engagement and limited response to the raised dental and self-harm concerns. His attendance at school was also poor, particularly in 2020 and moving into 2021, although this period coincided with the emergence of the COVID-19 pandemic, which may have provided at least a partial explanation for his poor attendance rates at this time, although the school remained open.[21]

FIRST OPEN CASE – JULY 2020

33. The deceased's father, who had remained in contact with the deceased's mother over the years, later reported to police that during 2020 he noticed a major shift in the deceased's mother's personality. She had generally been well and stable after their separation and during her next relationship, but when her marriage ended and she began a new relationship, he noticed a major shift in the deceased's mother's behaviour, including appearing distressed and paranoid on occasion.[22] A family friend also noted the deceased's mother appeared to have everything under control in her life until 2020, when her marriage ended and she began the new relationship with a man called Kyle Le Tang.[23] Evidence suggests her changed behaviour was also due to substance abuse.

34. On 13-14 July 2020, the deceased's mother was reported to have been on a three day cocaine and methamphetamine binge. She was said to have locked herself in a room and told her young daughter, LM, to care for the deceased and her baby sister. The police were called by her estranged husband, who had separated from the deceased's mother a few weeks before. The deceased and his sister were placed in the care of their father, while the youngest child was placed into the care of her paternal grandparents, as her father was also a drug user. The deceased's mother was taken to hospital by police and sedated.[24]

[20] T 85.
[21] T 94 – 95; Exhibit 1, Tab 22.
[22] Exhibit 1, Tab 12.
[23] Exhibit 1, Tab 13.
[24] Exhibit 1, Tab 19.3.

35. The deceased's mother was released from hospital the following day and resumed care of the two older children. Child Protection staff requested police conduct a welfare check on the two children on 15 July 2020 as the deceased's mother had been abusive towards Child Protection staff when they visited that afternoon, was behaving erratically and had refused to let them see the children. They had eventually been forced to leave the premises without sighting the children due to the level of aggression. The deceased's mother had also contacted the police around this time, demanding they assist her to get her youngest daughter back. Police officers were initially reluctant to attend solely for the purpose of conducting a welfare check on the children, as they did not feel that the Child Protection staff had established immediate concerns for the safety of the children. However, officers did eventually attend the deceased's home that evening to serve a violence restraining order on the deceased's mother and officers took steps to check on both children at that time. They established the mother was in a situational crisis but felt there were no grounds for detaining her under the *Mental Health Act*. The two children were sighted by police and reportedly looked healthy and well.[25]

36. Emma Wood, who was a Communities' Senior Child Protection Worker and the case manager involved at the time, was one of the Child Protection staff who had been refused entry by the deceased's mother on 15 July 2020. Together with her colleagues, Ms Wood had been making attempts to have a conversation with the deceased's mother since that time. The deceased's mother made it clear she would not communicate through phone calls but would respond to text messages or emails. Ms Wood gave evidence this was not uncommon with Communities' clients and while it was not her preference, Child Protection staff have to be flexible in such instances.[26]

37. After eventually establishing contact through texts, Ms Wood undertook a home visit with a colleague. During the visit she sighted the deceased and observed that he appeared to be much younger than his 11 years and it was apparent he needed constant care, similar to the care a toddler would require. The house was messy but clean and the deceased's room appeared to have all the items he might need, such as nappies and wipes and clothes. His mother appeared to be monitoring him appropriately during the visit.[27]

38. Ms Wood also met LM during this visit and later conducted a child interview with LM. The interview with LM established there were two occasions when their mother had gone out and LM had been left in charge of the deceased and her younger sister, and on one of these occasions a workman came to the house and she had felt scared.[28]

39. During the investigation, Ms Wood contacted NDIS to raise significant concerns about the deceased and to try to clarify the current services provided to him. Discussions with his NDIS Local Coordinator indicated that the deceased's mother received quite a bit of funding for in-home care, including a respite carer one night a

[25] T 100 - 101; Exhibit 2, Tab 3.
[26] T 100 – 101; Exhibit 2, Tab 3.
[27] T 103.
[28] T 103, 133 - 134; Exhibit 1, Tab 17 and Tab 19.3.

week, which the deceased's mother had reported she did privately with a friend, although there is no evidence of whom she entrusted with this role. Some women from a local church were identified as helping out sometimes, but they were not paid for their services, and a babysitter would only ever come for a few hours and generally did not stay overnight.[29]

40. Funding was also provided for therapy and supports. Ms Wood followed up with the Ability Centre, who indicated they had no particular concerns about their dealings with the deceased's mother, although they noted that his mother appeared to prefer him to get his therapy while at school and observed it was unusual, given the size of funding allocated for him that no funding had been allocated for support coordination. I note an allegation was made to Child Protection staff around this time by a family member that the deceased's mother was funding her drug use with the deceased's NDIS funding, as well as spending the money on other 'lifestyle choices not related to the deceased's particular needs'. Specifically, it was alleged the deceased's mother had found a way to falsely invoice the funds with other people's ABN's so she could get money to pay for her shopping and to buy cocaine.[30]

41. Further enquiries by Ms Wood established that the deceased was allocated $85,674 for the year and the funding was self-managed by his mother. The deceased's mother denied that she was using the funds for anything other than his care and support. Ms Wood contacted the deceased's NDIS support coordinator and asked for an audit to be completed of his funding and to query whether it was appropriate for his mother to continue to manage his funding or whether it should be managed externally from the family.[31]

42. There is evidence the allegation that the deceased's mother was misusing his funding was formally referred to the Scheme Integrity Branch at NDIS by the deceased's NDIS Local Area Coordinator in July 2020. It was not entirely clear at the time of the inquest what outcome came from this investigation, although Ms Wood recalled she followed up sometime later and was told NDIS either couldn't or wouldn't do anything about it.[32]

43. Certainly the evidence at the inquest suggested the same concerning behaviour remained, as it was apparent the deceased's mother was getting a large amount of deliveries to the home of not only take-away food, but also regular deliveries of alcohol, at considerable cost. The deceased appeared to have almost no clothes or personal belongings when Ms G collected him and he had significant therapy needs still requiring sign off by his mother before they could be funded..[33]

44. The evidence before me raised the question whether the deceased's funds were being directed as intended. Following the inquest, further enquiries were made with NDIS, which led to information being provided by the National Disability Insurance Agency. It took some time for the information to be able to be collated and released,

[29] Exhibit 2, Tab 3.
[30] T 134 – 135.
[31] T 135; Exhibit 2, Tab 3.
[32] T 118, 135 - 136.
[33] Exhibit 2, Tab 3.

but it was eventually provided on 2 April 2024. In brief, the Court was advised that the case was referred for a compliance review and a targeted engagement review was conducted, with some educational materials provided to the deceased's mother to clarify an individual's responsibilities and obligations under the Scheme. No further action was taken. Accordingly, I make no further comment on this issue.[34]

45. The paternal grandmother of the deceased's youngest sister had also raised concerns with Ms Wood during the child safety investigation. When she had collected her granddaughter from the deceased's home in mid-July, she had provided some nappies as the deceased did not have any and had noted the pantry was completely empty, so there was no food in the house for the children. Although the deceased was not her biological grandchild, she became very emotional when expressing her concerns about the deceased's mother's ability to properly care for him, fearing he was being neglected. She also indicated her understanding that the deceased's father was not interested in taking over the deceased's care.[35]

46. Ms Wood and another Child Protection staff member had a long meeting with the deceased's mother on 23 July 2020. She admitted using cocaine two to three times a week and marijuana every day, which occurred when the children were at school but also when they were at home. She denied amphetamine use and couldn't explain why she had tested positive for amphetamines at the hospital. She denied that her drug use impaired her ability to care for her children. She also denied any mental health history, although Communities had information that she had been admitted to hospital on 18 December 2019 following a suicide attempt by overdosing on her prescribed antidepressant medication and she had remained on medication for depression thereafter. The deceased's mother agreed to complete urinalysis testing to show she had now ceased illicit drug use, which she did in a three week period. She also provided a letter from the Palmerston Centre indicating she was waitlisted to participate in drug counselling.

47. The outcome of the Child Safety Investigation was that neglect was not substantiated for the deceased or the baby, because neither could verbalise any impact. Ms Wood explained that the focus of the Communities investigation is not whether the abuse or neglect occurred, but whether the child has experienced impact, which couldn't be assessed. However, the likelihood that LM had experienced child neglect was substantiated as she was able to express her distress.[36]

48. I did question the validity of this type of inquiry at the inquest, given the deceased's inability to communicate any distress did not mean he did not experience distress. However, Ms Wood explained it is very difficult to get evidence of prior distress in such circumstances. Ms Wood did indicate that the Child Protection staff might have been able to substantiate risk of future harm for all of the children, given they had been left unsupervised on more than one occasion, but this concern was able to be resolved to the satisfaction of the Child Protection staff by engaging in safety

[34] Correspondence from NDIS to Counsel Assisting, dated 2 April 2024.
[35] Exhibit 2, Tab 3.
[36] T 103 – 104.

planning with the deceased's mother to ensure she would not leave the children home alone again.[37]

49. On 20 August 2020, the case was closed after the safety planning had been conducted with the deceased's mother. In particular, the safety plan involved the deceased returning to school and engaging in therapy and the deceased's mother agreed to have a backup plan in case she relapsed into drug use. The youngest child, SJ, continued to stay in her paternal grandparents' care from that time, so only the deceased and LM were the focus of the safety plan while they remained in their mother's care. Ms Wood gave evidence that as the deceased's mother gave an undertaking not to leave the children home alone again, they were not able to demonstrate risk of ongoing harm.[38]

50. I make more comments about Communities' involvement with the deceased's family below, but at this stage I simply note my surprise that the case was closed, given the real concerns that had been raised about the deceased's mother's ability, and willingness, to provide appropriate care for the deceased at that time and to use his funding solely for his benefit. I note the deceased's mother's response to Communities comments was dismissive and she maintained she was a good mother, despite her drug use and other issues raised. She seemed to lack insight and her stated belief that she would be able to cease all illicit drug use from that time with limited assistance was unrealistic. The evidence establishes she continued to abuse substances, including illicit drugs and alcohol, after this time, which negatively affected her ability to provide the high level of care and support the deceased required, not to mention the care and support her young daughter LM also needed and deserved.

COMMUNITIES INTERACTIONS EARLY 2021

51. On 26 March 2021, the deceased's stepfather, whose relationship with the deceased's mother had ended, contacted Communities with concerns for the deceased and his sister LM. He alleged the deceased's mother had been using methamphetamine for five days. His own child was no longer living with the deceased's mother, so his concern was only for his two stepchildren. The report included information that the children were not attending school and there was alleged violence occurring between the deceased's mother and her new partner. Communities reportedly sought information from the deceased's school and spoke with his mother, who denied any illicit drug use. No further action was taken but the deceased's mother was warned that any further incident suggesting she was using drugs might result in a new child safety investigation.[39]

52. On 5 May 2021, the deceased's maternal grandmother (who had a fractured relationship with her daughter) reported concerns to Communities regarding the impact of their mother's drug use on the two children still in her care, being the deceased and LM. It seems the query was raised with the Central Intake Team and

[37] T 104.
[38] T 104 - 105.
[39] Exhibit 1, Tab 19.3; Exhibit 2, Tab 4.

Communities were recorded as taking no further action. I note the documents indicate that the children's grandmother acknowledged she had not spoken to her daughter, or had contact with her children, for some time and she was not raising any new concerns based on recent information. It was recorded that if any further concerns were raised, assessment might be warranted.[40]

53. On 20 May 2021, a concern was raised with Communities by the deceased's school principal, Ms Palmer. Ms Palmer advised that:[41]

- the deceased had only attended one day of school that term;
- his mother rarely returned calls from the school;
- the day before, his mother had sent a text message stating that she was thinking of putting the deceased back into home schooling again;
- his maternal grandmother had telephoned the school to express her concerns about his welfare;
- his stepfather had telephoned twice to enquire if the deceased's mother had submitted the online School Bus Service application for the deceased; and
- the deceased's physiotherapist from the Ability Centre had advised that the deceased's stroller was too small and his wheelchair would not be available for several months.

54. Ms Palmer gave evidence at the inquest and indicated that part of her role as the Principal at the Sir David Brand School was to identify barriers to a child's educations and put strategies in place to address them. She had worked closely with the deceased's mother in the past to allay her concerns and get her to enrol her son at the school. There had been ongoing complications around ensuring he attended school regularly, for varied reasons, but they had been able to work through most of those issues. However, at this time in 2021, Ms Palmer had become concerned that the deceased's physical and emotional needs were not being met and despite conversations with his mother, things had not improved. Ms Palmer said the deceased was a delightful child but he was showing signs of distress and was engaging in self-injurious behaviour that she thought was possibly related to his dental issues. A specialist dental service visited the school and they had expressed concern about his teeth and strongly recommended that he see a dentist specialist. This had been communicated to his mother a number of times but had not led to any action in response.[42]

55. Ms Palmer said she had noticed a marked difference in the deceased's mother's engagement with the school after his period of homeschooling and return to school in mid-2019. She had attended several meetings but had not signed off on therapy plans, leading therapists to discontinue service provision. Ms Palmer noted that the deceased was engaged with speech therapists, occupational therapists and physiotherapists, and the physiotherapy. The speech therapist was actively engaged in his mealtime management plan, which was crucial to the deceased's wellbeing, and the physiotherapist and occupational therapist's engagement was critical to arrange a new wheelchair and orthotics for the deceased, as his current ones were too

[40] Exhibit 1, Tab 19.3; Tab 202, p. 47.
[41] Exhibit 1, Tab 19.4, p. 2.
[42] T 83 – 84.

small for him. The school has a school-based chaplain who was also actively engaged in making contact with the deceased's mother, as well as the deceased's teachers and Ms Palmer. Ms Palmer indicated they had "case conference after case conference to try to engage" with the deceased's mother, without success. In the past, they could have worked with the Disability Services Commission to ensure the support was still provided, but with the advent of NDIS and the funding going to the deceased's mother for self-management, the school required her consent for the therapies to be approved. Therefore, when she didn't engage, Ms Palmer was forced to raise her concerns with Communities.[43]

56. On 24 May 2021, a Child and Family Therapist involved with the deceased's youngest sister (who was still living separately to the other children) also contacted Communities to raise her concerns about the deceased being in his mother's care. She had heard reports that he was left in his cot unattended at home in his younger sister's care for several hours a day while his mother left the house. Concerns were also raised about the deceased's mother's drug use. It was noted the deceased's mother had been participating in some urinalysis testing and had tested positive for cocaine twice and methamphetamine once, as recently as March 2021, before she had stopped attending urinalysis. She had reportedly been posting information about her drug use on social media. Information was also provided that the father of the two children was not active in their care and the stepfather was no longer involved since the marriage had ended.[44]

57. The concern was raised that the deceased and his sister might "slip through the cracks in the system"[45] as they were not covered by any court case and no one was fighting for their care, unlike their younger sister.

58. These concerns were noted to be similar to those raised previously in July 2020. It was apparent the deceased's mother had relapsed into drug use, despite her plan to abstain. The deceased was not being sighted at the school and his mother had ceased engaging with family supports, so the deceased was very isolated and not visible in the community, increasing the risk to him.[46]

59. On 27 May 2021, the Central Intake team spoke to Ms Palmer and obtained further information that the deceased was not receiving therapy from the Ability Centre as he was not attending school. He needed to be reviewed by the speech therapist from the Ability Centre for his mealtime as he required modified food textures to improve his diet (currently he was on four bottles of formula and a piece of fruit through a mesh feeder only). Physically, it was also mentioned he hyperextended his fingers and body, which could cause long term issues if not addressed and he required exploration for dental issues as he self-harmed by scratching his face, which was thought to be linked to dental pain. Ms Palmer advised that all of these behaviours would reduce with therapy, which would have a significant improvement on the deceased's health and wellbeing. Finally, it was noted that the deceased's heart and

[43] T 84 - 85.
[44] Exhibit 1, Tab 19.4, pp. 2 - 3.
[45] Exhibit 1, Tab 4, Case Note, 24.5.2021, p. 2 of 3.
[46] Exhibit 2, Tab 4.

oxygen levels were constantly monitored at school, but it was not clear if this occurred when he was at home.[47]

60. The deceased's mother was noted to present at the school in extremes of either hyper mood or very low mood and attempts to support her with an application for the bus to assist him to attend school had been unsuccessful. The suggestion that the deceased might be home schooled again had caused Ms Palmer particular concern as "it would result in him being less visible."[48] Previous agreed outcomes had also not been actioned by his mother. Ms Palmer advised Child Protection staff that when the deceased did present to school, his general presentation was okay,[49] but it seems he had only been at school one day that term.

61. Medical records reveal the deceased's mother attended Fresh Start on 29 May 2021 seeking treatment for cigarette and amphetamine addiction. She was prescribed oral naltrexone but did not return to the clinic.[50]

62. The children's maternal grandmother attempted to raise fresh concerns with Communities on 1 June 2021. Follow up on 2 June 2021 identified that her concerns centred around the deceased's mother's alleged drug use and the fact that when someone had visited the family home, the deceased "was shut in his room, there were bottles of formula all over the floor and the room smelt."[51] She advised the deceased's mother had recently separated from her new partner. There was an understanding that her drug use had escalated from just cocaine to cocaine and methamphetamines, it was alleged she might even be selling drugs, and it was said that "things were out of control."[52] It was noted that the deceased's mother's support network was poor and her friend Gary Baker, who was a big part of her support network, had not seen her for weeks. The deceased's grandmother reported she was very concerned as nobody was seeing the deceased and his sister at this time outside the home.[53]

SECOND CASE OPENED – JUNE 2021

63. As a result of these various interactions, on 2 June 2021 Communities did an intake of the deceased and his sister LM for a child safety investigation due to concerns of neglect, parental drug use and lack of support services/care/visibility of the deceased, who was noted to be highly vulnerable. A Child Safety Investigation for neglect commenced on 11 June 2021 and was initially allocated to the Mirrabooka District Office. There were particular concerns in relation to the deceased's mother's current capacity to meet his significant medical and therapy needs and care for him safely.[54]

[47] Exhibit 1, Tab 19.4, p. 3; Exhibit 2, Tab 4.
[48] Exhibit 1, Tab 19.4, p. 3.
[49] Exhibit 1, Tab 19.4, p. 4.
[50] Exhibit 1, Tab 1, p. 9.
[51] Exhibit 1, Tab 19.4, p. 4 and Tab 20, p. 57.
[52] Exhibit 1, Tab 19.4, p. 4.
[53] Exhibit 1, Tab 19.4, p. 4.
[54] Exhibit 1, Tab 19.3 and Tab 19.4, p. 4; Exhibit 2, Tab 4.

64. On 8 June 2021, the children's maternal grandmother spoke to Communities again and expressed further concerns, including a belief the deceased's mother would lock the deceased in his room unattended. Child Protection staff advised they would conduct an unannounced home visit that week. It was then ascertained that the deceased and his family were not living in the Mirrabooka District, so the case was re-allocated to the Communities' Perth District Office.[55] The case initially was on an unallocated list due to competing pressures and incoming work. Various Child Protection staff undertook individual tasks on the case, before it was allocated to Communities' Senior Child Protection Worker Sophie Papaluca on 30 June 2021. By this time, Ms Wood was the Acting Team Leader, so she still had oversight of the case.[56]

65. The deceased's mother was contacted by Perth District Child Safety Team staff on 11 June 2021. She was advised that a Child Safety Investigation had been opened particularly due to concerns the deceased was not able to access his therapeutic supports if he was not attending school. The deceased's mother said he was due to return to school the following week. The deceased's mother admitted she had been at a low point the previous year due to the breakdown of her marriage, her youngest daughter not living with her anymore and managing as a single mother. She also admitted using drugs over the past few months but said she was now attending counselling with Fresh Start and was on naltrexone. A home visit was arranged for 15 June 2021, which was then postponed at her request to 18 June 2021.[57]

66. In the meantime, the deceased's mother had been in contact with his school and advised he would be back at school full time from 14 June 2021. He did not actually attend school again until 18 June 2021.

67. Also on 18 June 2021, Ms Papaluca completed a home visit with the deceased's mother and Mr Le Tang present. The house appeared clean and tidy and the deceased's mother appeared sober with no signs of drug use. The deceased's mother told Communities she had been under a lot of stress over the previous months from her ex-husband, who she seemed to think had been making trouble for her in relation to the children. She acknowledged that she had used methamphetamine a month previously but claimed never to use at home or when the children were in her care. She denied current drug use and mentioned she was completing random urinalysis. She offered to send the results to Communities. They discussed the need to ensure the deceased attended school regularly and the deceased's mother agreed to meet with teachers, nurses and therapists to review the actions previously agreed in 2020 that had not been able to be progressed. She also agreed she would make and attend the deceased's medical appointments and indicated that she had ordered a new chair for the deceased that would be available in 2022, which would then enable him to catch the school bus. The deceased's mother declined to provide consent for Communities to complete a Child Assessment Interview with LM.[58]

[55] Exhibit 1, Tab 19.4.
[56] T 105 - 106.
[57] Exhibit 1, Tab 19.4.
[58] T 151 - 152; Exhibit 1, Tab 19.4.

68. Ms Papaluca gave evidence that after this home visit, her primary concern had been the behaviour of Mr Le Tang, who had seemed quite controlling and flagged possible family domestic violence issues, although there was no complaint of this made by the deceased's mother. This particularly came from the fact that Mr Le Tang was answering questions for the deceased's mother.[59]

69. Ms Papaluca followed up with a text message to the deceased's mother on 30 June 2021, as she was now the allocated case manager for the family and noted that the urinalysis results that had been offered had not been provided. Ms Papaluca received a text message in response that day and the following day, suggesting the deceased's mother thought the results would have already been provided to Communities and indicating she would follow it up. Ms Papaluca made her own enquiries and established that the deceased's mother had actually stopped participating in urinalysis since March 2021, at which time her results had been positive for methamphetamines.[60]

70. The deceased's maternal grandmother made regular contact with Ms Papaluca in early July 2021 and continued to express ongoing concerns for the deceased and his sister's welfare.[61]

TEMPORARY PLACEMENT OF CHILDREN WITH MS G

71. Police records indicate that on 15 July 2021, the deceased's mother was seen by WA Police and the Mental Health Co-Response Team due to reports of erratic behaviour. No acute risks or concerns were identified and there were no concerns for the children's welfare. It's unclear if Communities were aware of this police attendance.[62]

72. The deceased was still not attending school every day. On 21 July 2021, the situation escalated when the deceased attended school but his mother did not turn up to collect him from school on time. Ms Palmer contacted the listed secondary contact on their records, who was Ms G, the deceased's great aunt. Ms Palmer asked Ms G if she could come and collect him.[63]

73. Ms G advised the Court she had been previously concerned for the deceased's welfare while in his mother's care as she had been told by her sister (the deceased's grandmother) that his mother was a drug user and she regularly left him at home alone, which was unsafe as he needed constant care and supervision. However, Ms G was also aware the deceased's mother had a difficult relationship with her mother (Ms G's sister) and she was not always a reliable historian. Ms G said she had tried herself to guide the deceased's mother in a lot of ways, but had interacted with her separately from her own family, as she didn't want her own husband and children to be affected by the instability of her sister's family. On previous visits, Ms G had found the house was usually very tidy and the children appeared to be properly fed

[59] T 152.
[60] Exhibit 1, Tab 18.
[61] Exhibit 1, Tab 18.
[62] Exhibit 1, Tab 1, p. 10.
[63] Exhibit 1, Tab 14; Exhibit 2, Tab 3.

and looked after, so while she was aware of some concerns, Ms G had not seen anything herself to confirm those concerns.[64]

74. Unfortunately, things seemed to change in the later years, when the deceased's mother became more heavily involved in drug use. Ms G gave evidence she had ceased contact with the deceased's mother and her family after his mother had attended a family event at Ms G's home affected by drugs and had to be asked to leave. This was just preceding the time of her hospital admission in July 2020.[65] Further, in March 2021, Ms G's sister (the deceased's maternal grandmother) had contacted Ms G to say she was considering trying to get custody of the deceased and his sister LM. Therefore, Ms G was aware that there was some heightened concerns about her niece's ability to care for her children around this time.

75. Nevertheless, this contact from the deceased's school was unexpected, particularly as Ms G was unaware she had been put down as a secondary contact at the deceased's school.[66] She was taken by surprise and had to ask for some time to think about how to respond to the request.[67]

76. In the meantime, and before Ms G could give the school an answer, the deceased's mother arrived at the school. She was 1 hour and 10 minutes late and presented as wide-eyed, dazed and confused. She did not recognise the deceased's teacher, despite knowing her well, and seemed to forget why she was there. The deceased's younger sister LM appeared worried and seemed to be guiding her mother. Ms Palmer and the teacher both formed the belief the deceased's mother was substance affected. Ms Palmer was very concerned, and queried the deceased's mother's capacity to drive, so she immediately contacted Communities. Ms Palmer spoke to Ms Wood who took the information and then worked out a plan for how Communities would respond.[68]

77. Ms Papaluca, was already out on the road with a co-worker, so Ms Wood contacted them and they agreed to go straight to the deceased's home in order to assess whether the deceased's mother was in a fit state to care for the children. The Perth District Director approved the taking of intervention action pursuant to the *Children and Community Services Act 2004* (WA), should the deceased and his sister need to be moved or placed in care overnight.[69]

78. Ms Papaluca recalled that the deceased's mother presented as confused and distressed. She didn't appear to recognise Ms Papaluca or her own children and Ms Papaluca recalled the deceased's mother's behaviour was really unusual and very confusing. She also noticed a huge difference in the house compared to the previous visit in June, with an obvious overpowering smell of urine and it appeared very untidy (although not as bad as it later became in August 2021). Ms Papaluca called Ms Woods for advice and then contacted the Mental Health Emergency Response Line, who recommended she request an ambulance attend to take the deceased's

[64] T 55, 77 - 78.
[65] T 51 – 53; Exhibit 1, Tab 14; Exhibit 2, Tab 3.
[66] T 51, 54 - 55; Exhibit 1, Tab 14.
[67] T 51 – 53; Exhibit 1, Tab 14; Exhibit 2, Tab 3.
[68] T 87 – 88, 106; Exhibit 1, Tab 19.4.
[69] T 107, 154; Exhibit 1, Tab 19.4; Exhibit 2, Tab 4.

mother to hospital for assessment. The Child Protection staff then had to find someone to look after the children.[70]

79. Ms Papaluca and her colleague were supposed to be finishing for the day, and they contacted Communities' Crisis Care Unit to see if they could hand over to them, but the Crisis Care staff were too stretched so Ms Papaluca and her colleague chose to stay on to ensure the handover of the children to a caregiver was completed safely. Ms Wood, who was also off duty at a personal event, took steps to make alternative arrangements for the children to formally be taken into care if a family caregiver could not be found.[71]

80. Attempts were made by Child Protection staff to contact Gary Baker, who did not answer the call, and the deceased's father, who said he could not take the children as he had a newborn, despite being told that it was possible the children might need to go into care if another caregiver couldn't be found. He did give permission for the children to be cared for by their great aunt, Ms G. Ms G was contacted again and very kindly agreed to come and collect the children and take them to her home. Ms G confirmed she was familiar with the deceased's significant care needs, even though she hadn't seen him for a while. At that stage, Ms G understood she was just taking the children for the night in an informal arrangement while their mother received care. The children were not being formally placed with her, rather it was an informal care arrangement with the consent of the children's father.[72]

81. When Ms G got to the house to collect the children, she also noticed a "huge difference"[73] in the state of the house compared to what it had looked like when she had visited the deceased's mother in the past. LM was packed and ready to go, so Ms G went to assist the deceased. Ms G found the deceased crying on his back on the floor of his bedroom. There was a strong smell of urine, which had also been noticed by the Child Protection staff, but they had been unable to change him as he did not want them to touch him. Ms G noticed the deceased had a lilac covered plastic bin bag as a pillow case and no blankets in his room. Ms G struggled to find any clothing for the deceased and could only find a pair of odd socks, a pair of shorts and a couple of nappies. He allowed her to change him before they left and she noticed there were no baby wipes and the deceased had a terrible nappy rash that was obviously causing him pain. He also had a terrible sore on his left ear. She took the children home and put them to bed, thinking it would only be for the night, although in the end she had them for about three weeks. Over that time, she treated the nappy rash and sore on the deceased's ear and kept him clean and dry and they resolved.[74]

82. The deceased's mother was taken to RPH by ambulance. A doctor from RPH contacted Communities' Crisis Care Unit and advised the deceased's mother did not appear to know why she was at hospital nor the whereabouts of her children. The doctor was reassured that the children were safe and being cared for by a family member. The deceased's mother was discharged home the next day as she appeared

[70] T 138 – 140, 153, 155.
[71] T 138 - 140.
[72] T 138; Exhibit 1, Tab 14, Tab 16, Tab 17, Tab 18 and Tab 19.4.
[73] T 55.
[74] T 52 - 59; Exhibit 1, Tab 4, Tab 18 and Tab 14.

coherent and able to answer questions. She had undergone a CT scan and extensive bloodwork, which was all normal, her urinalysis was clean and no alcohol was detected in her blood.[75] I note at this stage that hospital toxicology testing is limited, so it is possible the deceased's mother was using substances that were not detected by this limited screening. Nevertheless, there was nothing on which Communities could base a conclusion that she had been drug affected, and it was equally possible there was a different underlying cause for her behaviour.

83. Child Protection staff informed Ms G, who expressed concern as she did not think the children should return to their mother's care given her recent presentation and the home environment. She was informed that there were insufficient grounds to bring the children into care at that time, although it was suggested Ms G could explore her options through the Family Court.[76]

84. On 22 July 2021, Ms Papaluca and another member of her team, Sarah Ryan-Wilkins, went to the deceased's home to see the deceased's mother on her return from hospital. They wanted to assess her presentation and discuss care arrangements for the children. They arrived at the house in Dianella at about 3.30 pm. The deceased's mother was locked out of the house at that time, having only just got home from hospital, so the Child Protection staff spoke to her outside. She appeared more lucid but was still vague about what had occurred the day prior. The Child Protection staff arranged to collect her house keys from Ms G, who had used the keys to collect the children. Ms G had declined to bring the children and keys to the house, given her concerns for the welfare of the children and the fact that LM had made it clear she did not want to go home and seemed "petrified"[77] at the prospect. When Child Protection staff arrived at Ms G's house, it was obvious that LM was reluctant to leave, so they went back and spoke to the children's mother, who gave permission to leave them with Ms G.[78]

85. Ms G was asked at the inquest about the deceased's presentation at the time that she had him. Ms G described him as a "very lovely loving child" who would give hugs and was quite happy to play by himself if he was given things to touch and feel. Ms G quickly imposed a daily routine and the deceased responded well to it. He would tell Ms G when he wanted his bottle and would know when it was time for a bath and to go to bed. She observed he had the intelligence to learn and adapt to a routine, but she didn't think "he had the opportunity to grow"[79] while being cared for by his mother.

86. On 23 July 2021, Ms G contacted Communities and advised that the deceased's mother and Mr Le Tang had attended her home that morning. Ms G reported that the deceased's mother presented as confused and disoriented. Mr Le Tang said she had been fine the night before but had woken up in a confused state. The deceased's sister, LM, told Ms G it had been happening a lot lately and her mother had been coming into her room at night dazed and confused and appearing not to know where

[75] Exhibit 1, Tab 19.4; Exhibit 2, Tab 4, Case Note 22.7.2021.
[76] Exhibit 1, Tab 19.4; Exhibit 2, Tab 4.
[77] T 62.
[78] T 62; Exhibit 1, Tab 14 and Tab 16 and Tab 18 and Tab 19.4.
[79] T 52.

she was or what she was doing. Ms G asked Mr Le Tang if the deceased's mother had taken drugs, but he denied it. Ms G advised Child Protection staff she would not return the children to their mother while she presented that way, but had told their mother she could stay with her and the children if necessary. Ms G contacted the children's father to confirm he was happy for them to continue to stay with her. She then spoke to Child Protection staff and agreed to contact Communities if the deceased's mother or Mr Le Tang attempted to take them home.[80]

87. A Communities Team Leader from an Intensive Family Support Team also spoke to the deceased's father that day and documented it was an unusual conversation as he queried why the children had been taken from their mother's care and was unwilling to provide his home address, as he did not want people coming to his home as he had a new family and was finding the situation with the deceased and his sister stressful. He seemed reluctant to be involved and apprehensive about his own capacity to provide any care for the children.[81]

88. According to records obtained by police, the deceased's mother presented at Sonic Health Plus in Rockingham for retrograde amnesia on the same date and was prescribed Augmentin Duo Forte, an antibiotic for bacterial infections.[82]

89. Ms G had also struggled to get the children's father to become involved and he refused to tell her where he lived, but he did agree to meet her at the shops. Ms G met the children's father with the deceased and LM that afternoon. Initially, she asked if he could take the children for the night, but he expressed concerns about his capacity to care for them as he worked full-time, had a new partner and baby and had not provided care to the children for a long while. In the end, Ms G agreed to keep the children in her care, provided the children's father took them for one night over the weekend so that she could get some respite and he could get an understanding of the children's care needs.[83] The children's father did take the two children to his home that weekend. There were no issues with their care, but he told Ms G when returning them that he would not be able to care for the children full-time given his new relationship and newborn baby. However, he said he might be able to share care with their mother when she was well again.[84]

90. Ms G told Child Protection staff that the deceased's mother had been in contact with various family members around 26 July 2021 and appeared delirious. In the circumstances, Ms G agreed to keep caring for the children temporarily.[85]

91. While caring for the children, Ms G engaged with the deceased's school and starting to take him regularly to school every day. She spoke with the staff about the deceased's needs and became concerned that the deceased's mother had not been working with the school staff to ensure the deceased had everything he needed to learn and grow. Ms G was informed there was funding available but it required the deceased's parents' 'signoff' for it to be accessed. It was clear to Ms G that the staff

[80] T 63 - 64; Exhibit 1, Tab 14 and Tab 19.4.
[81] Exhibit 2, Tab 4, Email 23.7.2021, 3:49 pm.
[82] Exhibit 1, Tab 1, p. 10.
[83] Exhibit 1, Tab 19.4.
[84] Exhibit 1, Tab 19.4.
[85] Exhibit 1, Tab 19.4; Exhibit 2, Tab 4.

were indicating they could do more to help the deceased, but it required his mother's cooperation. Ms G could see that the deceased loved going to school, so she was very supportive of ensuring he attended school regularly while in her care. Ms Palmer gave evidence the deceased's attendance was excellent while he was with Ms G, and she noted a marked improvement in his wellbeing, including the fact his rash cleared and he was putting on weight.[86]

92. On 28 July 2021, a Signs of Safety meeting was held. The deceased's father and Ms G attended, but the deceased's mother failed to attend. The deceased's needs, including equipment needs such as baby gates and other forms of financial support, were discussed as Ms G wanted to make her house a safer environment for him while she cared for him. It was agreed that the children would continue to stay with Ms G during the week and with their father on weekends to give Ms G some respite. The arrangement was to continue until another meeting with the deceased's mother could be arranged. It did not require departmental intervention at that time, as the deceased's father was willing to approve the arrangement. Ms G made it clear in the meeting she could not care for the children long term as she had her own family and work commitments. Ms G also expressed concern for the deceased's mother's health as she presented as confused and with memory issues, without a clear cause. All in attendance were surprised at the deceased's mother's negative drug screening result from RPH, but the Child Protection staff felt they were in a difficult position as she had been cleared medically so there was no medical explanation for her concerning presentation.[87]

93. The deceased's mother advised Child Protection staff after the meeting that she had not attended as she had not slept. She acknowledged her memory loss and could not explain it, although she said she was waiting for test results. She suggested it was possible she had a urinary tract infection that was causing her symptoms, although she later advised her medical results were negative. The deceased's mother also said she intended to go and collect the children from Ms G's that night. Based on that information, the Perth District Director approved intervention action under s 37 for the second time, should the children's mother follow through with her plan to remove the children from Ms G's care. Ms G was informed and she agreed to telephone Communities' Crisis Care if the children's mother attempted to remove them from her care. Ms G had visited the children's mother that day and had thought she seemed coherent but fearful of her partner Mr Le Tang, who was described as controlling.[88] In the end, the children's mother did not follow through with her stated intent to collect the children that night, and they continued to reside with Ms G.

94. On 30 July 2021, Ability WA contacted Communities to confirm the primary contact in respect of the deceased's therapy needs. It was confirmed his parents remained his legal guardians, despite the fact he was temporarily living with Ms G, so his parents would have to sign off on any plans that required access to his funding.[89]

[86] T 60, 65, 88, 91; Exhibit 1, Tab 19.4.
[87] T 108 - 109; Exhibit 1, Tab 17 and Tab 19.4.
[88] Exhibit 1, Tab 17 and Tab 19.4.
[89] Exhibit 1, Tab 19.4.

95. A second Signs of Safety meeting was held on 3 August 2021. The deceased's mother attended this time and advised she intended to collect the children from Ms G on the afternoon of Friday, 6 August 2021. She indicated she understood that Communities would need to be confident there was a safety plan and network in place, prior to that occurring.[90]

96. Ms G gave evidence that she was upset after the second Signs of Safety meeting and called Ms Papaluca to express her concern that the deceased's mother still did not appear to be back to her normal self. Ms G said she was concerned about the plan for the children to return to their mother, as she still did not seem right and did not appear to be fit to take back care of her children. However, Ms G had already had to give up work for a month and needed to make a choice as to when she would have to stop caring for the children and go back to her normal life. Therefore, she accepted it was a decision for Communities as to what happened next, and it appeared that they were committed to reuniting the children with their mother if Ms G could not care for them.[91]

97. Ms Wood gave evidence that, unlike Ms G, she thought the deceased's mother had appeared much better at the meeting on 3 August 2021. She was lucid and appeared to understand what was happening. She acknowledged that there had been an issue with her presentation and said she was still trying to get to the bottom of the cause with her GP. Ms Wood gave evidence she had seen the deceased's mother possibly under the influence of substances when she had worked with her in 2020, and at the meeting on 3 August 2021 her behaviour did not appear to be as a result of being substance affected. She was, however, avoidant of needing departmental involvement, but Ms Wood felt this was nothing new and generally consistent with her experience with the deceased's mother from 2020 onwards. Therefore, while Ms Wood agreed with Ms G's description of the deceased's mother's behaviour at the meeting as dismissive and quite avoidant, Ms Wood concluded the deceased's mother did not appear to her at that meeting "to present as someone who lacked the capacity to make decisions and take care of herself and the children."[92]

98. On Thursday, 5 August 2021, Ms G spoke to Child Protection staff to confirm that she was able to provide care for the children until mid-August 2021, but not after 20 August 2021. Ms G understood from the SOS meeting that after the children returned to their mother, the safety plan was that both children would attend school regularly, the children's father would be having them on weekends and Gary Baker would be checking on the family periodically and reporting back to Communities. LM would also have a phone with numbers to contact specified people if needed. The deceased's mother made it clear she didn't think the safety plan was needed, but agreed to cooperate with it in order to get her children back.[93]

99. On 7 August 2021, Gary Baker visited the deceased's mother at home. He was aware the children were staying with their great aunt and she was home by herself. Mr Baker and the deceased's mother discussed the fact that prior to becoming

[90] Exhibit 1, Tab 14, Tab 17 and Tab 19.4.
[91] T 69 - 70.
[92] T 110.
[93] Exhibit 1, Tab 14, Tab 17 and Tab 19.4.

involved with Mr Le Tang, she had only ever used cannabis recreationally. She alleged Mr Le Tang had introduced her to other drugs and this appeared to be at the root of her recent issues.[94]

100. On 10 August 2021, a physiotherapist from Ability WA contacted Communities seeking an update on consent as Ms G had reported that the deceased required a new car seat, but the NDIS funds for the deceased were self-managed by his mother and only she could access the equipment budget. The deceased also needed to be referred for new orthotics and they required consent to share his NDIS plan for the referral to be accepted. Ability WA staff also suggested there were other changes required to the deceased's NDIS plan.[95] It was confirmed the following day that the deceased's parents would have to provide the consent and some steps would be taken to liaise with NDIS about his plan.[96]

101. As noted above, there was evidence that this process would have been easier in the past when the disability services commission was involved in funding, as there would have been somebody from the commission available to go around and provide support, but those roles don't exist anymore under the NDIS. Instead, the therapists were required to deal directly with the deceased's mother, so if she was not willing to engage, it was difficult to make progress.[97]

102. The deceased's mother had nominated Gary Baker as a strong support to her. Ms Papaluca contacted him on 12 August 2021 and confirmed he was willing to be part of the safety planning for the two children. Mr Baker advised he had known the deceased's mother for many years and had taken on a father figure role. He was aware of her recent health issues and that the children had been living with Ms G. He said he had seen the deceased's mother a few days before and she had presented well, although there were still gaps in her memory from July 2021. He expressed concern about Mr Le Tang's influence on her, given his history of drug use, but noted Mr Le Tang was currently working away. Mr Baker was told it was planned that the children would return to their mother on Friday, 13 August 2021. Ms Papaluca recalled he agreed to telephone and visit the deceased's home daily over the weekend, although Mr Baker later told police he recalled he had said he would do so "if time permitted."[98] It was arranged that Ms Papaluca would then contact him on the Monday for feedback.[99]

103. The plan was then progressed for the children to return to their mother on Friday, 13 August 2021, with all parties informed. It was arranged that Ms G would drop the children at their respective schools in the morning and their mother would collect them at the end of the school day and take them home.[100]

104. Ms Papaluca had tried to contact the deceased's mother multiple times on the Thursday by phone call and text, but she had not answered. The deceased's mother

[94] Exhibit 1 Tab 13.
[95] Exhibit 1, Tab 19.4.
[96] Exhibit 1, Tab 19.4.
[97] T 84.
[98] Exhibit 1, Tab 13 [40].
[99] Exhibit 1, Tab 19.4.
[100] Exhibit 1, Tab 19.4.

later admitted that on that Thursday, 12 August 2021, the night prior to collecting the children, she consumed a one litre bottle of vodka. At the time, she regularly drank until she blacked out and would have no memory of events. It seems this night was one of those occasions.[101]

RETURN OF CHILDREN TO THEIR MOTHER

105. On 13 August 2021, the deceased and his sister LM returned to their mother's care. Their great aunt, Ms G, dropped them both to school in the morning. Ms G left all of the children's things at the deceased's school, and it was noted later she left a large amount of items, having obviously tried very hard to anticipate what their needs might be over the following weeks and ensure they were well cared for and comfortable. Ms G expressed concern to Ms Palmer during the drop off about returning the children to their mother as she did not feel the deceased's mother was capable of safely looking after them at that time due to her substance abuse and possible mental health issues, as well as her boyfriend's alleged substance use. However, Ms G was simply not in a position to keep caring for the children in the circumstances, noting she had been forced to take unplanned time off work and had her own family commitments to balance.[102]

106. Ms Wood was questioned at the inquest as to why the two children were returned to their mother at that time, given there were still some ongoing concerns being raised, at least by family members. Ms Wood advised that the deceased's mother had been presenting as lucid, coherent and able to meet the children's needs from around the last meeting on 3 August 2021, so the threshold for departmental intervention was not met at that point in time. She observed that the threshold to bring children into care is very high and just a suspicion that their mother had been using drugs was not sufficient for the Department to intervene. Ms Wood gave evidence that the deceased's mother "presented as being able to care for them, so we put a safety plan in place that allowed the children to go home with her."[103] Ms Wood made it clear that the case was not closed at that time as there were still concerns. From the Department's perspective, it was intended that once the children were returned, family and friends would check in on them and if they became concerned that her presentation declined, then the Department would be able to intervene.[104]

107. I queried Ms Wood as to whether they took into account the deceased's obvious vulnerability due to his severe disability when making their decisions. Ms Wood indicated it was "absolutely taken into consideration"[105] but also noted that the deceased's mother had been caring for him, with that level of needs, for 11 years and very rarely in that time had there been any concerns raised about her ability to meet his day-to-day care needs. Ms Wood acknowledged there were concerns about her ability to continue to meet those needs in mid-2021, but it was not sufficient just to demonstrate that she was not caring for him appropriately, as it was Communities' obligation to make efforts to support her to address those concerns and help her to

[101] Exhibit 1, Tab 1, pp. 10 – 11 and Tab 18.
[102] T 89; Exhibit 1, Tab 22.
[103] T 112.
[104] T 112 – 113.
[105] T 113.

meet his needs. In Ms Wood's experience, an application to remove him from his mother's care would not have been successful until those attempts had been made and they were able to demonstrate accumulative harm.[106] Ms Papaluca also noted the deceased's mother had been caring for him appropriately for many years and he had been vulnerable for his whole life, so the question was why she was now suddenly unable to meet his needs, and what could they do to help her be able to do so again.[107]

108. In addition, I queried with Ms Wood whether there was any attempt to have the deceased reviewed by a doctor in order to establish if his physical needs were being met at that stage. Ms Wood replied that getting a child to a paediatrician in WA is challenging due to the waitlists, but she accepted a family member (such as Ms G) could have been requested to take him to a GP for assessment, but this was not done as the Communities' workers didn't think it was necessary at the time. While she could not have been forced to do so, I have no doubt Ms G would have facilitated this request as she impressed me as a very diligent and reliable caregiver who wanted to provide the very best care for the deceased and his sister while she was responsible for them, and there is no obvious reason why his father wouldn't have agreed to this occurring as well. Instead, the deceased was returned to his mother without any medical review to assess his state of health at that time.[108]

109. There was evidence that Child Protection staff had been planning to get more health information from Perth Children's Hospital, in particular as to whether the deceased had been attending any follow-ups with specialists and whether he had any specific health needs, particularly in relation to his heart health. This enquiry would likely have identified he had not been attending cardiology follow ups. Ms Papaluca indicated the health information would have formed part of the child safety investigation and assisted in determining whether there were any barriers that were preventing him from being medically reviewed that could be resolved and whether his mother had the capacity to meet his care needs. However, this information was still in the process of being gathered, for the purpose of writing the child safety investigation report.[109]

110. The deceased's mother had confirmed with Ms Papaluca that she would be collecting the children that afternoon and everything progressed as planned. The deceased's mother arrived on time to collect the deceased. She apparently expressed amusement at the amount of clothing that Ms G had purchased, although she took it all.[110]

111. There is no confirmed evidence about what occurred on the weekend. Mr Baker, did not see them as planned, as he later said he had other competing family obligations. He told police he texted her on the Saturday to say he would come over if she needed him, but did not receive a request from her so he did not visit. It does not seem the children's father visited either.[111] Ms Papaluca later gave evidence that Mr Baker had seemed very willing, so she was enormously disappointed when he did not follow

[106] T 114.
[107] T 154.
[108] T 114 – 115, 210.
[109] T 171 - 172.
[110] Exhibit 1, Tab 22.
[111] Exhibit 1, Tab 12 and Tab 13.

through, as she had also given him the Communities' Crisis Care Unit number if he could not follow through with his commitment, but he did not call them when he could not go there.[112]

112. The deceased's mother later admitted that after she collected the deceased and his sister from school, she then went on "autopilot,"[113] not knowing what she was doing, not looking after the children and only doing the bare minimum.[114] However, as no one checked in on them, this was not noticed until the Monday.

113. Ms Wood was asked if it would have been possible to have a Communities' worker monitor the deceased's mother over the weekend instead, but she indicated they do not have the resources to perform those sort of out of hours checks. Urgent cases where a child may potentially have to enter care are dealt with by the after-hours crisis care service, but there are no resources to provide checks on safety plans after-hours. However, if Mr Baker had made it clear that he was not checking on the family and there were some concerns, it might have prompted a response.[115]

114. On Monday, 16 August 2021, the deceased and his sister did not attend school. Ms Palmer emailed Communities at 10.51 am to advise the deceased had not arrived and that his mother had not yet responded to an attendance query sent at 10.00 am. This prompted Child Protection staff to contact Mr Baker. He advised that he had telephoned the deceased's mother on the Saturday but she did not answer, so he sent a text message. They had no further contact. At no stage had he spoken to, or seen, the deceased's mother or the children over the weekend. Mr Baker offered to go over to the house on the Monday, but Child Protection staff advised they would now conduct their own home visit.[116]

115. Ms Papaluca gave evidence she was very disappointed on the Monday to hear that the support arrangement for the weekend had failed and that no one had sighted the children or their mother. She decided that Mr Baker would no longer form part of the support network and instead Ms Papaluca and a colleague made an unannounced home visit that afternoon. During the visit, Ms Papaluca spoke to the deceased's mother through the locked screen door. She was not invited inside and could not enter without consent. This obviously limited her ability to form a view of how the children were faring. Ms Papaluca could see the deceased's mother seated on the couch and LM was also present, but she did not see the deceased as the door to his room was closed. The deceased's mother gave minimal answers and was evasive when questioned, however her general demeanour was more similar to her usual behaviour and she appeared herself in terms of her responses, so Ms Papaluca felt somewhat relieved. The deceased's mother also looked pale with a slight cold, which matched her explanation of the children not being at school as they were unwell.[117]

116. A food delivery arrived at this time and LM came to the door to collect it. This gave Ms Papaluca an opportunity to see LM properly and speak to her briefly. LM

[112] T 157.
[113] Exhibit 1, Tab 1, p. 11.
[114] Exhibit 1, Tab 1 and Tab 18.
[115] T 115 – 116, 157, 163 - 164.
[116] Exhibit 1, Tab 19.4.
[117] T 157 – 158, 163; Exhibit 1, Tab 17 and Tab 19.4.

appeared physically fine and indicated she was okay. Ms Papaluca gave evidence she would have liked to see the deceased, but had no power to insist. Ms Papaluca also felt at that stage that there was enough evidence to suggest the deceased's mother was back to her usual self, so she was less concerned, although still not entirely reassured.[118] Based on what they had seen and LM's response, the Child Protection staff did not think a request to the police to conduct a welfare check would be successful, and there was not much else they could do at that time.[119]

117. Child Protection staff had sent a message to the children's father at around midday advising him the children had not attended school and querying whether he had seen them over the weekend. They sent another message to him at about 3.00 pm advising they had attended the house and determined that all three of them were sick. They sent the same information to Mr Baker, who apparently had spoken to the deceased's mother that morning.[120]

118. On Tuesday, 17 August 2021, the children again failed to attend school. Ms Palmer emailed Communities to advise of the deceased's absence without explanation, and Ms Papaluca also independently checked with LM's school. At 9.48 am, Ms Papaluca tried unsuccessfully to call the deceased's mother and eventually sent her a text at 10.33 am advising Communities were aware the children were not at school, noting she needed to contact the school about their absences, and also recommending that if the children were sick, they should be seen by a general practitioner. Follow up text messages were sent and the deceased's mother eventually responded at 10.58 am advising she had a carer coming to help her (which appears to have been a lie) as she felt very unwell. She also complained that the children's father had taken them swimming. He had apparently been in contact with her about the children not attending school again.[121]

119. Child Protection staff were understandably concerned about these events and the fact that the safety planning and support network did not seem to be working out as expected. Ms Papaluca gave evidence she really wanted the deceased to be attending school because of all the therapy that was provided to him there and all of the oversight, noting the staff there knew him best and could identify any concerns. Given he had not now attended school for two days, concerns were increasing. Accordingly, Child Protection staff sent a text message to the deceased's mother at 2.17 pm that day requesting she meet them on 20 August 2021 for further safety planning.[122] Ms Papaluca gave evidence that around this time her intention was to ensure the children were seen by a doctor, if they were still sick, and to then discuss the case with her colleagues, with the intention of moving the family on to the intensive family support path soon.[123]

120. Minutes after that text message had been sent to the deceased's mother, Ms G contacted Communities to advise that she had received concerning text messages from LM and that her son had seen the deceased's mother in an Uber on her own that

[118] T 164; Exhibit 1, Tab 19.4.
[119] T 120.
[120] T 121; Exhibit 1, Tab 19.4.
[121] Exhibit 1, Tab 18 and Tab 19.4.
[122] Exhibit 1, Tab 19.4.
[123] T 165, 170.

morning when she should have been dropping the children to school. The deceased's sister sent a number of distressed text messages to Ms G at this time. She told Ms G she felt unsafe at home as her mother had been drinking alcohol and had threatened to burn the house down while she was sleeping. LM begged Ms G to come and collect her. Ms G, who understandably was trying not to get drawn back in again despite her genuine concern for the children, told LM that she should contact her father or go the neighbour's house if she was scared. Ms G also contacted the children's father herself and then took screenshots of the messages and informed Child Protection staff of the little girl's desperate text messages, of which there were 34 in total.[124]

121. Child Protection staff then spoke to Mr Baker and the children's father. The children's father advised that he had spoken to his daughter and "things sounded more settled."[125] He reportedly planned to take time off work the following day to visit the family home and agreed to contact Crisis Care, should he have any concerns after hours.[126]

122. At 3.42 pm, Mr Baker telephoned Communities and advised that he had received a message from the deceased's mother stating, "Can everyone please stop stressing, me and the kids are sick at the moment."[127] In response, he encouraged her to communicate with everyone better as people were genuinely concerned.

123. In the end, the children's father did go to the home on the Tuesday night. He later told police that LM had sent him messages begging him to come and get her. She told him that she had not eaten for three days and that her mother's boyfriend ate in front of her but did not offer her any food. He texted Ms G at 4.23 pm to say he was going to get LM and Ms G assumed that he would be going to get both children, as if LM was in distress then she thought the deceased would definitely be in distress too and requiring help.[128]

124. The deceased's father went to the house at 5.00 pm that evening. LM answered the door and the deceased's father immediately noticed the house was "a complete mess with clothing, food and other things thrown about."[129] He could hear the deceased crying from within his bedroom and when he checked on him, immediately noticed a strong odour of urine indicated the deceased's nappy had not been changed. The deceased's father located the deceased's mother in the main bedroom asleep. He woke her up and asked her what she was doing? He said he was angry and upset and told her that she needed to get up, clean herself and the house up and tend to the deceased, who needed to be cleaned and cared for. He recalled the deceased's mother broke down and started crying. The deceased's father told her he was taking LM to his house and would return later for the deceased. He claimed he was unable to take the deceased with him as he had driven to the house in a two seater car that had no

[124] T 72 – 73; Exhibit 1, Tab 14 and 19.4; Exhibit 2, Tab 4.
[125] Exhibit 1, Tab 19.3, p. 4.
[126] Exhibit 1, Tab 14 and 19.4.
[127] Exhibit 1, Tab 19.4, p. 15.
[128] T 73, 78 - 79; Exhibit 1, Tab 4 and Tab 12.
[129] Exhibit 1, Tab 12 [87].

space for the deceased. He then left the house with his daughter and returned home.[130]

125. The deceased's father stated that he received a message from the deceased's mother at 7.13 pm that same evening saying that she was okay and could take care of the deceased. He told police that he believed the deceased's mother was capable of looking after the deceased, so he decided not to return and pick him up.[131]

126. On Wednesday, 18 August 2021, the two children did not attend school for the third day in a row. Child Protection staff checked with the school and then contacted the deceased's mother and his father. The deceased's father responded at midday, advising that he had seen both children and confirmed they were sick and he would telephone their schools to advise. The deceased's mother responded shortly after to Communities, at 12.09 pm, and advised that both the deceased and his sister were with their father and she was away, returning Friday.[132] Both of these statements were false.

127. The deceased's mother sent some messages to the deceased's father between 12.09 pm and 1.18 pm that day. She asked after LM and then said, "I'm so lost. I need your help. I'm gonna finish off cleaning the house and get organized. Can we meet tomorrow night and discuss a few things. I will take care of all this."[133] She did not mention the deceased in the messages. The deceased's father stated he responded and said he would drop LM back the next day and asked her to let LM's school know she wouldn't be attending.[134]

128. Child Protection staff messaged the children's father at 1.19 pm, asking him to confirm that he had both of the children. He responded at 2.34 pm and indicated that he only had LM with him, then clarified that he understood the deceased was with his mother but he wasn't sure of their whereabouts.[135]

129. At 2.41 pm, Child Protection staff sent a text message to the deceased's mother advising that only LM was with her father. They queried whether the deceased was with her. This text message is important, as other evidence suggests that up until this time, the deceased's mother had believed that both children had been collected by their father the night before. She immediately responded to Communities, "yeah we at my friends for the night."[136] This was not true. Phone records show she did not leave the house that day.[137]

130. Child Protection staff continued to make enquiries and they sent another message to the deceased's father at 2.46 pm advising that the deceased's mother had said they were with a friend. They asked if he had seen the deceased that day when he picked up LM. Importantly, they also asked if he held any concerns for the deceased. Rather

[130] Exhibit 1, Tab 4 and Tab 12.
[131] Exhibit 1, Tab 12.
[132] Exhibit 1, Tab 19.4.
[133] Exhibit 1, Tab 12 [105].
[134] Exhibit 1, Tab 12.
[135] Exhibit 1, Tab 19.4.
[136] Exhibit 1, Tab 19.4, p.16.
[137] T 41.

than providing a full account of what he had witnessed, which would have raised concerns for the deceased's safety, the deceased's father responded, "not really, he's just a little sick."[138] He also texted to say he was going around there tomorrow night.

131. Taking his response at face value, and interpreting it to mean he had seen the deceased that day, Child Protection staff were somewhat reassured and told the deceased's father they would contact him again the following day for an update. They then sent a message to the deceased's mother telling her they would check in with her the following day and confirming if she was still available to meet on 20 August 2021. They also let Mr Baker and Ms Palmer know.[139] In hindsight, both Ms Papaluca and Ms Wood expressed their disappointment that the children's father had not been more forthcoming, as if he had told them about the state of the house and the fact the deceased's mother had been passed out in bed, that would have been important information that might have prompted them to take action. Instead, they felt reassured that he had seen the deceased and there was nothing of concern.[140]

132. Accordingly, at the end of that afternoons' communications, Child Protection staff were under the mistaken belief that the deceased and his mother were going to stay with a friend. In relation to the deceased's welfare, his father had advised he was "just a little sick,"[141] so some of their fears were falsely allayed. Ms Papaluca had been very concerned when the children had not been taken to school for three days, but the father's confirmation the children were sick reassured her that the deceased's mother was not just making it up. Ms Wood also gave evidence that the information provided by the deceased's father had given the impression he had seen both children and they were safe and they relied upon the information he provided to reassure themselves no urgent action was required.[142]

133. Ms Papaluca gave evidence that if she had been informed by the deceased's father of the concerning state of the deceased's mother and the house, and the fact he had been compelled to wake her up and tell her to get up and care for the deceased, she would have been very concerned and would have responded very differently. Ms Papaluca said in her evidence that she just wished he had told them of his concerns, even just with a text saying "I'm worried," as the Child Protection staff would not have ignored his concerns and would potentially have taken different steps to reassure themselves that both children were safe.[143]

134. On this same day, Perth District staff were given approval for an extension to the Child Safety Investigation for the deceased and LM due to ongoing concerns around their mother's capacity to care for them. A Case Plan Supervision was completed, which outlined the next steps required in the Child Safety Investigation, noting the likelihood that neglect would be substantiated, and that the matter would be transferred to the Intensive Family Support team on 26 August 2021. Ms Papaluca indicated that she certainly believed the family were likely to be moving into the intensive family support team's care, given there were still identified Child

[138] Exhibit 1, Tab 19.4, p. 16.
[139] Exhibit 1, Tab 17, Tab 18 and Tab 19.4.
[140] T 158 - 159.
[141] Exhibit 1, Tab 19.3, p. 4.
[142] T 142, 174.
[143] T 174.

Protection concerns, and the planning for that was underway.[144] If not, she believed they would have moved to the more significant step of taking the children into care, given the level of concern. Ms Papaluca commented at the inquest that Child Protection staff are aware that it is an enormous undertaking to remove legal guardianship from a child's parents, and so they do not take such a decision lightly. However, it was still a real option in this case due to the concerns and the deceased's vulnerability. Ms Papaluca said they were frequently measuring the two options of intensive support and removal prior to the deceased's death, and they were in effect running parallel plans for both options, as well as exploring other family care options that might keep the two children together. However, any decisions were then overtaken by the deceased's death.[145]

THE DECEASED'S MOTHER'S HOSPITALISATION

135. At about 9.15 pm on Wednesday, 18 August 2021, two young men were travelling in a car on Beaufort Street in Mount Lawley when they came across the deceased's mother, who was driving a car behind them. They observed her to be driving in an unusually erratic and aggressive manner. The two men were sufficiently concerned that they rang emergency services and reported concerns for the driver. At some stage they lost sight of her, then shortly after they observed the same car parked at the Hungry Jacks store off Beaufort Street. They noticed the car showed signs of damage to the right wheel and fender and was parked haphazardly. They observed the deceased's mother to be the only occupant of the car and noted she was acting aggressively. It appeared to them that she was affected by drugs. They directed St John Ambulance staff to the car when the ambulance arrived.[146]

136. SJA paramedics went to the car, opened the driver's side door and spoke to the deceased's mother while she was still in the car. They asked her if she had consumed drugs or alcohol, but her reply was unintelligible. It appeared to the SJA officers that the deceased's mother was under the influence of an unknown substance, possibly "some sort of party drug"[147] as her pupils were dilated and she appeared dazed and confused but would intermittently become excitable and also seemed scared. There was a slight smell of alcohol "but it wasn't overwhelming."[148] They extracted her from the car and had to help her to stand as she could not stand unassisted due to her intoxication. They put her onto a stretcher, where her limbs were seen to be visibly twitching. Her observations were normal except for a slightly raised heart rate. She had no visible injuries to her body. She was non-compliant, so it was hard for the paramedics to conduct a full assessment of her.[149]

137. Two police officers, Senior Constable[150] Lance Munckton and First Class Constable Steven Gurr from Traffic Enforcement Group arrived after the deceased's mother had been put in the ambulance.

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[144] T 146 – 147.
[145] T 146; Exhibit 1, Tab 19.4.
[146] Exhibit 1, Tab 6 and Tab 7.
[147] Exhibit 1, Tab 8 [24].
[148] Exhibit 1, Tab 9 [16].
[149] Exhibit 1, Tab 9.
[150] First Class Constable at the relevant time.

138. Both police officers commented that the damage to the car appeared to be minimal, which did not suggest it had been involved in a significant crash. However, the way it was parked and some damage to the right front wheel rim did cause them to suspect the driver had been driving while intoxicated.[151]

139. Senior Constable Munckton went to the ambulance to speak to the deceased's mother. Senior Constable Munckton is a very experienced police officer, who has worked primarily in Traffic Enforcement in his over 42 years in the WA Police Force. Senior Constable Munckton gave evidence that based upon many years of experience, his observations of the deceased's mother erratic behaviour were consistent with the impression of other witnesses and SJA staff that she was drug-affected rather than simply alcohol intoxicated.[152] He noted the deceased's mother was "screaming quite badly in the back of the ambulance,"[153] even though it appeared to have been only a very minor crash, and he thought she was more agitated than injured. She also exhibited sudden clenching or spasms, which he had recently seen in people affected by GHB, also known as fantasy. He performed a preliminary breath test, which came back with a result of 0.18% BAC, so it was obvious the deceased's mother was definitely affected by alcohol, although potentially other substances were also involved. Senior Constable Munckton was concerned for the safety of the paramedics, so he remained with the deceased's mother in the ambulance.[154]

140. First Class Constable Gurr searched the car and noted there was an empty child's car seat in the car and a few other child-related items, but no sign of a child.[155] He gave evidence that he mentioned this to Senior Constable Munckton. Both officers made it clear in their evidence that they did turn their mind to the question of children, having noted these items, but there was no information to suggest to the two police officers that the deceased's mother had sole immediate care or responsibility for a child at that stage. She was also behaving erratically, so it was difficult to question her and elicit further information or details from her. At that stage, the two officers were focussed on ensuring the deceased's mother was taken to hospital without incident and making sure they put the car in a safe place.[156]

141. It was not unreasonable for the police officers to assume that any child she might usually be responsible for had been left with a responsible adult, as that would be the ordinary expectation in our community. If the deceased's mother had mentioned her children, both officers gave evidence they would have taken further steps to make sure the children were safe, but no mention was made of a child, even when questioned about her family at the hospital. I note that on a previous occasion, when police had been planning to arrest the deceased's mother in relation to a VRO breach, a senior police officer had contacted Communities in advance to ascertain what care arrangements might be put in place for the two children if the police did arrest their mother. This demonstrates how the ordinary policy works when the police are aware

[151] T 9; Exhibit 1, Tab 10 and Tab 11.
[152] T 17; Exhibit 1, Tab 10.
[153] T 16.
[154] T 16 – 18.
[155] T 9; Exhibit 1, Tab 10 and Tab 11.
[156] T 9 – 10; Exhibit 1, Tab 21.

of children who may require care. First Class Constable Gurr said in this case, he would have radioed it in and asked for someone to go to the deceased's home and conduct a welfare check. I am satisfied this would have been done in this case, if the police had been made aware that the deceased had been left alone.[157]

142. The deceased's mother was taken by ambulance to RPH with Senior Constable Munckton accompanying her for the safety of the SJA staff.[158] The ambulance staff waited for several hours at RPH before the deceased's mother could be admitted to a bed in the Emergency Department. Whilst waiting, her behaviour was observed by the ambulance and police officers to be erratic, sometimes being quiet and compliant and then at other times she became abusive towards the SJA staff and agitated. She also slept for some of the time.[159]

143. Another ambulance crew took over her care at 2.20 am. Around this time, the deceased's mother had begun to sober up and make more sense. She never mentioned anything about having children at home, although one of the ambulance officers did recall asking her about children at the scene as they were aware the police search of the vehicle had found nappies in the glove box of the car. At that time, the deceased's mother had only made noises. The noises gave no indication that she did have children, but she wasn't really responsive and was simply wailing and yelling out. One of the SJA officers also recalled the hospital staff again asked the deceased's mother if she had children, but she couldn't recall what, if any, response was given.[160]

144. Information provided by RPH indicated that the deceased's mother was brought to RPH by ambulance at 10.25 pm following a minor traffic incident, with no injuries sustained. It was noted in her medical records she had a breath alcohol level of 0.18% and had been exhibiting erratic and combative behaviours at the scene and spitting at staff. She refused to answer questions and was noted to be non-verbal, teary and had a vacant facial expression. Her hospital admission bloods recorded a blood alcohol reading of 0.18%, although it was noted to be still rising.[161]

145. Most of the deceased's mother's behaviour, including when she was administered the breath test, was captured on Senior Constable Munckton's body worn camera. It was clear from the footage that she was very erratic and at times became distressed, although she appeared coherent. Senior Constable Munckton was extremely kind and compassionate towards her, while still trying to do his job and get her to complete the breath test, which gave a reading of 0.174%. He also tried to draw out some personal information from her, including who she lived with, but she provided little information in response other than to make it clear she was unhappy and didn't have a good relationship with her mother. Senior Constable Munckton explained he was exploring her relationships in case he needed to find a family member to take charge of her, if she was released from hospital. However, it eventually became clear she was staying in hospital so he was able to entrust her to the care of a nurse. At no

[157] T 12; Exhibit 2, Tab 3.
[158] Exhibit 1, Tab 6 and Tab 7.
[159] T 19 - 20; Exhibit 1, Tab 8 and Tab 9.
[160] Exhibit 1, Tab 8 and Tab 9.
[161] Exhibit 1, Tab 23.

stage did the deceased's mother mention any of her children, and specifically for the purpose of this inquest, she did not mention the deceased. After she eventually completed the breath test, she was served with the relevant paperwork and the police officers left her in the care of health staff.[162]

146. Senior Constable Munckton noted at the inquest that at the time he was involved with the deceased's mother, he remained convinced she was affected by drugs as well as alcohol, but given her blood alcohol result and the relevant laws at the time, there was no basis to go on and do a drug test. Today, there is the option of also doing a preliminary oral fluid test, but it only targets certain illicit drugs in any event.[163]

147. Later evidence indicates the deceased's mother knew at that stage that her son had died while in her care and his body was at the house, but she did not disclose this information to police, ambulance officers or hospital staff at the time.[164]

148. By 5.40 am on 19 August 2021, the deceased's mother was communicating with RPH staff by writing but was still not talking. It was felt at this stage that she was making a deliberate decision not to talk, so it did not trigger a medical concern. Blood tests were taken, which were all within normal limits except for her blood alcohol, which on testing was now 0.22%.[165]

149. The deceased's mother was admitted to the Urgent Care Centre at 7.25 am with an admission diagnosis of alcohol intoxication and bizarre behaviours. She was still refusing to engage verbally, but she was wanting to write on paper and she wrote down 'no visitors'. She was offered food and declined. By 9.10 am, her breath alcohol had come down to a level of zero, and she was then referred to Psychiatry after she reported voices telling her to harm herself or possibly others.[166]

150. The Psychiatric Registrar noted that the deceased's mother seemed "highly distressed, teary, paranoid and hypervigilant."[167] She was physically able to talk, but not wanting to do so, and described hearing voices that were terrifying to her and that told her she was not allowed to speak. She agreed to try the anti-psychotic medication olanzapine. She was started at a low dose and then increased, and was reassured that she was safe. She later underwent a urine drug screen at 3.30 pm that day, which was negative for all illicit drugs. Her hospital admission bloods showed a number of prescription medications, including olanzapine, and also doxylamine, lorazepam, paroxetine and paracetamol, which were presumably related to her treatment.[168]

[162] T 21 – 25, 28; Exhibit 1, Tab 10.
[163] T 29.
[164] Exhibit 1, Tab 1, p. 15.
[165] Exhibit 1, Tab 1, p. 15 and Tab 23.
[166] Exhibit 1, Tab 1, Tab 4.2 and Tab 23.
[167] Exhibit 1, Tab 23, p. 2.
[168] Exhibit 1, Tab 1, Tab 4.2 and Tab 23.

DISCOVERY OF THE DECEASED'S BODY

151. At some stage, RPH staff became aware through their information systems that the deceased's mother had an open case with Communities for two of her children. An RPH social worker notified Child Protection staff by email at 10.18 am on the morning of Thursday, 19 August 2021, that the deceased's mother was at the hospital without her children.[169]

152. Ms Papaluca was on planned personal leave on this day but other Child Protection staff began to take action after receiving the notification from RPH staff, including the Communities' duty officer for that day, Ms Ryan-Wilkins. Ms Ryan-Wilkins rang the RPH social worker at 11.00 am and advised of Communities' understanding of the children's care arrangements for the previous night. She asked the social worker if she could go and speak to the deceased's mother and confirm the deceased's whereabouts and obtain the contact details for the friend with whom they had been staying.[170]

153. At 11.25 am, Ms Ryan-Wilkins contacted the deceased's school. Ms Palmer confirmed he was not at school and she held concerns for his welfare. Child Protection staff then made a number of unanswered telephone calls and sent text messages to the deceased's father. They also later made a number of unanswered phone calls and text messages to Mr Baker.[171]

154. In the meantime, at 11.33 am, the RPH social worker rang back and advised that the deceased's mother had been non-verbal since presenting at the hospital, although this was felt to be voluntary as there was no identified medical reason for her not speaking. She had been medically cleared for discharge but was awaiting a psychiatric consult. At 11.34 am the RPH social worker sent a follow up email in which she noted that she had attempted to talk to the deceased's mother, who chose not to talk, but the deceased's mother had written some things on a piece of paper. When asked where the children were, she wrote 'their father'. She was asked if both children were with their father, and nodded in response, but the social worker wasn't sure if this was accurate information.[172]

155. Child Protection staff renewed their efforts to contact the deceased's father, in order to confirm if he had the deceased as well as LM, but were unsuccessful.[173]

156. Ms G received a call from Ms Ryan-Wilkins at 12.20 pm. She was informed that the deceased's mother had been in a car accident and was receiving treatment at RPH. Ms G asked about the children and was told the deceased's sister was with her father but they were trying to confirm the deceased's whereabouts. Ms G advised that her last contact had been with the deceased's father the night before, when he sent a text message advising her he was going to collect the children. He had told her he would message her afterwards, but she had not heard from him again. She did not know

[169] Exhibit 1, Tab 19.4; Exhibit 2, Tab 4.
[170] Exhibit 1, Tab 19.4.
[171] Exhibit 1, Tab 19.3, p. 5 and Tab 19.4.
[172] Exhibit 1, Tab 19.4; Exhibit 2, Tab 4.
[173] Exhibit 1, Tab 19.4.

where he lived, as he had never disclosed to her his address, but she believed he lived in Lathlain.[174]

157. Ms G asked if anyone had checked the deceased's home. Ms Ryan-Wilkins said they had not and that they were checking with the deceased's father. Ms G got off the phone and discussed the call with her husband. Ms G explained at the inquest that she had gained an understanding in the previous month of the deceased's father's reluctance to take responsibility for his son. He had often tried to take only his daughter, and not the deceased, when he had come to Ms G's house to collect the children. She had a strong suspicion that he might have done something similar and it was possible the deceased had been left in his mother's care. She was also aware that the deceased's mother had left the deceased at home alone before. Accordingly, she decided to go immediately to his house to check.[175]

158. Meanwhile, at 12.50 pm, Child Protection staff requested Swan Taxis conduct a 'message call out' to the deceased's father requesting that he urgently contact the office. Apparently, Communities use 'message call outs' as an alternative method of contacting people who might otherwise not answer or respond to telephone contact, or if their phone number is not known. Ms Ryan-Wilkins also made plans to go to the hospital and speak to the deceased's mother.[176]

159. Before she left, Ms G spoke to Communities again at 12.52 pm. The Child Protection staff advised they still hadn't confirmed the deceased was with his father. Ms G said she was going to go to the deceased's home to check on him. Child Protection staff said they would contact the police. Ms G then drove with her husband to the deceased's home.[177]

160. On the drive to the house, Ms G also called the deceased's school and confirmed that he had not attended school that day. Ms G arrived at the deceased's home at about 1.00 pm. She could see no cars parked at the house and no people anywhere. She saw that the front flyscreen door was ajar and resting on the latch, and the front door was wide open. Ms G could see inside and she could not see anyone inside. She also could not hear any noise coming from inside. On the advice of her husband, Ms G called the police and sought permission to enter the house, which was granted given the circumstances.[178]

161. Ms G entered the house and went directly to the deceased's bedroom. She opened his bedroom door, which was closed, and immediately saw the deceased lying on his back on the floor near the door. His head was slightly tilted towards the bedroom door. She noted he appeared blue or purple in colour, but given his extremities sometimes appeared blue due to his cardiac issues, she wasn't immediately sure if he was simply unconscious. She then noted dried blood coming from his nose and his eyes appeared slightly open. Ms G rested the back of her hand on his forehead and checked the pulse on his neck with her fingers. She noted the deceased felt very cold

[174] Exhibit 1, Tab 14 and Tab 16 and Tab 19.4.
[175] T 74 – 75..
[176] Exhibit 1, Tab 19.4, p. 19.
[177] Exhibit 1, Tab 14 and Tab 15.
[178] T 76; Exhibit 1, Tab 14 and Tab 15.

and had no pulse and she recognised that he had passed away. Ms G was still on the phone to police at this time. Her husband, who was with her, escorted his wife from the house and took the phone as Ms G had understandably become very distressed. Ms G's husband spoke to the police, who arrived at the house soon after.[179]

162. In the meantime, Child Protection staff had gone to RPH to try to speak to the deceased's mother to try to find out the deceased's whereabouts and also to tell her that she was not to resume care of the children until Communities were able to meet with her to review the safety plan. Before they could speak to her, they were notified of the discovery of the deceased's body at his home.[180]

163. The deceased's father had become concerned as he hadn't heard from the deceased's mother and was then advised by Communities that she was in hospital. He drove to the deceased's home, arriving at 1.40 pm. Police were already in attendance and they advised him that his son had died.[181]

HOMICIDE INVESTIGATION

164. Constable Whittaker and Constable Cawley from Morley Police station were the first officers on scene at the deceased's home at 1.09 pm. They activated their body worn cameras, so their arrival and initial observations were captured. The two officers entered the deceased's bedroom and immediately began to perform CPR on the deceased. St John Ambulance paramedics arrived at 1.16 pm. They assessed the deceased and determined from the evidence of gravitational blood pooling (livor mortis or lividity) and the onset of rigor mortis that he had been dead for some time. Accordingly, all resuscitation efforts were ceased.[182]

165. Given the circumstances, Homicide Squad detectives were contacted and the house was declared a Protected Forensic Area. Homicide Squad detectives attended the scene, while Ms G and the deceased's father were still present.[183] The detectives noted as relevant information that:[184]

- it appeared the deceased's body had been moved after death;
- there was a purple bin bag used as a pillow case on the pillow in his cot;
- dried blood was identified on the purple bin bag;
- the house was unlocked and no other person was at home; and
- the deceased's mother had not disclosed the deceased's death to any person when she was apprehended the night before, nor to any person at the hospital.

166. As a result of these observations, Homicide Squad took carriage of the investigation and Operation Rugga was commenced. The Investigating Officer was Detective

[179] Exhibit 1, Tab 14.
[180] Exhibit 1, Tab 19.3.
[181] Exhibit 1, Tab 12.
[182] Exhibit 1, Tab 1.
[183] T 35.
[184] T 37 - 38; Exhibit 1, Tab 1.

Sergeant Fairlie and the Senior Investigation Officer was Detective Senior Sergeant Neubronner.[185]

167. In general, the house was observed to be in an untidy state, with rubbish from takeaway and food delivery services, including alcohol delivery services, scattered throughout the kitchen area. The deceased's room, where he was located, appeared to be in a tidy state but there was a strong odour of urine. A baby bottle containing coagulated liquid, believed to be baby formula, was observed on the floor of the room near the deceased. Samples of the liquid were obtained, as well as from similar bottles and a formula mix found in the kitchen, for possible testing. However, after toxicology of the deceased's blood and urine ruled out poisoning as a possible contributory factor to the death, further testing was not performed on these items.[186]

168. DNA and fingerprint testing found the deceased's mother's fingerprints on the deceased's cot and other items in the house, which was to be expected given she was his primary caregiver. There was nothing found in the house to suggest an unknown person might have been in the house at the relevant time or involved in his death.[187]

169. Ms G told police that when she had first taken the deceased and his sister into her care on 21 July 2021, she had seen a purple bin bag on the deceased's pillow, so this appeared to be consistent with how his mother ordinarily made up his bed and was less sinister than first appeared.[188]

170. Forensic Pathologist Dr Clive Cooke was notified by detectives of the death on the afternoon of 19 August 2021 and he was requested to go to the house that evening and inspect the scene. Dr Cooke arrived at the home in Dianella at approximately 9.25 pm. After a short briefing by police officers, he entered the house and examined the deceased briefly in his bedroom in the residence. Police had earlier attempted CPR, so the deceased was not in the exact position he had initially been found in by Ms G.[189]

171. Dr Cooke observed the deceased was lying on his back on the floor but he clearly had anterior post mortem lividity staining, with compression-type marking within the lividity on the front of the abdomen, indicating he had died while lying on his front. The deceased's arms were bent at the elbows, so that the hands were at the same level as his head, and his legs were partly bent. Lividity was also noted in the fingertips, with compression-type pallor of skin at the sides of the fingers, corresponding with the position of other fingers. There was some compression-type pallor to the skin of the left side of the face, the tip of his nose being deviated towards the right. There was also some brown coloured secretion to the tip of the nose, extending to the front of the cheek alongside the right nostril. There was congestion to the skin around the eyes, with several fine petechiae inside the lids of the left eye and post mortem drying of the sclera at the side of the right eye. There

[185] Exhibit 1, Tab 1.
[186] Exhibit 1, Tab 1.
[187] Exhibit 1, Tab 1.
[188] Exhibit 1, Tab 1.
[189] Exhibit 1, Tab 1 and Tab 3.2.

were no evident injuries around the mouth, and no marks inside the lips. There were also no evident marks or injuries to the rest of the body surface.[190]

172. Noting the brown coloured secretion at the top of the nose, Dr Cooke also observed that adjacent to the deceased was a cot and inside the cot was a pillow with a plastic liner, and a brown spot of apparently blood-stained secretion was located towards one corner of the pillow.[191]

173. The deceased's mother's car, which was still parked in Mt Lawley, was seized and subject to a full forensic examination. No blood was detected in the vehicle or anything else that might have been related to the deceased's death.[192]

174. At 3.15 pm, RPH staff had been notified by WA Police that the deceased's body had been found at his home and the circumstances of his death were unclear. An RPH doctor advised the police of the deceased's mother's current mental state. At 4.45 pm, a psychiatric review by psychiatrist Dr Oyewopo occurred. After initially communicating in writing, the deceased's mother began speaking in short sentences during the psychiatric review but only engaged in a limited way. Her diagnosis was unclear at that stage as her behaviour was not entirely consistent with someone acutely psychotic. She was put on a Form 1A under the *Mental Health Act 2014* (WA) to await further psychiatric review at another hospital. There was no discussion about the death of her son at that stage. She remained selectively mute with male staff, but was willing to speak to female staff.[193]

175. At 8.20 pm that evening, WA Police officers met with the deceased's mother at the hospital, advised her of the passing of her son and took forensic samples under a warrant. She cooperated with the warrant and allowed samples to be collected and her clothes and other personal items seized. A urine sample test was provided that was positive for buprenorphine. She remained calm and cooperative throughout the process and then ate some food and took some medication before going to sleep at about 11.00 pm.[194]

176. The next morning, the deceased's mother apparently awoke and seemed bewildered. She claimed she did not remember the psychiatric review the previous day and presented as irritable and angry, although she settled quickly. She talked about hearing voices in her head but declined to elaborate further. She denied delusions and showed no clear evidence of thought disorder or other psychotic symptoms. She became angry and screamed when questioned about her son. She admitted to drinking a large amount of alcohol every day and regular cannabis use and claimed she last used methylamphetamine four weeks ago. She appeared distressed about her son but was unable to fully articulate her distress. Dr Oyewopo considered that the deceased's mother would still require a period of observation to ascertain her level of risk and any developing underlying psychopathology. She remained unsafe for discharge at that stage, so remained under the *Mental Health Act*. The working

[190] Exhibit 1, Tab 1 and Tab 3.2.
[191] Exhibit 1, Tab 1 and Tab 3.2.
[192] Exhibit 1, Tab 1.
[193] Exhibit 1, Tab 23.
[194] Exhibit 1, Tab 23.

diagnoses at that stage were acute stress reaction with a differential diagnosis of psychosis and polysubstance abuse.[195]

177. The deceased's mother's was transferred under forms to the Sir Charles Gairdner Hospital (SCGH) Mental Health Unit on 20 August 2021 and admitted as an involuntary patient. Her previous history of drug overdose and possible drug-induced psychosis were noted. She was also noted to be difficult to engage. The psychiatric treating team were aware of the death of the deceased and the fact the police intended to interview the deceased's mother in relation to his death once she was sufficiently recovered in her mental health to be interviewed. The treating psychiatrist formed the opinion the deceased's mother had a psychotic disorder with possible mood disorder. She reported a recent miscarriage two weeks' earlier, but also appeared to believe she was pregnant during her admission, despite being shown negative pregnancy tests. She also had a polysubstance use disorder. She admitted a one year history of excessive cocaine, methamphetamine and alcohol use, reportedly drinking one to one and a half bottles of alcoholic spirits daily. The deceased's mother had already been treated for alcohol withdrawal and given antipsychotic medication, following which she reported her auditory hallucinations had reduced. However, she still became pressured in her speech and expressed unrealistic ideas of what she wished to achieve on discharge.[196]

178. Towards the end of her involuntary admission, the deceased's mother was able to provide an account of the days leading up to her hospitalisation, but her account was confused in terms of the chronology of events and she had blackspots in her memory. However, she recalled the deceased's father coming over at some stage and yelling at her about the state of her house before taking their daughter, then later finding her son deceased in his cot.[197]

179. She was considered fit for discharge on 2 September 2021 and was discharged on the anti-psychotic medications olanzapine and paliperidone. At that time, her auditory hallucinations had settled, she had insight and her memory had improved.[198]

180. Upon release from hospital, the deceased's mother was taken into custody and participated in an audio-visual record of interview with police. She told police that in the weeks prior to her son's death, she had ceased a medication that prevented memory loss episodes and was consuming a large amount of alcohol, which affected her ability to recall events. As a result, she had difficulty recalling the chronology of events leading up to the deceased's death. She did recall having an argument with the deceased's father on the day when he took LM home with him, but couldn't recall the date. She recalled that the deceased's father had said he was going to come back that night to get the deceased and that he had asked for keys and checked the house locks. The deceased's mother told police she 'blacked out' from there and was on autopilot. She recalled vomiting in the toilet until the toilet was blocked and then started vomiting in a bucket (which was confirmed by police on the day the deceased was found). She thinks she must have moved the deceased into his cot but did not

[195] Exhibit 1, Tab 23.
[196] Exhibit 1, Tab 1 and Tab 23.
[197] Exhibit 1, Tab 1, p. 11.
[198] Exhibit 1, Tab 1 and Tab 23.

recall doing so. She said she didn't want the deceased's father to return, so she admitted she messaged him to say the deceased was okay.[199]

181. The deceased's mother told police the next day she forgot that the deceased was still in the house. He was usually loud, but she didn't hear any noise, so she convinced herself he must have been collected by his father. She sat in the loungeroom in the dark, consuming alcohol, and was not aware the deceased was in his room. She did not recall exchanging messages with Child Protection staff. The deceased's mother said she went into the deceased's room at night time and observed him lying in his cot, with his head on the pillow. She noticed his feet were not the right colour. She took him out of the cot, placed him on the floor and rubbed his stomach and then she knew he was dead. She didn't try to call an ambulance as she realised it was too late.[200]

182. After coming to this realisation, the deceased's mother ordered more alcohol and recalled messaging Mr Le Tang and saying that her son was dead. She drank for one or two hours before driving form the house, with the intention of killing herself. She commented that she didn't think about ringing an ambulance "because she thought it was murder and that he was dead."[201]

183. The investigating officer, Detective Sergeant Fairlie, observed that the deceased's mother was cooperative during the interview and voluntarily answered all questions put to her. She appeared to genuinely have some gaps in her memory and she also seemed to show genuine grief and denied ever having ill thoughts towards her son. She had been his primary care giver for the entire 11 years of his life until his death, and there was no evidence to suggest she had ever deliberately caused him harm.[202]

184. Police obtained information that prior to her release from hospital, the deceased's mother had also given a similar account to her treating team.[203]

185. Gary Baker told police the deceased's mother had told him a very similar account a couple of days' earlier, on 29 August 2021. She recalled the deceased's father coming to the house and being very angry with her. He had taken LM and said he was going to come back for the deceased, so in her mind she convinced herself he had taken both of them. The deceased's mother told him she had gone into the deceased's room to change the sheets a few days' later and found him dead in the cot. She had left the house in her car and had wanted to smash it before she crashed.[204]

186. Phone records reveal that after being told by Child Protection staff at 4.43 pm that the deceased was not with his father, the deceased's mother responded that she and the deceased were at a friend's house for the night. Based on her other accounts, I am satisfied that the deceased's mother may not have been aware of her son's death at the time she sent her response. She lied in her response to Communities that they

[199] Exhibit 1, Tab 1, pp. 11 - 12.
[200] Exhibit 1, Tab 1, p. 12.
[201] Exhibit 1, Tab 1, p. 12.
[202] T 42, 45; Exhibit 1, Tab 1, p. 12.
[203] Exhibit 1, Tab 1.
[204] Exhibit 1, Tab 13.

were staying with a friend, but it may have been out of habit and also perhaps to buy herself time while she worked out what was going on. She then went to check on the deceased in his room and found his body in the cot. The deceased's mother then ordered an alcohol delivery to her house at 5.54 pm, which matches her account of ordering alcohol after discovering his body.[205]

187. At 7.21 pm, the deceased's mother exchanged a series of messages with her boyfriend, Mr Le Tang, including a message at 7.48 pm, "I will be in jail for the rest of my life,"[206] and another at 7.49 pm, ".. my son is dead."[207] She then sent further messages stating that she still had memory loss issues and it wasn't her fault.[208] It seems her boyfriend did not take her seriously.

188. After drinking the alcohol that was delivered and messaging her boyfriend, the deceased's mother then left the house in her car at 9.15 pm. This is confirmed by CCTV footage from a nearby service station. She then drove to Mt Lawley, where she was eventually spoken to by police in Mt Lawley at around 10.00 pm before being taken to hospital.[209]

189. Later evidence of the deceased's conversations with other persons showed she remained consistent in her account of the events surrounding the death of her son.[210]

CAUSE OF DEATH

190. Ms G indicated in her statement that when she found the deceased in his bedroom, he was lying on the floor of the room on his back. She did not observe any obvious signs of disturbance in the room and he did not appear to have any obvious injuries, other than a bandage on his left ear that she was aware was covering the sore that had been there for some time.[211]

191. Forensic Pathologist Dr Clive Cooke was the on-call pathologist that day and he was notified by detectives of the death on the afternoon of 19 August 2021. Dr Cooke was requested to go to the house that evening and inspect the scene. Dr Cooke arrived at the home in Dianella at approximately 9.25 pm. He engaged in a short briefing with detectives, during which the police officers made it clear they were seeking his opinion on a possible cause of death and if there were any particular concerning injuries to be seen externally. Dr Cooke then entered the house and went to the deceased's bedroom, where he examined the deceased's body briefly on the floor. Police had earlier attempted CPR, so the deceased was not in the exact position he had initially been found in by Ms G.[212]

[205] T 42; Exhibit 1, Tab 1.
[206] Exhibit 1, Tab 1, p. 8.
[207] Exhibit 1, Tab 1, p. 8.
[208] Exhibit 1, Tab 1.
[209] T 41; Exhibit 1, Tab 1.
[210] Exhibit 1, Tab 8.
[211] Exhibit 1, Tab 14.
[212] T 181; Exhibit 1, Tab 3.2.

192. Dr Cooke noted the deceased was lying on his back on the floor, adjacent to the cot. He observed the unusual feature that the deceased had obvious anterior post mortem lividity staining or livor mortis, which was very suggestive that the deceased had spent quite some time, usually many hours, after death lying facedown. This was in contrast to the fact he was now lying on his back. Based on what he observed in the room, Dr Cooke thought it most likely that the deceased had previously been lying face down in his cot, as there was a small amount of secretion on the corner of the pillow inside the cot, which could easily have come from his nose or his mouth. Dr Cooke also observed a brown coloured secretion at the top of the deceased's nose.[213]

193. The deceased's arms were bent at the elbows, so that the hands were at the same level as his head, and his legs were partly bent. Lividity was also noted in the fingertips, with compression-type pallor of skin at the sides of the fingers, corresponding with the position of other fingers. There was some compression-type pallor to the skin of the left side of the face, the tip of his nose being deviated towards the right. There was congestion to the skin around the eyes, with several fine petechiae inside the lids of the left eye and post mortem drying of the sclera at the side of the right eye. Dr Cooke explained that the petechiae are tiny blood spots which typically appear on the surface of the eyes. They can occur through neck compression, but Dr Cooke found no marks on his neck, which largely ruled out neck compression. The alternative explanation for the petechiae is if someone dies in the facedown position, the petechiae can form due as part of the process of lividity, which appeared to be the cause in this case.[214]

194. There were no evident injuries around the mouth, and no marks inside the lips. There were also no evident marks or injuries to the rest of the body surface.[215]

195. None of Dr Cooke's initial observations were inconsistent with the account later given of the deceased's mother finding him dead in his cot and taking him out and putting him on the floor. Put another way, nothing Dr Cooke observed on that night strongly suggested another person had directly caused the deceased's death by an action (as opposed to failing to take action), although the bruising and petechiae were features that required some further investigation to determine if there was a non-suspicious explanation for their presence.[216]

196. A full post mortem examination was undertaken by Dr Cooke and a forensic pathology registrar, Dr Downs, at the State Mortuary on 24 August 2021, with three police officers also in attendance. A CT scan undertaken as part of the examination showed signs of surgery to the heart, consistent with the deceased's medical history of cardiac surgery for congenital heart defects. The deceased's height and weight were well below the 3rd centile for his age, and dysmorphic features were noted, all of which were consistent with his diagnosis of Cornelia De Lange Syndrome. There was some congestion of the lungs, and some mucous in the upper airway, raising the

[213] T 181, 189; Exhibit 1, Tab 3.2.
[214] T 182 - 183; Exhibit 1, Tab 3.2.
[215] Exhibit 1, Tab 3.2.
[216] T 195 - 196.

possibility of early infection, but no evident infection was found on microscopic examination.[217]

197. Testing for significant respiratory and cardiac viral infections was negative. Microbiology testing showed the presence of mixed bacteria and abundant *Staphylococcus aureus* in several locations. Dr Cooke noted that staphylococcus causes a pneumonia illness, which can lead to sepsis and death, so its presence may have been of some significance. However, it is also a relatively common finding in postmortem samples where the body gets contaminated after death, so its presence may not necessarily indicate the deceased had a severe illness prior to death, although it can't be ruled out given there was some evidence he had been unwell. Biochemical testing showed slightly raised urea but the blood sugar was normal. Toxicology analysis showed the presence of acetone but no alcohol or common drugs. Acetone in a small quantity may be a consequence of illness or malnutrition.[218]

198. The post mortem examination found some evidence of subcutaneous bruising on the right side of the deceased's head and several bruises in the soft tissues of his neck and on the sides of his chest. Those on the chest could potentially be explained by CPR and the ones on his head and neck could potentially have occurred from seizures or if he had some falls. There was nothing to see externally on the body's surface. Dr Cooke commented that while you could never rule out the possibility that they are injuries from an assault of some type, they could also have been from a fall or from a seizure, if he hit himself against something or fell against something. Dr Cooke confirmed in questioning that the bruising did not contribute to his death.[219]

199. Based on the post mortem examination findings, a precise cause of death could not be identified. However, Dr Cooke and Dr Downs provided a number of possibilities that could explain the death, based upon the findings:[220]

- <u>Dehydration and undernourishment.</u> The detection of acetone in the toxicology testing the biochemical demonstration of a raised urea level may indicate a lack of fluids and food prior to death. However, these findings are not specific and alternative explanations can include sepsis and diabetes. Additionally, it was noted that their presence does not necessarily indicate an underlying process that would inevitably be fatal (acetone and urea may be raised in non-fatal conditions). Unfortunately, post-mortem examinations of deceased people who have died of acute dehydration and undernourishment typically don't show any diagnostic findings. The examination did show that the deceased had some fluid in the stomach and normal appearing intestine contents, but the forensic pathologists were not certain how these related to the very recent adequacy of his hydration and nourishment.

[217] Exhibit 1, Tab 3.2 and Tab 5.
[218] T 187; Exhibit 1, Tab 3.1 and Tab 4.
[219] T 185 – 186.
[220] Exhibit 1, Tab 3.1.

- Epileptic Seizure. Seizures may occur in Cornelia de Lange syndrome, most commonly of partial seizure type. Seizures are known to occasionally be fatal. With a fatal grand mal seizure there may be bruising of the tongue from biting during the seizure. No such bruising was observed in this case, but the absence of bruising does not exclude the possibility of a seizure occurring.

- Heart disease. The deceased had a severe type of congenital heart disease, which had been surgically treated but had resulted in scarring and calcification of the heart muscle and tissues. Severe heart disease can result in death by way of a cardiac arrhythmia, or if there is significant further illness or disease, it makes a fatal outcome more likely. A fatal arrhythmia leaves no other findings in the body, so cannot be proven of itself.

- Sepsis. The *Staphylococcal* bacterial organisms were found in several locations, which may therefore indicate infection (sepsis), a condition which can be fatal. The examination of the body organs and tissues did not show a source of infection, but on occasion there can be fatal sepsis without a demonstrable source. However, as noted above, misleadingly, these bacteria may also grow in the body after death, as a post mortem contaminant, so their presence may not be due to an infection leading to death.

- Suffocation and smothering, or neck compression. Occlusion of the nose and mouth, resulting in airway obstruction and compression of the neck, may result in death. These may occur in a number of circumstances including those that result in impaired consciousness, such as after a seizure or if there has been a fall, and the person rests in a position that occludes breathing or compresses the neck. There were no marks on the skin around the deceased's nose and mouth and no marks on the skin of the neck, but if the occlusive or compressive forces are mild and broad then there may be no marks or injuries to the face or neck. There were several small bruises in the neck subcutaneous tissues, on both sides, which would indicate some type of impact at these locations, including from a fall or seizure or from neck compression. There were also petechiae around the eyes, which are another feature that can indicate neck compression, but can also be a feature of being face down after death, which it was noted seemed to be the case, with the blood-stained secretion on the pillow covering and the presence of lividity in the front of the deceased's body.

200. In conclusion, Dr Cooke was not able to advise a definite cause of death.[221]

201. It was noted that the deceased had very severe heart disease, to a degree that he could have had a fatal cardiac arrhythmia at any time. It could have arisen either spontaneously, or it could have been initiated by any of the other factors listed above. For example, if the deceased had been left lying in his cot without nourishment for a period because his mother was not attending to him, then he would have been more vulnerable to a fatal cardiac outcome.[222]

[221] T 191; Exhibit 1, Tab 3.1.
[222] T 191, 193 - 194; Exhibit 1, Tab 3.1.

202. Dr Cooke also raised the possibility of a seizure occurring, which was supported by evidence from his younger sister, who told police that she had observed her brother experiencing a 'seizure-type' event at approximately 3.00 pm on 17 August 2021, a couple of hours before she was collected by her father.[223]

203. Dr Cooke explained further at the inquest that the deceased may have died from dehydration or undernourishment, but there is nothing in the body that can tell us that definitively. He observed that in the deceased's case, his pre-existing conditions, particularly his very severe heart disease, would have been more likely to then result in a fatal outcome in those circumstances.[224]

204. The *staphylococcal i*nfection could also have been a terminal event for the deceased, although it may also have been simply a postmortem contaminate.[225]

205. The other possibility of suffocation or smothering, if it occurred and contributed to the death, did not show any typical features of forceful smothering, and was more consistent with accidental smothering by the deceased just being in a facedown position, possibly following a seizure.[226]

206. Ultimately, following all post mortem investigations, it could only be said that there were many possible causes of death, that may have operated either separately or in combination, and the cause of death has been left as unascertained.

MANNER OF DEATH

207. As a result of the physical evidence, and based on the forensic pathologist's opinion, Homicide Squad detectives concluded the deceased appeared to have died in his cot at home and was moved to the floor after his death. This was supported by the lividity staining on the deceased's front, indicating that he lay in a prone position after death and was later moved to a supine position. This matched the account of his mother, who admitted moving him from the cot to the floor.[227]

208. The attending police officers saw no signs of a disturbance or any obvious injury to the deceased, and this was confirmed by Dr Cooke.[228]

209. No definitive cause of death could be determined and five possible explanations were given for the death by Dr Cooke. These included that death could have arisen spontaneously from an arrhythmia or that he might have suffered a seizure, which are known to be occasionally fatal or can cause impaired consciousness that can leave a person like the deceased vulnerable to suffocation and smothering.[229]

[223] T 190; Exhibit 1, Tab 1, p. 16.
[224] T 188.
[225] T 192.
[226] T 192.
[227] T 39 – 40.
[228] T 38; Exhibit 1, Tab 1 and Tab 3.1.
[229] Exhibit 1, Tab 1.

210. Evidence was obtained from the deceased's sister that she had observed the deceased experiencing a seizure type event on 17 August 2021 at approximately 3.00 pm. He was still alive and crying when his father arrived after that time, but he was not seen alive again after LM left with their father at about 5.00 pm that night.[230]

211. Based on the evidence obtained, the police investigation reached the conclusion the deceased died in the period between 5.00 pm on 17 August 2021, when LM left with their father, and 7.48 pm on 18 August 2021 when his mother sent a message to her boyfriend acknowledging she was aware that he had died.[231]

212. Homicide Squad detectives considered whether charges of Manslaughter, by virtue of failing to provide the necessaries of life (ss 262 and 280 of the *Criminal Code*), or Failing to Protect a Child from Harm (s 101 of the *Children and Community Services Act 2004* (WA) were established. It was noted that no act or omission could be proven to have directly or indirectly caused the death of the deceased as the time, mechanism and cause of death have not been established. The deceased's mother's mental state was also relevant, and included her state of intoxication and psychiatric condition. Having considered all of the evidence, the investigation did not identify a prima facie case against the deceased's mother for either charge, or for any criminal behaviour in relation to her son's death. No one else was implicated in his death. Accordingly, no charges were laid.[232]

213. The opinion of the forensic pathologist points primarily to a natural cause, although potentially with some contribution by positional asphyxia and/or dehydration and undernourishment if he was left in his cot for a long period of time before death.

214. However, the police investigation concluded it was also possible the deceased died not long after his sister and father left the house, given his sister's description of witnessing a seizure-type event before she left and the fact the deceased's mother said she did not hear him after that, and he was normally quite loud.[233]

215. Noting the unascertained cause of death and the uncertainty surrounding the events leading up to his death, I have decided to make an open finding as to the manner of death.

COMMUNITIES' INTERNAL REVIEW

216. The Department of Communities' Specialist Child Protection Unit conducted its own Independent Case Review into the deceased's case after his death in order to consider future learning and practice considerations across the Department. A copy of the Independent Case Review report was provided to the Court by counsel for Communities after the inquest, at my request. It's not clear from the document when the report was prepared, but it was provided to the Court on 15 November 2023.

[230] Exhibit 1, Tab 1.
[231] T 40; Exhibit 1, Tab 1, p. 16.
[232] T 45 - 46; Exhibit 1, Tab 1, p. 17.
[233] T 45.

217. I understand the report preparation involved a review of the various records available, as well as interviewing certain relevant staff. It was noted that the record-keeping was done to a high standard, which made it easy to follow the interactions with the family, although there was an unexplained gap between 6 and 21 July 2021.[234]

218. The Review noted that the Communities' Casework Practice Manual specified that Child Protection staff must take additional measures to protect a child with disability who is vulnerable to abuse, including neglect, and must ensure that specialist clinical advice, co-ordination and support is available where the child has high and complex disability support needs within the Child Protection system, or who is at risk of entering the Child Protection system. This would obviously have applied to the deceased.[235]

219. It was noted in the review that the level of planning needed in this child safety investigation, given the issues, was better suited to work occurring in the intensive family support space. There was evidence that the staff involved had intended to refer the family to an intensive family support team, but the deceased died before this could occur. As it was, the staff involved had a significant amount of contact with the family during safety planning and were taking active measures to support the family to develop adequate safety plans and address the needs of both children in the context of the concerns about non-school attendance and neglect.[236]

220. The focus of the findings for future learnings arising from the Review were focussed primarily on practices following the death of a child in a Child Protection context, which was noted to be "the worst fear for Child Protection workers."[237] However, the Review also recommended that further information could be added to the Casework Practice Manual guidance for Child Protection workers supporting children with disability, including what minimum actions (if any) staff should undertake and where staff can consult within Communities to access specialist advice. Accordingly, the Review recommended Community Services Division should consider reviewing the relevant section of the Manual to capture more specific guidance.[238]

221. Further information was provided by Communities in submissions to the Court as to Communities' current response to children with a disability and high care needs, interactions with the NDIS and proposed changes to practice guidelines arising out of this inquest. Communities advised that on 18 September 2023, Child Protection staff were informed of two new entries created and published to the Casework Practice Manual in relation to Medical Child Abuse and Medical Neglect. The new entries are designed to promote a consistent child-focussed approach to assessing and responding to medical child abuse concerns, with the key messages including that:[239]

- Younger children are more at risk of medical child abuse;

[234] Exhibit 3.
[235] Exhibit 3.
[236] Exhibit 3.
[237] Exhibit 3, p. 9.
[238] Exhibit 3.
[239] Submissions filed by Department of Communities dated 24 November 2023.

- Communities has a statutory role to investigate and determine whether the child has experienced physical, emotional or psychological harm that has a detrimental effect, and is significant in nature, due to medical child abuse; and
- In cases of medical child abuse, collaborative efforts with health professionals/medical practitioners are vital to understand the medical issues and potential consequences for the child.

222. Communities has also provided additional guidance in the Casework Practice Manual for staff who are supporting children with a disability and working with the NDIS. They are specifically focussed on children already in the CEO's care, but it was indicated that the guidance also provides information of a general nature for staff involved in all cases involving a child with a disability. Further, Communities advised they are progressing work to include delivery on Western Australia's commitment to actions for the *National Framework for Protecting Australia's Children*,[240] working towards the shared goals of making substantial and sustained progress to reduce the rate of child abuse and neglect and its impact across generations. The National Framework identifies children and young people with a disability as one of four priority groups under the framework, with several actions relating to disability. In particular, it involves:[241]

- improving the mechanism between the NDIS and child and family services (including Child Protection);
- developing practice guidance, training and implementation of support for child and family services to increase staff capability in understanding, identifying and working with people with disability; and
- strengthening the interface between policies and service systems supporting children and families, and those addressing the social determinants of child safety and wellbeing.

223. As for the conduct of the individual staff in this matter, evidence was given that the decisions they made, and their conduct overall, was in line with the Department's expectations and within the broad policy and guidelines, as well as within the limits of the resources available. It was acknowledged that if the deceased had been viewed as falling more broadly into the 'high risk infant' category due to his developmental age, as compared to his chronological age, then might have prompted more intense supervision at an earlier stage, but other than seeking a warrant for entry from a magistrate based on immediate safety concerns or asking the police for assistance with a welfare check, there would still be no power to force entry without the consent of the deceased's mother. It was felt that the Child Protection staff members had appropriately responded to the seriousness of the situation, based on what was known at the time, and were on the right path in terms of directing the family towards the intensive family support team, but sadly things were worse than the information suggested and the deceased died before that could be progressed.[242]

[240] *Safe and Supported: the National Framework for Protecting Australia's Children 2021 – 2031.*
[241] Submissions filed by Department of Communities dated 24 November 2023.
[242] T 200, 204 - 206.

224. Mr Brendan Mooney, the Regional Executive Director for the South-West for Communities at the time of the inquest, also gave evidence about a recent jointly funded initiative with the Department of Health. Known as the Health Navigator pilot programme, the initiative involves helping caseworkers and carers and older children navigate through the healthcare system. It has been found to improve the speed of health assessments and improve pathways to specialists for children with complex needs. The programme is currently being piloted with about 40 families in the south west of this State.[243] It is not directly related to the deceased's case, but it is an indicator of the way Communities and Health can work together to improve health care for children with complex needs like the deceased.

225. I am advised that in February 2023, Communities' Leadership Team approved the allocation of two fulltime FTE's to implement a formalised and consistent approach to undertaking internal reviews of Communities practice following certain deaths of children who were either in the care of the CEO or who were open to Communities at the time of their death, with a high priority for children whose deaths will be subject to a mandated coronial inquest. The results of the review can then be included in coronial reports to assist the Coroner at the inquest. Oversight of the internal review processes will be performed by a System, Practice and Review Committee, chaired by the Communities' Chief Practitioner, Specialist Child Protection Unit. The Committee held its inaugural committee meeting in May 2023, with future meetings planned to be held quarterly. I understand the purpose of this Committee is to track, monitor and ensure oversight of the implementation of recommendations made by the Ombudsman WA and the WA Coroner's Court.

226. With those processes in mind, I make the observation that reports provided to the Coroner's Court in the past by Communities have been primarily chronological accounts of the factual events that occurred in the course of Communities' involvement with the deceased child, without any critical analysis of how the care was provided. Whilst the chronology is always helpful, I understand that the new internal reviews are intended to analyse Child Protection practice in the context of a particular case to determine whether Communities' involvement was in accordance with Communities' legislation and practice guidance and the reviews will support ongoing learning and promote accountability amongst Communities' management and Child Protection staff. This will be of significant assistance when considering whether any recommendations should arise out of an inquest.[244]

GENERAL COMMENTS

227. Whilst it is not mandatory for me to make comment on the deceased's treatment, supervision and care at the time of his death, I consider it appropriate given the Department of Communities had an open case due to significant concerns about his mother's capacity to provide him with appropriate care and keep him safe. Sadly, the events demonstrated those concerns were well founded and his mother was not, at that time, capable of provide appropriate care for such a vulnerable child. His younger sister was able to advocate for herself and agitate to get someone to come

[243] T 218.
[244] Submission from Department of Communities dated 24 November 2023.

and rescue her, but due to his profound disability, the deceased was not. He was left alone with his mother and died while in her care. Therefore, I consider the decision-making that led up to the deceased being returned to his mother's care, and the level of supervision in those last days, was sufficiently connected to his death to require comment.

228. From the perspective of the police, who came into contact with the deceased's mother on the day of the deceased's death, both police officers emphasised that they took the case seriously, as it was unusual to find a person so intoxicated on a weeknight, and the child-related items in the car had prompted them to ask some questions. However, the deceased's mother was not forthcoming and there was nothing obvious to suggest a child might have been left in an unsafe environment. As two men who are not only trained police officers, but also men with their own family responsibilities, they made it clear they would have responded very differently if they had been alerted to the fact there was a child left unattended.

229. Senior Constable Munckton commented that as a father and grandfather it was "quite heart-wrenching"[245] to find out about the death of the deceased and he had reflected upon what else he might have done differently, but was satisfied there was nothing that he would have done differently, knowing what they did at the time.[246] In any event, it became clear that nothing the police could have done would have changed the tragic outcome in this case, only the amount of time that would have elapsed before the deceased's body was discovered.

230. As for the involvement of Communities in the lead up to his death, Child Protection staff had appeared to understand that the deceased required constant care and that in his final months his mother's ability to provide safe and appropriate care from him was diminished. However, it seems they had not, at that stage, understood how seriously things had deteriorated at home, at least in those last few days.[247]

231. This contrasted with the evidence of Ms G, who was very concerned around the time she gave the children back that their mother was not in a fit state to care for them. Ms G was not in a position to continue to care for the children herself due to her own family and work commitments, so she felt she was "up against a wall."[248] Ms G said she felt she had to trust that Child Protection staff would monitor the situation closely, although she remained very concerned, particularly when she began receiving the texts from the deceased's sister a few days after relinquishing their care. Her fears were proven to be well founded. Ms G emphasised that she was sympathetic to the difficulties faced by the individual Child Protection staff members and did not wish to blame anyone, but she also said thought that she felt more could have been done by Child Protection staff on the day LM was messaging her begging for help, to confirm that both LM and the deceased were safe, which may have led to a different outcome.[249]

[245] T 26.
[246] T 26 – 27.
[247] Exhibit 1, Tab 16 [8].
[248] T 77.
[249] T 75 – 77.

232. There was evidence at the inquest that the deceased's mother would generally not answer telephone calls and would only respond to text messages. This was said to be common to a lot of the parents involved with Communities.[250] Ms Papaluca gave evidence it is extremely frustrating to have to engage by text message as "you don't get the same sense of a situation in a text message"[251] and you have to make certain assumptions, but ultimately they have to work with whatever communication preference the family dictate. It does seem that the method of communication masked some of the issues for the family, as the deceased's mother was able to provide misinformation without the chance it would be subject to verification quickly. I recognise that it was difficult for Child Protection staff as they were both limited in their resourcing and in their powers to do anything while the children were not formally 'in care'. However, given it was known that the children's father would often choose to take only the deceased's sister, and it was obvious from LM's texts that the situation with their mother had deteriorated, more should have been done to confirm that the deceased was safe.

233. Ms Palmer was very complimentary of her interactions with Child Protection staff, describing their response to her concerns as "brilliant"[252] when she raised concerns. However, Ms Palmer also recognised that the Department of Child Protection staff are always working under a massive amount of pressure with limited resources, and she considers they are "way too stretched."[253] Ms Palmer was similarly very complimentary of his care by Ms G, noting that during the three weeks he was with his great aunt, the deceased's school attendance was good and he seemed happy and showed an overall improvement in his wellbeing.[254] This noticeable change demonstrated that there was a level of neglect occurring when he was in his mother's care, as when he was with a diligent caregiver, many of his issues quickly resolved.

234. Ms Wood commented that "sadly on a systemic level, if we brought children into care every time we suspect a parent is abusing drugs, there would be more a crisis in out of home care in this state than there already is."[255] While I accept that as a proposition, the Department's own review noted that the Communities' Casework Practice Manual specified that Child Protection staff must take additional measures to protect a child with disability who is vulnerable to abuse, including neglect, such as the deceased.[256] Given the deceased's level of disability, he was particularly vulnerable to harm if subject to neglect, as he required full-time supervision and could not in any way provide for his own needs.

235. Ms Wood gave evidence that the Communities' team were very conscious of the deceased's level of needs, but they felt the deceased's mother had demonstrated she had the capacity to care for him, given her past track record. They hoped that if they put enough supports in place, they could get her back on track. Ms Wood also noted it was unlikely they would have been able to place the children together if they were removed, as they were struggling to find foster placements for all children at the

[250] Exhibit 1, Tab 17 [75].
[251] T 149.
[252] T 88.
[253] T 90.
[254] T 88; Exhibit 1, Tab 22.
[255] T 113.
[256] Exhibit 3.

time, and finding a place for a child with the deceased's complex needs would have been an additional challenge. He would, therefore, most likely have been placed in a group home separately from his sister. However, at the time this was not at the forefront of their mind, as they really hoped they could put the resources in to keep the children in their mother's care. [257]

236. Ms Papaluca also gave evidence that the option for the deceased if his parents had relinquished care was likely to be care in a group home setting, with a number of other children with high care needs, rather than a foster home at that time. Ms Papaluca commented on the "dire situation with getting carers," both then and now, which has made things very hard. She noted that there is an out of home are reform underway to move to a needs-based model, so they are matching children with the placements they need, but if anything it is potentially leading to less placement options for a child with complex needs like the deceased, not more.[258]

237. I expressed my view that in a case like the deceased's, being a child with complex care needs and concerns are being raised about the caregiver's capacity to care for them, it would be appropriate for a medical review to take place to ensure their needs are being met. Ms Wood agreed that this would be a reasonable step to take in a future case.[259] Ms Papaluca also agreed that in hindsight, with additional information about the missed appointments for the deceased, she would have felt differently and would likely have prompted a medical check. She did note that she requested the deceased's mother to take him to his GP in the last days of his life, when he was reported to be unwell, but she agreed a more comprehensive health assessment would have been appropriate at an earlier stage. It was pointed out that it is a requirement that a child has an initial health assessment when coming into care, so if the deceased had been taken into care, that would have occurred, and Ms Papaluca had thought she would have made a similar recommendation when he otherwise moved to the intensive family support team. However, while there was still a question about whether he would be taken into care, it was not considered by them to be a necessary step.[260]

238. As it was, Ms Wood and Ms Papaluca were unaware that the deceased had not been taken to see his cardiologist since November 2019 and he had not been examined by a GP since early 2021. Ms Wood gave evidence Communities will often become involved in a case where the referred is Perth Children's Hospital, if a family has not followed up on the medical needs of children and the health staff have concerns, but that had not occurred in the deceased's case, noting they did not understand there were any immediate medical concerns for the deceased, although they were aware he was at risk of sudden death at any time, based on his known health conditions.[261]

239. I acknowledge the evidence of Dr Cooke was to the effect that the deceased had very significant heart disease and he thought it unlikely anything more could have been done for him from a surgical point of view. Given the level of scarring and

[257] T 125 – 127.
[258] T 175 - 176.
[259] T 126.
[260] T 161 - 162.
[261] T 130, 146.

calcification and noting he had already undergone surgery, Dr Cooke thought a cardiothoracic paediatric surgeon would be very cautious about recommending further surgery.[262] Nevertheless, the lack of any recent cardiology review of the deceased, along with any other kind of general paediatric review or even a full health assessment by a GP, was concerning given the allegations of neglect.

240. Ms Wood has reflected at length on this case, given its tragic outcome. She indicated she felt incredibly disappointed at the adults in the deceased's life, who should have been his first protectors and carers. Whilst she was obviously devastated at the news of his death, she felt the Child Protection staff did what they could with the information that was available to them and within the systems they were working in. Ms Wood explained that at the relevant time, her team were very stretched as they were managing an unallocated list of anywhere between 30 and 50 families (which could conservatively mean 80 to 100 children) on top of their usual caseload of about 12 cases each. However, Ms Wood expressed her opinion that Ms Papaluca still went above and beyond for the deceased's family, and her involvement with the family was particularly intense in the weeks leading up to his death. Ms Wood commented that she did not think they could have done any more on this case, even with more resources, as they were putting everything into it, despite their stretched resources.[263]

241. In Ms Wood's opinion, the outcome may have changed if the deceased's father had been more forthcoming about the deteriorating home situation when he went and collected LM. This information would have allowed Communities to respond differently.[264]

242. Ms Papaluca also gave evidence about her shock and distress when she was informed of his death, and indicated she had reflected on the conduct of Child Protection staff. She gave evidence she was confident in the decisions that her team made, based on the information they had at the time. There was obviously a lot of information they were not privy to, that might have changed things, but they only learned of those things later. Ms Papaluca indicated this experience has made her hypervigilant in other cases, as it has made it hard for her to trust herself as she keeps wondering what she missed. It has also affected her trust in others as well, given her disappointment in some of the support network members involved.[265]

243. Ms Papaluca gave evidence that she was "so baffled by [the deceased's mother's] presentations across the assessment"[266] as she was aware that the deceased's mother was extremely avoidant of contact with Child Protection staff but her messages were generally coherent, whereas her physical presentation was varied. Ms Papaluca said it was "truly baffling to try and ascertain what was going on"[267] for the deceased's mother and why she was presenting in that way. Ms Papaluca gave evidence she had been shocked when the testing from the hospital had come back with no obvious cause for her presentation, as the deceased's mother had seemed confused and a little delirious but very compliant and easily directed, which was very different to her

[262] T 191.
[263] T 123 - 127.
[264] T 127 - 128.
[265] T 167 – 168.
[266] T 150.
[267] T 150.

usual aggression and heightened behaviour. It had given Ms Papaluca the impression she had some intellectual capacity issues or mental health issues, rather than an obvious drug presentation (particularly given it was known she usually used methylamphetamine), but she was also aware the deceased's mother had no history of mental health or cognition issues, so it had been hard to understand why she seemed dazed and confused. The lack of a diagnosis from the hospital had been perplexing and made it harder for the Child Protection staff to predict what might happen next.[268] Ms Papaluca also noted that the deceased's mother had been quite fixated at the time on trying to get her other child returned to her, which had been a distraction.[269]

244. In terms of moving forward, Ms Papaluca indicated she is aware that there is now a huge focus on high-risk infants, being children from newborn to the age of three years, as they are considered the most vulnerable and do not have a voice. In those cases they will seek regular updates from child health nurses and weekly visits from Child Protection staff. Ms Papaluca indicated she would consider a child like the deceased to be equivalent to a high risk infant, despite his age, given his inherent vulnerability. In those circumstances, the more intensive visits would be implemented. Nevertheless, Ms Papaluca noted that in the case of the deceased, both she and Ms Wood had been conscious of the deceased's vulnerability due to his developmental age and complex needs, so much of what would occur in the current space occurred then. A significant change for her, however, would be to try to arrange for a similar child to have a medical assessment at an early stage.[270]

245. Both Ms Wood and Ms Papaluca expressed deep sadness for the outcome in this case. Ms Wood, noted that for the team involved, "the impact is enormous"[271] and while she would not compare their grief to that of a family member, she did say that they have as a team grieved for the deceased and the heartbreaking outcome in his case.

246. Ms Papaluca commented that child safety was then, and always is, a primary concern for all of the Child Protection staff, so the loss of a child like the deceased in such tragic circumstances was deeply distressing and "the most heartbreaking case of [her] career."[272] Ms Papaluca gave evidence that she remains devastated and thinks about the deceased every day when she is doing her work, noting that she considers her work to be a privilege, working for better outcomes for children every day, and it is clear she keeps the memory of the deceased with her when trying to help all of the other children who for various reasons require support from Communities.

247. Ultimately, I accept that there was always a risk that the deceased could die suddenly, due to his underlying health conditions. There is no way of knowing if he succumbed to a sudden medical event not long after his sister left the house, or if he died following a longer period of neglect while his mother was intoxicated and oblivious to the fact that he was still at home, alone in his room.

[268] T 150 – 151.
[269] T 169.
[270] T 170.
[271] T 143.
[272] T 177.

CHANGES AND RECOMMENDATIONS

248. At the conclusion of the inquest, I discussed with counsel for the Department of Communities my belief that there is a gap in their policy for a child like the deceased, who was not by definition a high risk infant due to his biological age, but who was a highly vulnerable child with complex needs. Counsel for Communities agreed with this assessment.[273]

249. I sought written submissions from Communities at the conclusion of the inquest on whether their policies and guidelines have been amended in the wake of this death. I received a submission from the Acting Director of the Central Review Team – Specialist Child Protection Unit, Mr Nigel Van Santen, in response. Mr Van Santen confirmed the information in the Internal Review about the two new entries created in the Casework Practice Manual (CPM) related to *Medical Child Abuse*[274] and *Medical Neglect*[275] and referred to the sections of the CPM that provide guidance for staff supporting children with a disability and working with the NDIS, namely sections 3.4.28 *Supporting children with a disability* and 3.4.29 *Working with the National Disability Insurance Scheme*.[276] I was also advised that Communities has a dedicated project team within the Specialist Child Protection Unit which is focussed on delivering, from a State perspective, on the National Framework *Safe and Supported*.

250. In addition, following this inquest, Mr Van Santen advised that Communities has committed to strengthening the CPM entries to include guidance for Child Protection staff on:

- Requesting information from hospitals or health services providers for children with a known disability/complex health or medical needs,
- Highlighting the need for regular sighting of children with an increased vulnerability due to disability/complex health or medical needs by Child Protection staff; and
- Specifications for Child Protection staff on how to report suspicion of fraudulent use of NDIS funds.

251. I have recently been informed these updates to the CPM are now complete and are contained within sections 2.2.4, 3.4.28 and 3.4.29 of the CPM. The changes emphasise the need to request relevant health information as early as possible for children with a disability or chronic health issues and ensure such children are prioritised and visited more regularly. In addition, guidance is provided that neglect includes refusing the child access to remedial and therapeutic care required to support a child with a disability, and this encompasses redirecting funds away from

[273] T 220.
[274] Casework Practice manual section 2.2.23.
[275] Casework Practice manual section 2.2.24.
[276] Submission from Department of Communities dated 24 November 2023.

the child's NDIS plan to for other purposes, which should be reported as fraud on the NDIS portal if suspected.[277]

252. I had indicated at the conclusion of the inquest that I was minded to make some recommendations in a similar vein, if I felt it was required. However, I am satisfied that the changes made independently by Communities are generally sufficient to address the concerns raised in this inquest. The only area I consider requires some further guidance is the aspect of prompting an overall health assessment if there are concerns about neglect and there is limited information about the current health status of a child with a disability or chronic health issues available, either because the child has not previously been medically assessed or not recently. I understand once the child is taken into care, they will automatically receive an overall health assessment to establish a baseline for their ongoing care, but I consider in the case of a child with a disability or chronic health issue, it may be important for that assessment to occur at an earlier stage while there is an open case, in order to inform the decision-making. Therefore, Child Protection officers should encourage and support a parent or caregiver to facilitate such an assessment, if there is limited recent health information available.

Recommendation

I recommend that the Department of Communities consider further updating their Casework Practice Manual section 2.2.4 to include guidance on encouraging a general health assessment to be completed by a general practitioner where a child has a disability or chronic health issue and there is no recent relevant information about the child's health and there are concerns about neglect.

CONCLUSION

253. The deceased was a little boy with very significant care needs who was let down when his parents, who were going through their own personal issues, failed to ask for help. As a result, we don't know exactly when or how he died, only that he died alone in his room and no one realised. When his body was discovered by his great aunt on his bedroom floor, the deceased was alone in an empty house with the front door wide open. His mother had been hospitalised the night before in a psychotic state and no one knew what had happened leading up to this point. Police immediately became involved as it was unclear whether someone else was involved directly or indirectly in his death or whether he died by natural causes, accident or some other manner.

254. Following a comprehensive post mortem examination, an extensive police investigation and an inquest, we unfortunately still know very little about what happened in the last hours of the deceased's life. The evidence indicates the deceased

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died alone in his room sometime after 5.00 pm on 17 August 2021 and before 5.54 pm on 18 August 2021 while his mother was in the house, but intoxicated and unwell. She did not realise he was home with her until she received a message from Child Protection staff on the afternoon of 18 August 2021. When the deceased's mother went to check on him, he was lying facedown in his cot, unresponsive. After she took him out of his cot and realised he had died, she drank more alcohol then left his body alone in the house and went out. Homicide Squad detectives concluded there was no evidence the deceased's mother directly caused his death.

255. It is possible the deceased may have died suddenly sometime after his sister left the house the previous night from a medical event. He may also have died after being left alone untended in his cot for a number of hours and becoming dehydrated and malnourished. Either way, I am satisfied he had been deceased for a number of hours when his mother found him in his cot in the early evening of 18 August 2021. I am unable to make a finding as to his cause of death, so it must remain unascertained. This limits my ability to reach a finding as to his manner of death, which must remain open.

256. As for the involvement of Communities in the deceased's care leading up to his death, I have expressed some concern that he was returned to his mother's care several days before his sudden death, given there had been ongoing concerns raised about possible neglect in the context of his mother's possible drug or mental health issues. However, I accept there was limited evidence as to what was causing his mother's presentation at that time and Child Protection staff were balancing the outcomes for the children if they were removed from their mother's care against the risks of leaving them in her care by trying to create an appropriate support network around her. The deceased's mother had been able to care for the deceased appropriately for many years, so they were hopeful they could support her to get back on track, rather than be forced to remove the deceased, which would involve separating him from his sister and likely placing him in a group care home.

257. With the benefit of hindsight, it is clear that the deceased's mother had lapsed into serious substance abuse issues, which had deprived her of the ability to properly care for her son, who was extremely vulnerable and needed an attentive and sober caregiver at all times. I am not critical of any of the individual Child Protection staff, as it is clear they were doing their very best in difficult circumstances. The deceased's death has impacted them all very greatly, and I don't want to make their difficult jobs any harder by unfairly placing any blame upon their shoulders.

258. However, from a more overarching perspective, in my view there was a need for the Department of Communities' staff to identify the particular vulnerability of the deceased. He was a child with significant health issues, complex care needs and no ability to speak for himself, which made him more vulnerable to neglect than an ordinarily abled child of his age. When repeated concerns were raised by multiple extended family members and the Principal of the deceased's school, there should have been a framework surrounding his case that prompted the staff involved to try to have his health properly assessed, as he was known to be at risk of certain health conditions and showed obvious signs of physical neglect in terms of chronic nappy rash and sores. Such an assessment may have identified aspects of cumulative harm

that could not be established verbally. I accept it may ultimately have made no difference to the tragic outcome in this case, but without a health baseline being established, it has made the task of determining how he died that much harder in this case.

259. I also accept that the focus of Communities is on supporting families to stay together, but in this case the deceased's parents were not capable at that time of putting his significant needs ahead of their own. While there were limited options available to place the deceased elsewhere, he deserved to be cared for in a place where he was kept safe and supervised properly and given every opportunity to live a full and happy life within the scope of his abilities, not to be left to die alone and forgotten.

260. This was a very sad case for all involved, and I am confident lessons have been learnt for the future.

S H Linton
Deputy State Coroner
4 April 2024