QUEENSLAND COURTS

OFFICE OF THE STATE CORONER

Non-inquest findings of the investigation into the death of LB

CITATION:	**Investigation findings into the death of LB**
TITLE OF COURT:	Coroners Court
JURISDICTION:	Cairns
FILE NO(s):	2012/2849
DELIVERED ON:	9 December 2014
DELIVERED AT:	Cairns
FINDINGS OF:	Jane Bentley, Northern Coroner
CATCHWORDS:	Death of a baby, inappropriate response of the Department of Communities, Child Safety and Disability to child protection concerns

At the time of his death LB was six weeks old. He and his twin brother were born at 34 weeks gestation in June 2012 at the Cairns Base Hospital.

LB and his brother spent four weeks in hospital after his birth and then resided with his mother, his twin brother and his sister, aged two years, at an address in Cairns.

At 6:52am on 10 August 2012 LB's mother called the Queensland Ambulance Service and advised that he had stopped breathing. Paramedics arrived at the residence at 7:05am and transported LB to the Cairns Base Hospital where he was pronounced deceased at 8:02am.

The mother told police that she was feeding LB a bottle of formula at about 6:00am when his right foot started to spasm. He then began to convulse, turned white and stopped breathing. She said that she phoned QAS and commenced CPR after receiving advice from the operator. She said that LB had been well in the days prior to his death.

An autopsy revealed that LB died from a subdural haemorrhage. The pathologist noted:

> *This child has asymmetry of the head consistent with a blow to the left side of the face and internal examination of the head demonstrated a bilateral subdural haemorrhage. There may also be an intra-cerebral haemorrhage at the left side (to be further evaluated by fixation, followed by neuropathology). There was also internal bleeding associated with the frenulum of the lower jaw, this appearance being consistent with a severe slap or similar to the left side of the face. There is a separate injury which is well demarcated at the right side of the forehead.*
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> *In my opinion, this child has had a substantial blow to the left side of the face and the neuropathology demonstrated by this child is, in my opinion, entirely consistent with such trauma to this infant.*

The medical evidence was further reviewed by a Consultant Paediatric Radiology Consultant who found multiple rib fractures (which were about 10 days to two weeks old), multiple brain tears and bleeding (which were one to two days old).

Queensland Police Service investigation

Police obtained information from friends and associates of the mother and also obtained CCTV footage from Smithfield Shopping Centre recorded on 9 August 2012. The footage depicts that at about 5:29pm the mother reached into the pram in which the twins were lying and made a violent movement. Shortly after this she reached into the pram again and placed her hand over the chest of one of the twins and moved her hand back and forward quickly. The baby could be seen to move back and forth accordingly.

Police interviewed the mother on 17 August 2012 and she stated that LB started having a fit when she was feeding him a bottle.

On 19 September 2012, police again interviewed the mother. She stated at this time that the night before LB died she put him to sleep on a single bed in another room to sleep. Previously she had stated that he was asleep in the cot. She said that she placed him on the bed with some pillows and towels around him. She said that at about 3:00am she found him lying on the floor beside the bed. She could not provide any explanation for LB coming to be on the floor.

On 3 October 2012, employees of Department of Child Safety went to speak with the mother about her surviving children. During the conversation the mother told them that she had slapped and shaken LB.

Police interviewed the mother again that afternoon. She said that she slapped LB once and shook him a few days before he died. She said she slapped him reasonably hard on the cheek.

On 17 January 2013, the mother was charged with the murder of LB.

On October 2014, the mother entered a plea of guilty to the manslaughter of LB and was sentenced, in the Supreme Court at Cairns, to seven years imprisonment with eligibility for parole on 17 May 2015.

Child Protection History

LB and his twin brother were the youngest of nine children born to the mother. At the time of his death LB, his twin brother and their half-sister, aged 22 months, were the only children in the care of the mother. Her six older children were in the care of relatives.

The mother had been known to the Department of Communities, Child Safety and Disability Services (the Department) for approximately 15 years. The child protection history included seven Notifications, six Child Concern Reports and Additional Notified Concerns.

Departmental records contain consistent allegations of serious physical abuse by the mother against her other children over a number of years. Other concerns related to substance abuse, domestic violence, neglect and sexual abuse of one of the children by one of the mother's previous partners.

When the mother was pregnant with LB and his twin brother three of her other children were being cared for by their father and three were being cared for by their maternal grandmother. These care arrangements were as a result of the mother's ability to care for those children and the lack of allegations of her physical abuse and neglect of those children.

On 4 May 2012, the maternal grandmother advised the Department that she was unable to care for the three children currently in her care due to her ill health. She advised that they should not be returned to their mother and that the mother had the 19 month old in her care and she was pregnant.

The Department carried out an investigation and concluded that the three children could not be returned to the mother's care as she showed no insight into the children's needs or capacity to care for them.

The three children were placed into a short term placement and then returned to the maternal grandmother.

On 27 July 2012, the Department received information from a notifier about the mother's care of the twins and their half-sister. The notifier contacted the Department by telephone and also sent a facsimile outlining the following concerns:

- The mother was intoxicated whilst holding one of the babies.
- The mother did not attend to the babies when they were crying.
- One of the babies had a 4cm scratch on his hand and the mother could not explain how it occurred.
- When changing the baby's nappy the mother handled him roughly and did not support his head.
- The mother was unreceptive to support services.
- One of the babies was left crying for a significant period of time.

On 31 July 2012, the Department recorded the information as a Child Concern Report on the basis that there was 'insufficient evidence to demonstrate significant physical and/or emotional harm to the children due to the actions/inactions of their caregiver'.

On 31 July 2012, the notifier provided the Department with additional information in relation to the mother's care of the babies and their half-sister when the babies were in the Special Care Birth Unit of the hospital following their birth:

- The mother hit the sister and threatened to put her head down the toilet.
- The mother consistently demonstrated an unwillingness and inability to care for the twins.
- The mother avoided services and did not accept a referral to a support agency as she did not want to be told how to do things.
- The mother had been aggressive towards health providers.
- A psychologist from Community Health had previously raised concerns with the Department in regard to the mother's parenting and considered that she had no reflective parental capacity.

On 6 August 2012, the notifier again contacted the Department to advise that the mother had declined a health service follow-up for the twins.

Based on the new information, on 7 August 2012 the Department reassessed the concerns of 31 July 2012 and recorded a Notification with a 10 day response timeframe. The required investigation and assessment process had not been commenced at the time of LB's death.

The actions and response of the Department were the subject of an internal Systems and Practice Review and that Review was the subject of review by the Child Death Case Review Committee (CDCRC).

The initial review identified concerns in relation to:

1. the decision to record the information received from the notifier on 27 July 2012 as a Child Concern Report; and
2. the delay in processing and assessing the information received on 31 July 2012.

In relation to the first concern, the review found that further information should have been obtained from Queensland Health before the decision was made to record the information as a Child Concern Report rather than a Notification (which would have resulted in further investigation and assessment). Insufficient information was gathered and limited critical analysis undertaken to make a fully informed decision as to the most appropriate response to the child protection concerns received. The information provided by the notifier was clearly sufficient to indicate the need for further information to be gathered taking into account:

- the mother's extensive child protection history over a period of 15 years
- the child protection history within the preceding two years included allegations of leaving children unsupervised, failing to engage with support services, mental health and substance misuse issues
- the mother was known to be the sole carer of three children under two years and had been observed to be affected by and smelling of alcohol
- the written information provided by the notifier outlined similar concerns by staff from the extended midwifery service and this could indicate a pattern of concerning behaviour.

The review found that on 27 July 2012 there were sufficient risk factors to suggest that LB, his twin brother and their half-sister were at risk of harm.

In relation to the second concern, the review found that the matter should have been recorded with a five day response timeframe.

The review noted that Departmental staff in the region who had been involved in the decision making process were overworked at the time and, 'the large volume of work was a significant barrier to consistently being able to undertake and complete intakes of the highest quality'.

The CDCRC noted that the Department was aware of the risk factors present for LB given the mother's long history with the Department. The Committee considered the failure of the Department to record a Notification in May 2012 when it became aware of the mother's pregnancy and the Department's poor handling of the information received in July 2012 meant that LB remained in an unsafe environment that ultimately led to his death.

The Committee found:

- the Department knew about the significant child protection concerns
- the Department did not act adequately to ensure the safety of LB
- significant level of risks associated with LB continued and escalated until his death
- there is no reasonable excuse why the Department did not adequately protect LB
- LB may not have died had the Department discharged its obligations.

The Committee concluded that the inactions of the Department were linked to LB's death.

The Committee made the following recommendations:

1. The case be referred to the Department's Ethical Standards Unit.

2. The Department considers and implements strategies to provide practice and personal support to both the management and front-line staff of the Regional Intake Service and the Customer Service Centre who have been involved.
3. The Committee's report be provided to staff who participated in the review, the Director, Child Protection Development and the Director, Organisation and Workforce Development.

The Department has complied with and implemented the above recommendations:

1. The case was referred to the Ethical Standards Unit on 6 May 2013 and the investigation, which was completed in December 2013, identified that the issues were systemic in nature.
2. The department reviewed its practices and rolled out a number of improved training sessions, monitoring and structural changes to front line service delivery.
3. The internal Systems Practice Review Report and the external DCDRC report were provided to the relevant officers on 17 May 2013.

The Department has also independently implemented further changes within the Region to specifically address the circumstances of the death of LB:

1. Reports of physical injury or neglect relating to a child under the age of 18 months must be discussed with a Senior Team Leader immediately.
2. There is ongoing monitoring of workloads and experience of staff in the Regional Intake Service.
3. Staff are now rotated between the Regional Intake Service and the Customer Service Centre to vary their workload and provide them with more experience and professional development.
4. The backload of the Regional Intake Service has been addressed by support from other workgroups in the far north region.
5. Staff have received training and a new regional supervision framework is being developed.

The Department referred the death of LB to the Queensland Child Protection Commission of Inquiry. Many recommendations were made as a result of the Inquiry and many of these are in the process of implementation by the Department.

I find that LB died from a subdural haemorrhage. That fatal injury was inflicted on him by his mother.

I find that the inappropriate response of the Department of Communities, Child Safety and Disability to information received about child protection concerns in relation to LB meant that he remained in the unsafe environment in which he was ultimately killed. At the time Departmental employees dealt with the notifications regarding LB they were overworked and understaffed and this contributed significantly to the poor decision making.

Jane Bentley
Northern Coroner
Cairns
9 December 2014