Coroners Act 1996
[Section 26(1)]

Western *Australia*

RECORD OF INVESTIGATION INTO DEATH

Ref: 50/17

I, Sarah Helen Linton, Coroner, having investigated the death of ***LCTM*** *with an inquest held at the* ***Bunbury Courthouse*** *on* ***11 – 13 December 2017*** *find that the identity of the deceased person was* ***LCTM*** *and that death occurred on* ***24 February 2014*** *at* ***Princess Margaret Hospital*** *as a result of* ***complications of head injury*** *in the following circumstances:*

Counsel Appearing:

Ms S Teoh assisting the Coroner.
Ms J Shaw together with Mr W Fitt (State Solicitor's Office) appearing on behalf of the Department of Communities,[1] the WA Country Health Service, the Department of Justice[2] and the WA Police.

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[1] Formerly known as the Department of Child Protection and Family Support.
[2] Formerly known as the Department of Corrective Services.

SUPPRESSION ORDER IN PLACE

There is a suppression order in place in relation to the deceased's name for the purposes of publication. The deceased is generally referred to as LCTM, Baby L or the baby throughout the finding.

There is a suppression order in place in relation to the deceased's father's name for the purposes of publication. He is generally referred to as LCM or Baby L's father throughout the finding.

There is a suppression order in place in relation to the deceased's mother's name for the purposes of publication. She is generally referred to as CTB or Baby L's mother throughout the finding.

INTRODUCTION

1. Baby L was born six weeks premature on 21 January 2014 at Bunbury Regional Hospital. He remained in hospital for several weeks after his birth for medical reasons related to his prematurity.

2. Baby L was the first child of his teenaged parents. Baby L's father was in the care of the CEO of the Department of Child Protection and Family Support (the Department) and he had a history of substance abuse, violence and crime. His relationship with his girlfriend, Baby L's mother, was highly volatile and suspected of being marred by domestic violence.

3. Due to these identified issues, the Department had been involved in pre-birth planning with the couple and remained involved following Baby L's birth. Departmental staff had coordinated two Signs of Safety Meetings to work out a plan for Baby L's discharge from hospital that was intended to ensure that he was safe.

4. In the meantime, Baby L's mother was able to visit Baby L in the hospital. For most of that time his father was also permitted to visit him.

5. On 5 February 2014 the Department decided that there was insufficient evidence to take action to remove Baby L from his parents' care and a plan was developed for Baby L to be discharged home with his parents. In preparation for that event, it was arranged that Baby L's mother would stay on the ward for two nights in order to learn mother-crafting skills and gain confidence. His father was also permitted to stay with them during visiting hours.

6. On 15 February 2014 the deceased's parents collected Baby L from the nursery and took him to their room at the hospital. His mother left the room, leaving Baby L's father alone with the baby. This was the first time Baby L's father had been alone with Baby L. In a timeframe of three to ten minutes Baby L's father deliberately struck the baby's head against a hard surface in the room with considerable force at least twice. These blows fractured Baby L's skull and caused severe brain injuries.[3] He did not go and seek assistance for the baby but remained with him in the hospital room.

7. When Baby L's mother returned to the room she realised Baby L was not breathing and rushed him to the nursery where efforts were made to resuscitate him. Baby L was subsequently transferred to Princess Margaret Hospital for further treatment.

8. On 16 February 2014 Baby L was taken into the provisional care and protection of the CEO of the Department. Sadly, Baby L could not recover from his severe injuries and he died on 24 February 2014 as a result of complications of his head injury.

9. As Baby L was in the Department's care when he died, a coronial inquest is mandatory and I must comment on his care, treatment and supervision prior to his death.[4] I held an inquest at the Bunbury Courthouse on 11 to 13 December 2014.

10. Prior to the inquest Baby L's father, LCM, was convicted of manslaughter in relation to Baby L's death, so the circumstances of his death were already largely established.[5]

11. As noted above, Baby L was only taken into care a few days prior to his death. However, given the involvement of various government agencies in pre-birth planning and thereafter, consideration was given at the inquest to the decision not to take Baby L into care at an earlier stage.

12. The documentary evidence comprised five volumes of materials, including the police investigation report and witness statements, as well as extensive documents provided by the Department and Bunbury Hospital.[6]

13. Oral evidence was heard from witnesses who were involved in caring for Baby L while he was in hospital. Other witnesses gave evidence as to their involvement with LCM and CTB, either as part of LCM being in care or on court orders, or in the context of parental planning surrounding the birth of Baby L. In addition, evidence was heard from the Department's Executive Director of Country Services and Therapeutic Care.

[3] Exhibit 1, Tab 9, p. 46.
[4] Pursuant to sections 3 and 22(1)(a) *Coroners Act* the death is deemed to be a 'death in care'.
[5] *LCM v The State of Western Australia* [2016] WASCA 164.
[6] Exhibits 1 – 5.

BABY L'S PARENTS

14. Baby L's father, LCM, had an upbringing characterised by domestic abuse, neglect, abandonment, disrupted attachment relationships, parental substance misuse and involvement in the criminal justice system.[7] LCM had been taken into the care of the Department from 2004 to 2006, before being returned to the care of his family. Sadly, his father died in 2008 and his family situation deteriorated again. LCM was eventually taken back into provisional care in April 2011, which was formalised in May 2011 with an order that he remain in care until he turned 18 years of age.[8]

15. Once back in the Department's care LCM did not have stable accommodation in which to live or proper supervision or care as many of his Departmental placements broke down due to his behaviour and on other occasions he absconded from Departmental placements, electing instead to stay with various friends or extended family members. He reportedly did not like being placed in group care with people he didn't know and rules he didn't necessarily want to follow.[9] The placement options were also limited due to his "extensive history of criminal matters."[10]

16. LCM had commenced using illicit substances at the age of 11 years and his polysubstance abuse continued at high risk levels from that time.[11] He dropped out of school in Year 8 and his literacy and vocational skills were limited.[12]

17. From April 2011 LCM's Departmental Case Manager was Megan Harvey (as she was then known) who was based in Cannington. Ms Harvey's evidence was that LCM did not engage very well with the Department and he only came and saw her when he needed financial assistance or other practical help and otherwise she generally only managed to make contact with him when he was incarcerated.[13] Ms Harvey described her contact with LCM as "very inconsistent."[14] He would generally not answer the telephone if she tried to call him and later declined to provide his telephone number to the Department.[15]

18. Ms Harvey was asked about her impression of LCM and she observed that he "was a nice kid, however, he seemed to get caught up with a lot of different people or be persuaded to do different things which led him down an unfortunate path. He didn't have a lot of family members around him that were supportive"[16] and they did not encourage him to seek support from the Department. He also had a lot of unresolved grief issues around the death of his father but was not open to counselling.[17]

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[7] *LCM v The State of Western Australia* [2016] WASCA 164 [49] (Mazza JA & Beech J).
[8] Exhibit 1, Tab 11 and Tab 16; Exhibit 5, Tab 25.
[9] T 149.
[10] T 149.
[11] *LCM v The State of Western Australia* [2016] WASCA 164 [88] (Mazza JA & Beech J).
[12] *LCM v The State of Western Australia* [2016] WASCA 164 [49] – [52] (Mazza JA & Beech J).
[13] T 149.
[14] T 150.
[15] Exhibit 5, Tab 25 [40] – [41].
[16] T 150.
[17] T 150 – 151.

19. Baby L's parents had begun a relationship sometime around the start of 2013 after CTB moved to live in Perth. The relationship remained ongoing although it was troubled.[18]

20. LCM's criminal history involved some serious offending, including offences involving violence, and he also had a number of recent charges that were pending at the time of Baby L's death. One of his last offences involved threatening Baby L's mother, CTB, with a knife at a train station. He then threw the knife at her. It missed CTB but injured an incident bystander. The incident occurred in February 2013 and he was remanded to Banksia Hill shortly afterwards and then eventually bailed to his grandmother's house.

21. There had been allegations that after moving to his grandmother's house LCM had been fighting with CTB and had injured her by cutting her on at least one occasion in March 2013.[19] LCM was visited by his case manager, Ms Harvey, and offered a referral to drug and anger management counselling at that time but he declined any referral.[20] LCM and CTB then moved to live with one of her relatives and there were allegations from this relative that they both hit one another on occasion and CTB had been seen wearing a bandage after allegedly being stabbed by LCM. LCM was also fighting with males in the household and causing problems so the relative wanted him to leave.[21]

22. On 24 April 2013 the Department applied to the Children's Court to have LCM's bail revoked as he was not residing at his bailed residence and he was subsequently reported to the police as a missing person.[22]

23. It later became apparent that LCM had been spending time living with CTB and her family in Bunbury. He was arrested in Bunbury in late July 2013 after allegedly committing some property and drug offences and was released on bail into the Department's care. CTB must have fallen pregnant around this time as she was reportedly five weeks' pregnant at the time of the court appearance on 24 July 2013. At the time Baby L's mother became pregnant she was 16 years of age and his father was 15 years of age. The pregnancy was unplanned.[23]

24. LCM's offending was escalating by this stage and his case manager, Ms Riley, was quite concerned.[24] LCM returned to Perth to live with his grandmother after the court appearance and CTB accompanied him. On 26 August 2013 LCM's grandmother spoke to LCM's case manager and said that she no longer wanted LCM staying with her as he was smoking cannabis and he and CTB were fighting. She also expressed concerns to the Department that she could no longer care for him due to his anti-social and aggressive behaviour, including property damage that had caused issues with the Department of Housing.[25]

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[18] Exhibit 1, Tab 9, p. 49 and Tab 29 [16]; Exhibit 5, Tab 25 [64], [68].
[19] Exhibit 5, Tab 24 [32] – [33].
[20] Exhibit 5, Tab 24 [39].
[21] T 154; Exhibit 5, Tab 24 [43] – [44].
[22] Exhibit 5, Tab 24 [45] – [47].
[23] Exhibit 1, Tab 20 [8] and Exhibit 5, Tab 24 [51].
[24] T 154.
[25] T 152 - 153; Exhibit 1, Tab 11 and Exhibit 5, Tab 23, Attachment 1 and Tab 24 [53], Attachment J.

25. LCM was convicted in the Children's Court on 9 September 2013 in relation to the knife incident at the train station. He was sentenced to a nine month Intensive Youth Supervision Order with Detention (Conditional Release Order) for that offence and two others. As part of the terms of the order he was required to report regularly to his supervising officer and attend substance use counselling. He was also required to inform his supervising officer of any change of address.[26]

26. It was known to the Department at the time LCM was sentenced on 9 September 2013 that LCM was to become a father. It was mentioned in Ms Harvey's report to the Children's Court and she indicated that he would be required to engage in pre-birth planning.[27]

27. Ms Harvey was intending to do the pre-birth planning with LCM together with supportive family members and engaging any other services and the maternity hospital where the baby was due to be born.[28] However, on 13 October 2013 LCM was asked to leave his grandmother's house and he then moved again to Bunbury to live with CTB and her family without informing Ms Harvey.[29] As she did not know his whereabouts, she could not start the pre-birth planning process.[30]

28. Ms Harvey became aware that LCM was residing in Bunbury with CTB and her family on 11 November 2013 after she was advised by staff from the Youth Justice Services. Following up information indicated that he was doing well and it was initially thought he was in a supportive environment.[31]

29. As for Baby L's mother, CTB, there was also a history of contact between her family and the Department, including some reports of parent-adolescent conflict between CTB and her own mother.[32] However, it was described by CTB's mother as only the "ups and downs just like any mother and daughter would."[33]

30. After LCM moved to Bunbury it does not appear that he forged strong relationships with CTB's family. He was described as very quiet and he rarely made eye contact or spoke to anyone other than CTB.[34] Concerns were expressed by her sisters about potential domestic violence between the pair, which prompted her mother to speak to LCM once to tell him that he could not 'put his hands' on CTB. She did not see LCM ever hit her daughter, although she acknowledged that she did hear them have arguments where they shouted at each other.[35]

[26] Exhibit 1, Tab 10.
[27] Exhibit 5, Tab 24 [54], Attachment J.
[28] Exhibit 5, Tab 24 [55].
[29] Exhibit 1, Tab 11 and Exhibit 5, Tab 24.
[30] T 163.
[31] Exhibit 1, Tab 16 and Exhibit 5, Tab 24 [59] – [61].
[32] Exhibit 1, Tab 16.
[33] Exhibit 1, Tab 18 [9].
[34] Exhibit 1, Tab 18 [13] – [15].
[35] Exhibit 1, Tab 18 [16] – [21].

31. CTB claimed in a statement she gave to police a few days after Baby L was injured that the only time LCM was ever violent towards her was the occasion when he threw the knife at the train station.[36]

32. However, this is contradicted by evidence from CTB's family members. CTB's father recalled that CTB told him when she was living with LCM in Midland he was very aggressive towards her and would hit her.[37] CTB also told him that LCM would hit her in the head while they were living with her mother.[38] CTB's father had also seen LCM slap CTB to the head more than once. He had told her to leave him but she always wanted to go back to LCM.[39]

33. CTB's sisters also indicated that they had seen LCM be violent towards CTB many times, both before and after she gave birth to Baby L, and he often yelled and swore at her.[40] One of her sister's recalled seeing bruises and bumps on CTB regularly and she also received a black eye on one occasion while pregnant.[41] He was also aggressive towards CTB's sisters and they had reportedly initiated violence restraining order proceedings against him.[42]. These events occurred while CTB and LCM were living with CTB's family in Bunbury, right up until a few days prior to LCM's assault on Baby L.

34. During this time LCM was still subject to his conditional release order but, as noted above, he was moving around and it was difficult for Youth Justice Services and the Department to keep track of him.

PRE-BIRTH PLANNING

35. The Department has in place pre-birth planning processes to manage child protection risks to unborn children. These processes usually commence 20 weeks into the pregnancy but in circumstances where the child protection risk is reviewed late in the pregnancy, a condensed timeframe for assessment is implemented.[43]

36. The Department must assess whether the child is likely to suffer significant harm as a result of abuse or neglect and whether the parents are unlikely or unable to protect the child from harm.[44]

37. As noted above, the Department's Cannington office became aware in July 2013 that Baby L's mother was approximately five weeks' pregnant. In August and September 2013 the Cannington office documented its intention to commence pre-birth safety planning but this did not occur as LCM left the city and his case worker lost contact with him.

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[36] Exhibit 1, Tab 20 [227] - [229].
[37] Exhibit 1, Tab 29 [17] – [19].
[38] Exhibit 1, Tab 9 [28] – [31].
[39] Exhibit 1, Tab 29 [42] and [58].
[40] Exhibit 1, Tab 22 and Tab 23 and Tab 24 and Tab 25.
[41] Exhibit 1, Tab 23.
[42] Exhibit 1, Tab 22 and Tab 23 and Tab 24 and Tab 25 and Tab 29.
[43] Exhibit 1, Tab 8.1.
[44] Exhibit 1, Tab 8.1.

38. Ms Karen Smith was working for the Department as a Youth and Family Support Worker in the Bunbury Office in late 2013/early 2014. Her role involved role modelling as an Aboriginal woman, working with children and youth at risk to try to re-engage them in education and training and the community generally.[45] Ms Smith had provided a lot of support to CTB and her family in late 2012 when CTB and her sisters had been referred to her by family due to their behaviour in the community and their disengagement with school. They had established some rapport but CTB had disengaged after a confrontation about CTB taking credit from Ms Smith's phone.[46]

39. However, on 29 November 2013 CTB re-engaged with Ms Smith by coming past to introduce her boyfriend, LCM, to Ms Smith and to tell her that she was pregnant. CTB told Ms Smith that she was 26 weeks pregnant at that time and indicated she wanted some help because she was back in Bunbury and needed some support accessing services during the pregnancy.[47]

40. Ms Smith drove CTB and LCM to the Antenatal Clinic at Bunbury Hospital so she could be reviewed by a doctor. There was an argument between CTB and LCM in the car, which seemed to be sparked by Ms Smith asking LCM some questions about himself and CTB resenting the diversion of attention from herself.[48] Ms Smith formed the impression both CTB and LCM were "very needy"[49] and "very dependent on each other"[50] but that their relationship was also quite volatile.[51] Ms Smith noticed during the drive that CTB had a very bruised black eye and asked her how it had happened. CTB denied that it had been violently inflicted and claimed it was just due to puffiness related to being pregnant. Ms Smith did not accept this answer and had suspicions that there was domestic violence in the relationship although CTB denied it.[52]

41. CTB did, however, concede that she and LCM verbally fought a lot and confided to Ms Smith her fears that her parents wanted the baby taken off them because of their fighting.[53]

42. At the Antenatal Clinic CTB and LCM invited Ms Smith to come in with them to see the doctor and Ms Smith was present when CTB asked the doctor about whether she could hurt the baby if she 'bumped herself'. In front of the doctor and LCM Ms Smith asked CTB why she would ask, as she was concerned that it was linked to domestic violence and wanted to air the issue in front of the doctor. However, CTB dismissed her query and said she just thought it could occur when cooking or in the kitchen.[54]

43. The doctor indicated at the end of the appointment that the pregnancy was progressing well but by this stage Ms Smith had become seriously concerned

[45] T 57.
[46] T 57 - 58.
[47] T 58 - 59.
[48] T 59.
[49] T 60.
[50] T 60.
[51] T 60.
[52] T 60 - 61.
[53] T 60 – 61.
[54] T 61; Exhibit 5, Tab 23.

about the welfare of the unborn baby given the increasing signs that the relationship was potentially violent.[55] Ms Smith asked to speak to the doctor on her own and conveyed her concerns to the doctor, asking the doctor to flag CTB on their system for concerns about possibly physical violence.[56]

44. After the appointment Ms Smith followed up with an email to LCM's Case Manager in Cannington, Megan Harvey, as she had some financial concerns and needed support. She also mentioned her concerns about CTB's black eye.[57]

45. Ms Smith also raised her concerns about CTB's noticeable black eye and CTB's denials of physical violence with her local Team Leader and the Aboriginal Practice Leader, Tracey Ninyette, as she felt that Departmental involvement was warranted.[58] Janet Rapkins was the Team Leader of the Department's Bunbury Intake and Assessment Team at the time and she first became aware of CTB's pregnancy that day via a conversation with Ms Ninyette, who also forwarded a copy of an email she had been sent by Ms Smith.[59] Ms Rapkins was concerned that the hospital clinic staff might think CTB had been referred to the Department due to Ms Smith's involvement, so she wanted the matter investigated further to find out more about CTB and what needed to be done.[60]

46. Ms Smith received an email in reply from Ms Harvey on 11 December 2013. Ms Harvey had been LCM's case manager since April 2011. Ms Harvey indicated that LCM had not told her he was moving to Bunbury and she had only found out through his Community Corrections Officer. Ms Harvey expressed concerns about the volatile relationship between CTB and LCM and their pattern of fighting. She noted LCM was on a court order for an incident where he had thrown a knife at CTB. Ms Harvey stated that the couple would need to attend pre-birth planning meetings. Ms Harvey also indicated she would speak to her Team Leader about allocating a co-worker from Bunbury to assist LCM given she was based in Perth.[61]

47. Given Ms Harvey's expressed concerns, the matter was referred to the Department's Bunbury Duty Team for assessment and follow up that same day.[62] The duty officer, Melanie Armstrong, consulted with Ms Ninyette and Ms Smith about CTB. On 13 December 2013 Ms Rapkins instructed Ms Armstrong to make contact with the Team Leader of the Responsible Parenting Services Team, Ms Nicole Mitchell, to clarify whether there was a role for pre-birth planning and, if so which team would be responsible for that process.[63]

48. On 19 December 2013 Ms Smith drove CTB to an assisted housing appointment that she had helped to set up. During the drive CTB told

[55] T 61.
[56] T 61 – 62; Exhibit 5, Tab 23 [14].
[57] T 63.
[58] T 64.
[59] Exhibit 5, Tab 19 [18] – [25].
[60] T 192.
[61] Exhibit 5, Tab 23, Attachment 1.
[62] Exhibit 5, Tab 19 [26] and Tab 23, Attachment 1.
[63] Exhibit 5, Tab 19 [28].

Ms Smith that LCM had left her mother's house with his belongings two days earlier after an argument and had not spoken since. At that time CTB told Ms Smith she wanted to live on her own with the baby when it was born and her mother was supportive of this as her house was very crowded.[64] However, CTB apparently told the housing officer that day that she intended to live with LCM and the baby and after the appointment CTB asked Ms Smith to drop her off to a location so that she could meet with LCM's mother.[65]

49. After dropping CTB off Ms Smith rang CTB's mother to discuss her concerns for CTB and her unborn baby and her fears that LCM was assaulting CTB. Ms Smith recalled that CTB's mother shared her concerns and said that she had warned CTB that she could have her baby taken off her if he hit her. Ms Smith explained that Departmental workers would want to meet with the family and the baby could come into care if they were not satisfied about the baby's safety.[66]

50. Ms Smith emailed her Team Leader later that day to update her on CTB's situation. Ms Smith was concerned that CTB's family were underreporting the potential violence in the relationship and she indicated her concern that CTB's family did not seem able to protect her from LCM. Ms Smith was satisfied that in all other ways CTB was looking after herself during the pregnancy and was healthy and well, but her concerns related to CTB's relationship with LCM.[67]

51. Ms Smith was aware that CTB was referred to pre-birth planning and the Department became involved. CTB's family disengaged with Ms Smith after officers from the Department's Bunbury office became involved and she was not involved by the Department in the pre-birth planning, so her involvement with CTB ceased from this time.[68]

52. From 19 December 2013 another Youth Justice Officer, Ms Colleen Sara, was LCM's supervisor for his IYSO. At that stage LCM was reporting once a week by phone and once in person.[69] Ms Sara spent time trying to build a rapport with LCM and she had no issues with his behaviour.[70]

53. On 20 December 2013 the duty officer, Ms Mitchell, emailed the Duty Team (including Ms Rapkins) to recommend that a referral to pre-birth planning should be put in place for CTB and LCM. She also provided some information from Ms Smith about how the couple were going.[71]

54. CTB was 'intaked' for pre-birth planning, approved by Ms Rapkins, on 23 December 2013. At that stage the estimated birth date was 5 March 2014. At that time, Ms Rapkins decided that a particular case worker, Julie Fordyce, should be allocated responsibility for completing the pre-birth

[64] Exhibit 1, Tab 23 [19].
[65] Exhibit 1, Tab 23 [20].
[66] Exhibit 1, Tab 23 [21] – [23].
[67] T 67- 69; Exhibit 5, Tab 23, Attachment 2.
[68] T 68 – 69, 71; Exhibit 1, Tab 23 [23] – [25].
[69] T 73.
[70] T 75.
[71] Exhibit 5, Tab 19 [30].

planning. Ms Rapkins explained that Ms Fordyce was qualified to continue working with the family after the birth and into the future, which Ms Rapkins considered was likely, and Ms Rapkins had a lot of confidence in Ms Fordyce's vigilance in terms of prioritising a baby's safety.[72] However, over Christmas and New Year the Bunbury office went down to 'skeleton' staff and there were competing demands in terms of case allocations so the matter did not progress further.[73] Ms Rapkins explained that if there had been no queue of cases to allocate she would have allocated a case worker immediately but in her judgment there were other children, who were alive and living in situations that meant they needed to be assessed, so she prioritised these cases over pre-birth planning for an unborn child.[74]

55. In the lead up to the birth of Baby L his mother and father both seemed happy and excited about the impending birth of their first child.[75]

56. On 20 January 2014 Ms Harvey telephoned the South West Aboriginal Medical Service (SWAMS) regarding LCM and CTB and spoke with an Aboriginal Health Worker who advised that CTB had attended all of her appointments and was usually accompanied by LCM. She also advised that they appeared to have a lot of support at home and noted that CTB was linked in with the High Risk Clinic at Bunbury Hospital and everything seemed to be progressing well. CTB was 33 weeks' pregnant at this stage.[76]

57. On the same day Ms Harvey received an email from the Participation Coordinator from the Department of Education who advised that LCM and CTB had met with her that day and advised that LCM was desperate for financial support and housing for himself and CTB. He had been advised he needed to engage with Ms Harvey to progress this.[77] Ms Harvey emailed the Department's Bunbury Duty and Intake Team that afternoon and advised them of LCM and CTB's circumstances and the expected birth date of the baby at that stage. In her email Ms Harvey stated that she would be concerned about this baby given LCM's behaviour/history and the fact his relationship with CTB had been highly volatile in the past. She asked whether the Bunbury office was in a position to open, assess and pre-birth plan with CTB at that stage.[78]

58. Ms Harvey also emailed her Assistant District Director Carol Jacobs that day to report her concerns for LCM, CTB and their unborn baby and her belief that a new case needed to be opened. She also requested a co-worker in Bunbury be allocated for LCM, which is done at the Assistant District Director level. Ms Jacobs forwarded the email to the Bunbury Assistant District Director Paul Burge that afternoon and formally requested that a co-worker be appointed for pre-birth planning and longer term concerns for LCM.[79] Unfortunately, this was not able to be achieved before Baby L was born as he arrived much sooner than expected.

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[72] T 192.
[73] Exhibit 5, Tab 18 [26] and Tab 19 [32] – [34], [42].
[74] T 194.
[75] T 76; Exhibit 1, Tab 18 [22] and Tab 20 [20].
[76] Exhibit 5, Tab 24 [69] – [70].
[77] Exhibit 5, Tab 24 [71].
[78] Exhibit 5, Tab 24 [73], Attachment N.
[7979] Exhibit 5, Tab 24 [75] – [76].

BIRTH OF BABY L

59. Baby L's mother went into spontaneous labour on 20 January 2014 and the baby was born at approximately 1.00 am on 21 January 2014 following an uncomplicated delivery.[80] At birth he had an Apgar Score of 9 out of 10, which indicated he was in good health although he showed some respiratory distress shortly after birth, which was felt to be hyaline membrane disease, a not unusual condition in a pre-term newborn. As Baby L was approximately six weeks premature, he required intensive neonatal care in the nursery. He settled well into the nursery.[81]

60. Baby L's mother, CTB, was happy and excited in the days after the birth of the baby. Her parents noted LCM was quiet, but this was not unusual.[82] LCM's mother also believed her son was happy and a proud father.[83]

61. Baby L was kept in the nursery and Baby L's mother visited Baby L every day. Baby L's father also visited regularly. Baby L always remained in the nursery during these visits and at least one nurse was always present. The nurses showed Baby L's mother and father how to care for the baby, including how to hold him and feed him and bathe him.

62. Ms Julie Matters, a Senior Social Worker at Bunbury Hospital, became aware of CTB and LCM for the first time on 22 January 2014, the day after Baby L was born. Ms Matters' role involves providing support to the family and relevant health information to the Department to assist them in doing risk assessments in regard to the family. Ms Matters is usually involved in pre-birth planning when the Department is involved with an expectant mother, but in the case of CTB and LCM Ms Matters did not have any notice of, or contact with, the family until after the birth.[84]

63. Ms Matters was conducting a routine daily visit to the Maternity Ward when she became aware of CTB due to a social work sticker next to her name. Ms Matters read her file and then decided to contact the Department given CTB was only 16 years of age. Ms Matters spoke to the Department's Duty Officer and was informed that CTB was with the Department's Intake and Assessment Team for pre-birth planning.[85]

64. At 2.15 pm that day Ms Matters emailed the Duty Officer of that team, Ms Melanie Armstrong, and advised that CTB had given birth to Baby L at 34 weeks and advised that Baby L was likely to be in hospital for at least another week.[86]

65. Ms Matters received a response from Ms Armstrong about an hour later advising that the case had not been allocated a case worker yet and also indicating that the family were not aware of the referral to the Department at that stage. Ms Armstrong also indicated that the main concerns raised

[80] Exhibit 3.
[81] Exhibit 3.
[82] Exhibit 1, Tab 18.
[83] Exhibit 1, Tab 19 [31].
[84] Exhibit 5, Tab 18 [12] – [13].
[85] Exhibit 5, Tab 18 [22].
[86] Exhibit 5, Tab 18 [24] – [25].

related to LCM's drug use and possible domestic violence in the relationship. Ms Armstrong indicated she would see if pre-birth planning could be followed up prior to Baby L's discharge and asked Ms Matters to advise the Department if she had any concerns prior to Baby L being discharged.[87]

66. Ms Matters gave evidence that it would have been helpful to have known of the upcoming birth in advance, given LCM was a child in care, so the hospital social workers and ALO staff could have tried to engage with the couple during the pregnancy and referred CTB to Better Beginnings.[88] I note that CTB had been attending the hospital's High Risk Antenatal Clinic since 27 November 2013 when she was 26 weeks' pregnant and it had been identified at the clinic at an early stage that the Department was involved, so it is not clear why the clinic did not transfer that information to the hospital's social work department.[89]

67. Ms Matters indicated that normally when there is pre-birth planning the whole history would be available and the mother and father and their families would be there to respond to that and address risks and concerns. In this case, it was apparent to her that there was considered to be a risk, as the Department had opened the case and intaked it for pre-birth planning, but without pre-birth planning taking place she only had limited information available to her, as provided by Ms Armstrong.[90]

68. On 22 January 2014 Ms Harvey, LCM's case manager based in Cannington, received an email from Karen Smith, the Bunbury Youth and Family Support Worker, advising that CTB had given birth that day to a premature baby. Ms Harvey forwarded this email to her Assistant District Director Ms Jacobs, her Aboriginal Practice Leader and her Team Leader. She also replied to Ms Smith and advised her that she was going on pre-planned leave that afternoon for a few days and recommended that Ms Smith follow up with the duty officer in her absence.

69. The following day Ms Matters spoke to Julie Fordyce, the Child Protection Worker in the Assessment and Intervention Team in the Department's Bunbury office that Ms Rapkins had previously identified as being the person she would allocate to do pre-birth planning with the family. In Ms Rapkins' absence on leave, Ms Fordyce had been appointed as the case worker for Baby L 23 January 2014 by the Bunbury Assistant District Director.[91]

70. Ms Fordyce advised Ms Matters that she was going to undertake safety and wellbeing assessment and complete some signs of safety planning.[92] Ms Fordyce had only been assigned the case that day and had no previous experience with the family.[93] Ms Fordyce was not assigned as LCM's co-worker from Bunbury, and no co-worker had been allocated yet as his local

[87] Exhibit 5, Tab 18 [26], [28].
[88] T 91 – 92.
[89] Exhibit 5, Tab 26 [37] – [[38].
[90] T 93.
[91] Exhibit 5, Tab 19 [38].
[92] T 168.
[93] Exhibit 5, Tab 21 [11] – [13].

case manager, but her role was to deal with the new family unit and focus on Baby L's safety.[94]

71. Ms Fordyce advised Ms Matters that she was planning on attending the Maternity Ward to meet CTB and her family on 24 January 2014 and undertake an initial 'Signs of Safety' meeting. The purpose of a Signs of Safety meeting in this context is to identify any concerns about the parents/family and work out whether it is safe for the baby to go home.[95]

72. Ms Matters met CTB for the first time on the afternoon of 23 January 2014 to discuss the proposed Signs of Safety meeting with her. Senior Aboriginal Liaison Officer, Sue Henry, attended with Ms Matters. Ms Henry is a very experienced health worker and she had worked with Aboriginal people in the health setting for more than two decades before she retired. Her role as the Senior ALO included meeting expectant Aboriginal mothers at the High Risk Antenatal Clinic and ensuring that they were culturally comfortable at the hospital and their wellbeing was looked after. She also facilitated their engagement with external supports and assisted with practical issues like transport to and from hospital, with the assistance of other ALO's under her supervision.[96]

73. Ms Henry has known CTB since she was born and had a lot of contact with her family other the years. Ms Henry did not meet LCM until after Baby L's birth and as he wasn't from Bunbury she did not have community knowledge of his family.[97] At the meeting on 23 January 2014 Ms Matters and Ms Henry explained to CTB that the following day she would meet with the Department's staff to discuss safety for Baby L, and gave her some information so that she would be prepared for the meeting. Ms Henry also suggested she could bring her mother for support.[98]

74. Ms Henry described both CTB and LCM as very quiet. CTB was open to suggestions and was always compliant but LCM did not interact with her.[99]

75. Ms Matters did not attend the meeting the following day as she was not at work. She arranged for another social worker, Carol Attard, to attend on her behalf. Ms Henry also did not attend the meeting but she did visit CTB earlier that morning to explain to her a bit more about what the meeting would entail and reassure her.[100]

76. Ms Fordyce understood prior to the first SOS meeting that concerns had been raised about possible domestic violence between CTB and LCM. Ms Fordyce also spoke to Karen Smith on the morning of the meeting to get more information about CTB and LCM. Ms Smith was not invited to attend the meeting, as the Department wanted to preserve her relationship with the family and it was felt that involving her in the meeting may have

[94] T 169.
[95] T 92; Exhibit 5, Tab 18 [31].
[96] T 116; Exhibit 5, Tab 14.
[97] T 117; Exhibit 5, Tab 14 [21] – [22].
[98] T 118.
[99] T 118.
[100] Exhibit 5, Tab 14.

compromised that relationship and caused the family to disengage from her.[101]

77. The meeting included Ms Fordyce, Ms Attard, another Child Protection Worker, CTB and her mother. LCM did not attend and Ms Fordyce told CTB and her mother that he would need to attend future meetings in order for her to assess safety. He was encouraged to bring a support person.[102]

78. At the meeting hospital staff were able to provide very positive feedback to the Department about the interactions between CTB and Baby L. It was noted that LCM was obviously nervous but he was also present and engaging with the baby. There was no negative feedback from the hospital's perspective at that stage.[103]

79. The main concerns raised at the meeting came from the Department and related to the past history of fighting between the couple, coupled with CTB's recent black eye, and LCM's lack of finances. It was explained that there was a concern that Baby L might be hurt accidentally if there was fighting between the couple. CTB denied there was any domestic violence in the relationship.[104]

80. At the meeting a plan was put in place to provide extra support to LCM, including arranging for him to attend a men's group, and also support for CTB through Best Beginnings. It was agreed Ms Fordyce would review the situation two weeks prior to Baby L's discharge.[105] A second Signs of Safety meeting was scheduled for 28 January 2014. Ms Fordyce formally requested information from the WA Police and Bunbury Hospital to provide relevant information to her, to assist her in the planning. The information that came back provided little detail so it made it difficult to get a full picture of what was happening with LCM recently.[106] Much of the information available to Ms Harvey about recent potential violent incidents between the couple, including possible stabbing of CTB, were not identified as they were not reported to police.[107]

81. Ms Harvey, LCM's Cannington case manager, was not able to participate in the second Signs of Safety meeting as she was on leave at the time. She agreed that it would have been better if she had been able to participate as more information would have been able to be shared.[108] Ms Fordyce advised the court that she had initially booked a videoconference for Ms Harvey to participate in the meeting, mistakenly believing she would be back from leave in time. Ms Fordyce indicated that she had wanted to speak to Ms Harvey as she believed the information Ms Harvey could have provided "would have been very important and her input would have been vital."[109]

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[101] T 172 - 173; Exhibit 5, Tab 21 [12] – [14].
[102] T 172; Exhibit 5, Tab 21 [15] – [16].
[103] T 94.
[104] Exhibit 5, Tab 21 [17].
[105] Exhibit 5, Tab 18, Attachment 5.
[106] T 174.
[107] T 176.
[108] T 158.
[109] T 171.

82. When she realised Ms Harvey would still be on leave, Ms Fordyce invited Ms Harvey's Team Leader, to participate in the next meeting, but she indicated that she did not have much personal knowledge of LCM and therefore would not be able to add anything to the meeting.[110] A question was asked as to whether it might have been worth postponing the meeting to allow Ms Harvey to participate, but this was rejected as the feeling was that planning needed to get underway now that the baby was born.[111]

83. Ms Fordyce acknowledged that the email Ms Harvey had sent gave a "good synopsis of what life was like for LCM"[112] but it was the little nuances that don't always get down on paper that are sometimes really important to hear, which was why she had hoped to personally involve Ms Harvey or someone from the Cannington office.[113] This does seem to be the case, as Ms Fordyce acknowledged at the inquest that she was not aware of the information that Ms Harvey knew about LCM possibly having stabbed CTB more than once.[114] Further, none of the support network were disclosing that behaviour.[115]

84. Ms Fordyce did not have any contact with LCM's Youth Justice Worker, so no additional information was provided from that source.[116]

85. Ms Matters attended the second Signs of Safety meeting along with CTB, LCM, CTB's mother, LCM's mother, Julie Fordyce, Sue Henry, Janet Rapkins (Team Leader of the Bunbury Intake and Assessment Team) and Stacey Currie from the Department.[117]

86. Prior to the meeting Ms Henry had spoken to CTB's family about the prospect of Baby L going home to their house. Ms Henry did not have any concerns about the plan, knowing the family dynamics as she did. Ms Henry knew CTB came from a very large family with a very capable and supportive mother and father and there was already one sister with a newborn baby at the house.[118] Ms Henry had seen CTB with Baby L and thought she was a lovely mother and LCM had seemed to be good when she saw him with the baby.[119]

87. Ms Henry had also spoken to CTB alone about potential domestic violence in the relationship but CTB had denied it.[120] Ms Henry noted that usually she would hear about such things through the community but because CTB and LCM and only been back in Bunbury a short time and his family was not from here, so there was no time for community talk to develop about them and no local source of information.[121]

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[110] T 171; Exhibit 5, Tab 21 [20].
[111] T 200.
[112] T 171.
[113] T 171 - 172.
[114] T 176.
[115] T 176.
[116] T 177.
[117] Exhibit 5, Tab 21 [22].
[118] T 119; Exhibit 5, Tab 18.
[119] T 119.
[120] T 118; Exhibit 5, Tab 18 [35].
[121] T 118 – 120.

88. Ms Matters advised at the meeting that CTB had bonded well with Baby L and that Baby L was still expected to remain in hospital for approximately 10 more days. No concerns had been raised with Ms Matters in relation to LCM or CTB by nursing staff so Ms Matters had no negative information to provide. Ms Henry advised that she thought CTB was mother crafting well and was very good with Baby L.[122]

89. During the meeting the Department's concern was still the potential for family violence between LCM and CTB and the impact this would have on Baby L physically, emotionally and developmentally.[123] LCM raised concerns about still not having a case worker based in Bunbury and there were reports he had been abusive to Department staff.[124] However, Ms Rapkins indicated she was pleasantly surprised with how he participated in this meeting.[125]

90. At the meeting it was indicated that the plan was for CTB to be discharged from hospital while Baby L was to remain in the nursery. Ongoing support was to be provided for CTB and LCM.[126] In particular, it was decided that the ALO's would arrange transport for CTB to the hospital in the morning and the Department would provide a Cabcharge for her to get home in the evenings.[127]

91. The future plan at that stage was for CTB, LCM and Baby L to live together with CTB's mother after Baby L was fit for discharge. Members of CTB and LCM's family were identified as "safety people" as part of the safety plan put in place for Baby L. Family members agreed that they would report back to the Department if they had any concerns for Baby L's safety. There was also a plan for the Department to discuss with CTB a referral to the 'Best Beginnings' program so she could receive ongoing support.[128]

92. CTB was discharged home from the maternity ward on 29 January 2014 and Baby L remained in the nursery. CTB remained happy despite the difficulties of having to be discharged home while her baby remained in the hospital nursery.[129] The Department supported CTB to breastfeed three hourly by arranging taxis to take them home every night.[130]

93. Ms Fordyce recalled that she emailed Ms Harvey on 29 January 2014, as she was due back from leave at that time. She provided Ms Harvey with a copy of the SOS mapping from the meeting the previous day and also asked Ms Harvey to call her to discuss LCM, although she could not recall if that occurred.[131] It was put to Ms Fordyce that Ms Harvey did recall a conversation they had on 29 January 2014, and Ms Fordyce conceded that

[122] Exhibit 5, Tab 18 [41].
[123] Exhibit 5, Tab 18 [35] – [42].
[124] Exhibit 5, Tab 14 [40].
[125] T 199.
[126] Exhibit 5, Tab 18 [43].
[127] Exhibit 5, Tab 18 [44] – [46].
[128] Exhibit 5, Tab 18 [44] – [48] and tAb 21 [23].
[129] Exhibit 1, Tab 18; Exhibit 5, Tab 21 [25].
[130] Exhibit 5, Tab 21 [26].
[131] Exhibit 5, Tab 21 [27].

they may have spoken on the telephone and she had not made a record of the conversation.[132]

94. Ms Harvey, who had been managing LCM on behalf of the Department for a number of years, was asked whether she still held ongoing concerns about LCM and CTB's ability to parent at this time. Ms Harvey indicated that the information she had received about the plan, involving the couple going to a supportive family who had experience with babies, made her feel a little bit more comfortable, "but there were always concerns around how the two would go as parents."[133] Ms Harvey's particular concern in relation to LCM was in regard to his "antisocial and violent behaviour"[134] and she felt that she had conveyed those concerns to her team leader and relevant staff in Bunbury as best she could.[135] Ms Harvey conceded that face to face conversations might have helped to convey her concerns better than in an email or written correspondence, or to have been involved in meetings by videolink, and she accepted that this could have been done.[136]

THE CODE BLACK INCIDENT

95. The incident referred to as the 'Code Black Incident' occurred on 30 January 2014, two days after the second Signs of Safety meeting. The incident occurred at the hospital, between the Maternity Ward and the nearby lifts, and it was unclear from witness reports whether it involved LCM being aggressive and violent towards CTB and/or his mother.

96. CTB described LCM as having a fight with his mother involving arguing and yelling and LCM possibly pulled his mother's hair. CTB told police that she "got in between them to stop him"[137] and also yelled at LCM to stop. This was the only time she recalled there being fighting at the hospital.[138]

97. CTB's sister provided a statement to police after Baby L's death in which she stated that she witnessed LCM punch CTB at the hospital during the incident that led to the Code Black. The incident occurred after LCM called CTB out of the nursery in an angry manner as she had his iPad. It occurred in the presence of LCM's mother and other family members. CTB's sister recalled that LCM punched CTB while they were at the lift and his mother called out to him and told him not to hit her. They then took the lift down and walked out of the hospital and drove away in a car.[139]

98. CTB's sister recalled that her cousin's partner, Naomi Thorne, was also at the hospital.[140] Ms Thorne gave a statement to police on 18 February 2014 and confirmed that she was at the Maternity Ward of Bunbury Hospital on 30 January 2014 visiting a friend. She saw one of CTB's sisters and was

[132] T 177 – 178.
[133] T 161.
[134] T 161.
[135] T 161 – 162.
[136] T 162.
[137] Exhibit 1, Tab 20 [34].
[138] Exhibit 1, Tab 20 [30] – [36].
[139] Exhibit 1, Tab 24.
[140] Exhibit 1, Tab 24 [52].

informed that CTB had recently had a baby. After vising her friend Ms Thorne walked towards the nursery to see CTB's baby. She saw LCM banging on the nursery windows. Ms Thorne looked through and saw CTB inside the nursery. In response to LCM's banging CTB came outside the nursery. LCM immediately began swearing at CTB and abusing her. Ms Thorne reprimanded him for speaking to CTB in that manner and he responded in an angry and aggressive manner towards Ms Thorne. Ms Thorne was not worried about her own safety but she was worried for CTB's safety given how he reacted.[141] CTB tried to calm things down and the couple walked away.

99. CTB and LCM walked past Ms Thorne towards the lifts and walked around the corner out of sight. CTB's sisters and LCM's mother followed them. Shortly after Ms Thorne heard yelling. She was already walking towards the lifts and as she reached the corner she saw what she believed to be several nurses standing near LCM and CTB and one of the nurses was speaking to them near the stairs and telling LCM "not to hit her", which she assumed was a reference to CTB.[142] Ms Thorne did not, however, see the incident itself.[143]

100. Ms Janet Iveson, a Patient Care Assistant at Bunbury Hospital, was working on the Surgical Ward at the hospital that night, which is opposite the Maternity Ward. Ms Iveson and a colleague, Nicole Boon, were walking from the lifts to the Surgical Ward at around 7.00 to 7.30 pm and witnessed an argument between an Aboriginal male teenager and an older Aboriginal couple outside the Maternity Ward. The teenager, who was identified as LCM, and the older woman were behaving aggressively. The group moved towards the lift and Ms Iveson saw LCM lunge towards the woman as if to hit her, but he did not make contact. Ms Iveson yelled at him not to hit a woman and then called out for security. She spoke to them as they tried to enter the lift together and then LCM came out of the lift and went down the stairs. As Ms Iveson walked away she believed she saw a young Aboriginal girl come out of the Maternity Ward and walk that way. Ms Iveson spoke to a security officer and asked him to go after the group she had seen arguing.[144]

101. Ms Boon also gave evidence that she had witnessed a scuffle between LCM and an older Aboriginal woman near the lifts. She recalled there were other Aboriginal people around the lifts at the time of the incident. Ms Boon went into the Surgical Ward to get someone to call security and did not have any other involvement in the matter.[145]

102. A midwife who was working in the Maternity Ward that evening, Brenda Bligh, recalled seeing LCM arriving at the ward at approximately 6.30 pm and begin "banging furiously"[146] on the window to attract CTB's attention. She got up immediately and said that he wanted his iPad. She left the nursery and Midwife Bligh made a note that LCM "greeted"[147] her in inverted

[141] T 9; Exhibit 1, Tab 26.
[142] T 12.
[143] T 9 – 10; Exhibit 1, Tab 26.
[144] T 13 – 17; Exhibit 1, Tab 4.
[145] T 17 – 18; Exhibit 5, Tab 20.
[146] T 20.
[147] T 20; Exhibit 5, Tab 13 [8].

commas as he appeared to speak to CTB in a loud and cross manner. Midwife Bligh's entry in the medical notes also indicates that the couple walked around to the lifts and LCM "wacked her."[148] Midwife Bligh did not see this occur but she had put her head out the nursery door and a visitor walked passed and told her this had occurred.[149]

103. Midwife Bligh understood that other hospital staff had contacted security and she took action to notify the Nurse Manager by telephone.[150] Midwife Bligh spoke to CTB a little while later on the telephone. CTB rang the nursery as she was aware Baby L was due for a feed. The midwife told CTB that the feed was due but LCM should not come with her. CTB appeared to be concerned about DCP being informed of the incident and told Midwife Blight that LCM did not hit her but had tried to grab his mother's bag and been verbally abusive. Midwife Bligh responded that his "behaviour was not acceptable in the hospital"[151] and he was not to come in. She believes this directive had probably come from her conversation with the Nurse Manager.[152]

104. Clinical Nurse Tammy Reading was the Hospital Coordinator or After Hours Manager that evening and recalled that there was a 'Code Black' incident, which involves a personal threat, either verbal or physical, to a patient or visitor from an individual.[153] It was Nurse Reading's job as the Hospital Coordinator to 'de-escalate' the situation by taking appropriate steps to identify the individuals involved and reduce the risk of harm, possibly by removing the person from the premises. Nurse Reading did not formally initiate a Code Black that night but the steps were largely the same as if she had done so, with security being notified and steps being taken to identify the parties involved. It became apparent that all the parties involved had left the hospital, which is why Nurse Reading did not take further steps to initiate a formal Code Black but it was generally referred to by staff as a Code Black incident.[154]

105. Police and the Department were notified of the incident and, along with the Shift Coordinator Midwife Assimina Di Lollo, Nurse Reading took steps to initiate a lockdown of the Maternity Ward. This usually involves the ward not being accessible without an access card or permission by staff on the ward, but the locks were inactive so a security officer was placed at the entrance to the ward to enforce the lockdown until the locks could be repaired. The purpose of initiating the lockdown was to exclude LCM and prevent any further incidents until the matter could be properly investigated by the Department and it was deemed safe for LCM to return to the ward.[155]

106. Robert Hislop was one of the security officers on duty at the hospital that night and he received a page to attend the Maternity Ward. By the time Mr Hislop and his colleague arrived at the ward the parties involved had left.

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[148] Exhibit 1, Tab 13 [8].
[149] T 21; Exhibit 1, Tab 13 [12].
[150] T 21.
[151] T 23.
[152] T 22 – 23; Exhibit 1, Tab 13.
[153] T 33; Exhibit 5, Tab 27 [7].
[154] T 34 – 35.
[155] T 35 – 36; Exhibit 5, Tab 27 [30] – [31] and Tab 15.

They confirmed the staff and patients were safe and then made they made their way to the front of the hospital. As they reached the front of the hospital they saw a car go by with at least one young Aboriginal female in the car. Some hospital visitors, probably Ms Thorne, told the security officers that the people who had left in the car were the people involved in the incident. Mr Hislop and his colleague then went back to the Maternity Ward to effect the lockdown while the engineering issues were resolved. They also conducted regular patrols in the area for the rest of the night.[156]

107. Mr Hislop confirmed in his evidence that he reviewed the available security footage after the event and the sole camera from the area did not cover the relevant area near the lifts where the incident allegedly occurred.[157] Apparently since that time more cameras have been installed in the area, so there is more potential for independent security footage of similar incidents to be available now.[158]

108. Midwife Di Lollo telephone CTB's mother and spoke to both her and CTB. Midwife Di Lollo advised that LCM could not come back to the hospital until the Department had spoken to him.[159]

109. Nurse Reading received a telephone call from the police about an hour after she had notified the police of the incident. She was informed that police officers had spoken to CTB and she was unharmed but not forthcoming with information about the incident.[160] Nurse Reading was not involved in the later decision to lift the lockdown and permit LCM on to the ward and she had no further involvement with the family.[161]

110. Ms Matters arrived at work on Friday, 31 January 2014 and was informed that a Code Black had been called the previous night in relation to LCM's behaviour. Ms Matters read the notes and then spoke to Ms Fordyce. Ms Fordyce asked if there was any CCTV footage, and it was established that there was not. Ms Matters also tried to get in contact with Ms Thorne, but was unable to make contact with her.[162]

111. Ms Matters spoke to LCM sometime that morning at the hospital. She told him he could not attend the hospital until the matter had been investigated. Her recollection was that he agreed and did not make a fuss.[163]

112. Ms Fordyce had been informed of the incident by the Department's Crisis Care Unit (the out of hours emergency unit). The Crisis Care Unit report indicated the incident had involved LCM assaulting his mother, although LCM's mother had later denied this. The report indicated that Baby L was not at risk of harm as he was not due to be discharged yet.[164] Ms Fordyce

[156] T 53 - 55; Exhibit 2, Tab 10.
[157] T 54.
[158] T 54.
[159] Exhibit 5, Tab 15
[160] Exhibit 1, Tab 27 [34].
[161] T 36; Exhibit 1, Tab 27 [38] – [39].
[162] Exhibit 5, Tab 18 [51] – [58].
[163] T 100.
[164] Exhibit 5, Tab 21, Annexure 7.

agreed that this was the kind of incident that caused alarm bells to ring for her.[165]

113. Ms Fordyce spoke to Ms Matters, who indicated that it may have been CTB that had been assaulted, not LCM's mother as there were conflicting reports from witnesses. Ms Fordyce asked if a search could be made for any CCTV footage of the incident. Ms Fordyce then spoke to her Team Leader, Jan Rapkins, and arranged an internal signs of safety mapping meeting for 4.00 pm that day.[166] Ms Fordyce recalled that she told Ms Rapkins that she did not feel confident that Baby L would be safe at home with his father. "Despite all the positives in parent crafting and the fact that [LCM] was up at the hospital bathing baby the previous day, there were still some unknowns around [LCM] and the family denied any violence."[167]

114. Ms Fordyce advised Ms Matters of the 'internal mapping' meeting scheduled for 4.00 pm that afternoon and indicated LCM was not allowed into the Maternity Ward until then.[168]

115. A number of Department staff attended the internal mapping meeting, including Ms Fordyce and Ms Rapkins, but no one from the Cannington office and no one from the hospital social work team. Ms Fordyce explained that the only time she could get her team together was at 4.00 pm, which was unfortunately after the hospital social work team had finished for the day.[169] It was not clear why no attempt was made to include Ms Harvey, LCM's Cannington case worker, by telephone and it was agreed by Ms Rapkins that in retrospect it would have been a good idea.[170] Ms Rapkins accepted that they didn't really have enough information about LCM's history to fully understand the risk but what they had heard from LCM was that he didn't have a good relationship with his case worker or the Cannington office, so they didn't think that they would be able to provide a lot more information.[171]

116. Ms Fordyce recalls the staff at the internal mapping meeting expressed worries about the number of reported domestic violence incidents between LCM and CTB and the fact that the people in their identified safety network (family members) did not seem open about the violence as they denied it when asked directly.[172] Ms Fordyce suspected that violence was occurring at CTB's home, which she explained came from "gut instinct"[173] but she had no evidence to support this view. She was concerned Baby L might be at risk of accidental injury if domestic violence occurred. However, all of the information from the hospital was that CTB and LCM were doing well in looking after Baby L and there were no concerns in terms of LCM's behaviour towards the baby. It was noted that the couple wanted to successfully parent Baby L but there were concerns they would not have the

[165] T 179.
[166] Exhibit 5, Tab 21 [30].
[167] Exhibit 5, Tab 21 [30].
[168] Exhibit 5, Tab 18 [59] – [64] and Tab 21 [31].
[169] T 186.
[170] T 200.
[171] T 201 – 202.
[172] T 180; Exhibit 5, Tab 21 [33].
[173] T 180.

maturity or capacity to deal with their issues.[174] LCM's impulsivity was also a general concern, given what had happened in the hospital.[175]

117. In terms of the actual incident at the hospital, Ms Rapkins explained that it had been apparent at the second Signs of Safety meeting that there was tension between LCM and his mother and "she knew how to stir him up,"[176] so although he admitted assaulting his mother it wasn't obvious that this made him a greater risk to the baby.[177]

118. The Department staff at the meeting ultimately decided that there was not enough evidence to provide a basis for taking statutory action to bring the baby into the formal care of the Department. They relied upon feedback from hospital staff that did not suggest Baby L was at risk during the incident and the reports around their parent crafting was positive. With an understanding of what is required to take an application before a magistrate, it was felt that the lack of evidence made any statutory application challenging.[178]

119. However, they updated the case plan in response to Ms Fordyce's concerns over the pending discharge to ensure further investigations were carried out. Ms Fordyce intended to arrange another meeting at the hospital the following week and in the meantime they were going to investigate CTB's alleged history of violence and get further witness accounts of the incident at the hospital.[179] Although they were planning towards Baby L going home with his parents, no final decision had been made at that stage.[180]

120. That evening Ms Fordyce sent an email to Ms Matters at 5.48 pm advising that Departmental staff would attend the ward the following week to speak to CTB and LCM. She indicated the Department had found it difficult to identify what had occurred the previous night as there were two conflicting accounts and "it was the hospital's decision as to whether [LCM] should be allowed back into the hospital."[181] This information was also communicated to the Shift Co-ordinator, Dianne Johansson over the telephone.[182] Ms Fordyce was going on two weeks' leave and requested that Ms Matters inform Janet Rapkins of any developments while she was away.[183] Ms Fordyce also asked if a copy of the midwife's notes from the Code Black incident could be provided to the Department so they could try to assess the risk. A formal request for the information was made a few days later.[184]

121. It was raised in evidence at the inquest that the Department did not suggest that there should be any special supervision of LCM once visits resumed. It was explained that the Department could only have imposed such

[174] Exhibit 5, Tab 21 and Annexure 8.
[175] T 181; Exhibit 5, Tab 19 [49].
[176] T 203.
[177] T 204.
[178] T 182.
[179] T 181 – 182.
[180] T 204.
[181] Exhibit 5, Tab 18 [65].
[182] Exhibit 5, Tab 22 [14].
[183] Exhibit 5, Tab 18 [67].
[184] Exhibit 5, Tab 18, Attachments 7 and 8.

requirements if it had taken Baby L into the care of the CEO or obtained a restraining order on his behalf.[185]

122. Ms Matters had already left for the day when Ms Fordyce's email was sent so no decision was made that evening by the hospital to lift the ban and then the weekend intervened. The social work service is not normally staffed at the hospital over the weekend so LCM remained banned from entering the Maternity Ward until the matter could be further considered on Monday, 3 February 2014.[186]

123. CTB's sisters were under the impression that CTB and LCM broke up after this incident for a few days, but CTB does not refer to a separation in her statement. If they did separate temporarily, it is clear they had reconciled very quickly as by the end of the weekend they were together again.

124. Ms Matters returned to work after the weekend and was informed by hospital staff that both CTB and LCM's families were unhappy that LCM had not been allowed to visit the hospital over the weekend. Ms Matters spoke with the Nursing Unit Manager, Katrina Jones, and they agreed that Ms Matters would speak to LCM and CTB about LCM's behaviour and then LCM would be allowed to visit during normal visiting hours but not during the rest period.[187]

125. In making that decision Ms Matters accepted that ultimately it is the hospital's decision as to who is allowed access to the hospital, but she also took into account that the Department did not indicate it wanted to prevent anyone having access to Baby L and both CTB and LCM's families were supportive of LCM being able to visit his son. Further, Ms Matters was aware the Department was planning at that stage for Baby L to go home with CTB and LCM in the near future. Ms Matters had been informed by the nursing staff that LCM had been engaging well with LCM and there was no display of aggression towards Baby L in the nursery, so she had no concerns that whatever had occurred at the lift might represent harm to the baby, the concern was whether the baby might be hurt indirectly amongst domestic violence.[188]

126. The Coordinator of Nursery and Midwifery at the hospital was advised of this decision, and it was conveyed to the Operations Manager of the hospital, who both agreed with the decision, although it was not formally documented.[189]

127. Ms Matters met with CTB and LCM in the company of Senior ALO Ms Henry at 11.30 am on 3 February 2014. During the meeting LCM admitted that he had hit his mother near the lifts but denied he had struck CTB. LCM and CTB both agreed that, nevertheless, LCM's behaviour was not acceptable. Ms Matters encouraged them to work with their case worker from the

[185] Exhibit 5, Tab 25 [109].
[186] T 90.
[187] Exhibit 5, Tab 18 [71] – [73].
[188] T 99; Exhibit 5, Tab 18 [72] – [74].
[189] T 139.

Department, whose role it was to assist and support them with the baby and to ensure the baby was in a safe environment.

128. Ms Matters told LCM in the meeting that he was allowed back into the Maternity Ward to visit Baby L between normal visiting hours (8.00 am to 8.00 pm) but not during the rest period. Ms Matters also told LCM that he was not to attend the hospital if he was feeling upset. LCM agreed with this condition and indicated that he was attending a men's group run by the SWAMS and that he also wanted to do anger management counselling.[190]

129. On the same day Midwife Bligh, made an entry in Baby L's medical notes at 1.15 pm. She recorded that LCM was "quite edgy and curt" with her and said words to the effect that she thought he didn't "know anything because he is young."[191] Midwife Bligh recalled that this occurred when she passed LCM a nappy while he was changing Baby L. She indicated that she thought that LCM was quite rude to her and she was surprised and taken aback by his comment as she didn't think that and didn't think her actions had suggested that. Midwife Bligh didn't want to interact with him when he was obviously edgy so she didn't reply and LCM "stormed out of the nursery."[192]

130. Midwife Bligh informed the Shift Co-ordinator, Ms Johansson, who went and observed him and did not note any aggression.[193] Midwife Bligh also spoke to one of the Aboriginal Liaison Officers' (ALO) of LCM's curt behaviour and she understood that the ALO spoke to him about the incident. Midwife Bligh had not had any similar previous incident with LCM, noting that in her experience he wasn't there very often and he rarely spoke, even to Baby L.[194] There were no repeats of this incident.[195]

131. Ms Henry drove CTB and LCM home from the hospital that day and she discussed with LCM that he should only visit the hospital in short bursts and also discussed his anger issues with him. Following on from the incident with Midwife Bligh that day, LCM stated that he felt that the nurses were talking down to him because he was young. Ms Henry told him if he felt angry he was to leave the nursery and go for a walk or come and talk to ALO Clem Jetta. LCM got upset with Ms Henry and got out and walked away.[196]

132. Another meeting was convened the following day by Ms Matters with CTB and LCM and Ms Henry. In addition, the meeting was attended by ALO Ms Jetta, Community Mental Health Aboriginal Worker, Bill Turner, and Ms Rapkins from the Department with another Departmental staff member. During the meeting Ms Henry advised that CTB's mother had expressed concerns to her about CTB and LCM's capacity to parent effectively, as well as some concerns about domestic violence.[197]

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[190] Exhibit 5, Tab 18 [75] – [82].
[191] T 25; Exhibit 5, Tab 13 [16].
[192] T 25 - 26; Exhibit 5, Tab 13 [16].
[193] T 123 – 124.
[194] T 26 - 27.
[195] T 26.
[196] Exhibit 5, Tab 14 [54] – [55].
[197] Exhibit 5, Tab 14 [57] – [58] and Tab 18 [87] – [95].

133. Ms Rapkins discussed issues of domestic violence with the couple and made it clear at the meeting that the Department would be concerned if there were any reports of domestic violence between them. It was noted that LCM was attending the men's group regularly and learning anger management strategies. He seemed comfortable with Mr Jetta and Mr Turner and was more relaxed in the meeting.[198]

134. CTB and LCM indicated in the meeting they felt intimidated by hospital staff. Ms Henry agreed to speak to nursing staff and ask them to explain what they were doing when nursing Baby L, which she later did.[199]

135. Ms Rapkins made it clear at the end of the meeting that CTB and LCM were expected to proactively engage with the Department and the Department would be concerned if they did not.[200] At the time of the meeting Baby L was still to come off the nasogastric tube feeding before he could go home.[201]

136. On 5 February 2014 Ms Rapkins met with the Bunbury District Director, Ms Lynda Atherton, to discuss the concerns held for Baby L. Ms Rapkins explained that she wasn't prepared to make the decision on her own because she was concerned that she might be too close and might not be seeing it as clearly as someone not involved in the case, so she wanted to discuss it with the Director. The Director is also the person who has the final say as to whether or not an application can be made to take a child into care, so her opinion was important.[202]

137. The identified risk at that stage was that the baby might be exposed to harm incidentally due to parental arguments or fights. It was agreed that it was a "high risk matter"[203] but that there were insufficient grounds at this time to bring Baby L into the care of the CEO of the Department. This was particularly so given CTB was apparently doing so well with mother crafting and bonding with the baby. It was decided the plan was for child centred family support to be continued after Baby L was discharged from hospital.[204]

138. On 6 February 2014 LCM spoke to his Youth Justice Officer, Ms Sara, about his alleged negative behaviour at the hospital. When Ms Sara raised it with LCM he told her he needed to do anger management counselling and the Department were going to arrange this but nothing had happened as yet. He agreed to Ms Sara's suggestion she arrange for him to undertake psychological counselling with a Youth Justice psychologist. Ms Sara spoke to her Team Leader after the conversation and it was agreed that a referral should be completed. Ms Sara spoke to Dr James Hanly, a psychologist, who consented to the referral. Ms Sara completed the referral and the referral was acknowledged by Dr Hanly on 10 February 2014.[205]

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[198] T 120; Exhibit 5, Tab 14 [57] and Tab 18 [87] – [95].
[199] Exhibit 5, Tab 14 [60].
[200] Exhibit 5, Tab 18 [94] and Tab 19 [59].
[201] Exhibit 5, Tab 18 [96].
[202] T 209 – 210.
[203] Exhibit 5, Tab 19 Attachment 11.
[204] T 211; Exhibit 5, Tab 19 [61] and Attachment 11.
[205] T 77; Exhibit 2, Tab 21, Attachment 2(a).

139. Ms Sara did not know the incident at the hospital involved a potential assault and she did not investigate further.[206] He could not be formally breached on the order unless he had been convicted of an offence or failed to comply with the conditions of his order.[207] He was attending all his substance appointments and complying with the order.[208]

140. LCM did not ever start the anger management counselling because the incident with Baby L occurred before he could attend the first appointment, which had been scheduled for 18 February 2014.[209]

PLANNING FOR BABY L TO GO HOME

141. On 10 February 2014 Ms Matters emailed Ms Rapkins at the Department to check whether Baby L would be going home with his parents as he was getting ready to be discharged from hospital. Ms Rapkins informed her that Baby L was to go home with CTB but the Department would remain involved with the family. Ms Rapkins also requested that Ms Matters refer CTB to the Best Beginnings program.[210] In the email Ms Rapkins said that Department was "fully cognisant of the risks but at this stage the assessment is that the risk can be managed."[211] It was intended that a safety plan would be developed prior to Baby L's discharge and after Ms Fordyce returned from leave on 13 February 2014.[212]

142. Although all of this suggests that a decision had been made that Baby L was going home with CTB and LCM, Ms Rapkins indicated that "we were still in areas of grey"[213] in terms of the final planning decision. Ms Rapkins was waiting for Ms Fordyce to return from leave so that they could have another Signs of Safety meeting and look at the issues that were still unsorted and see what came out of that.[214] As it turned out, Ms Fordyce returned from leave and then unexpectedly went on sick leave again, so no further meeting was arranged.[215]

143. There were no incidents involving LCM or CTB from this time and the nursing staff were generally impressed with CTB's parenting skills and had no active concerns about LCM's, although they had less involvement with him. It was noted by one witness that when LCM was in the nursery he would often pull the curtains around so that they couldn't be observed, which was permissible and not out of the ordinary but made it hard to watch him interact with the baby.[216]

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[206] T 77.
[207] T 78.
[208] T 78 - 79.
[209] T 80.
[210] Exhibit 5, Tab 18 [99].
[211] Exhibit 5, Tab 19, Attachment 13.
[212] Exhibit 5, Tab 19 [64].
[213] T 205.
[214] T 208.
[215] T 209, 241.
[216] T 27.

144. Midwife Bligh expressed the opinion that LCM was competent around the baby but couldn't say much more about his parenting skills as she had very little interaction with him. On the other hand, she had been able to form the view that CTB was generally loving and behaving appropriately towards Baby L.[217] Midwife Bligh was able to clarify that any aggression she had seen shown by LCM was either towards CTB or herself, but never Baby L. She had not seem him ever appear cross or rough with the baby. Nevertheless, when she heard there had been a major incident involving the baby at the hospital, she guessed who it involved.[218]

145. Midwife Di Lollo, who returned to work a week after the Code Black incident, understood that LCM had been granted 'supervised access,' which meant that the midwives and hospital staff would be assisting and supervising his 'father crafting' skills.[219] They were in the "going home phase"[220] by this time, so things were being done on the basis that Baby L would be going home with his parents soon. Midwife De Lollo thought CTB was "amazing and doing a fantastic job considering she was so young."[221] Unfortunately, she did not have an opportunity to view LCM with the baby. She understood that staff would have raised their concerns with the Department if any concerning behaviour had been observed.[222]

146. In that regard, what constitutes concerning behaviour perhaps changes with the benefit of hindsight. At the inquest, it became apparent that there had been a few incidents in the last couple of days prior to the tragic events on 15 February 2014 that might have provided some clue that LCM's ability to cope was decreasing, but it was either not apparent to the nursing staff at the time or they minimised it as they did not want to cause trouble for the young couple.

147. Midwife Jacqualyn Maughan (as she then was) saw LCM on the morning of Thursday, 13 February 2014 at around 10.00 am when he first arrived at the nursery. She said in her statement that "he walked right past me and didn't say hello, he looked pissed off – annoyed or irritated."[223] She said he then picked up Baby L and unwrapped him and jiggled him around, trying to wake him. LCM then took a bottle and the baby and pulled the curtain around so that she could not see him. She assumed he was going to try to feed Baby L, although she was aware he had been fed not that long before so probably wasn't hungry. Midwife Maughan went to check on another baby and then she heard Baby L begin crying in a distressed manner. She was going to go and check on him but at that time CTB arrived.[224]

148. A little while later CTB and LCM approached Midwife Maughan and said there was blood in baby L's mouth and asked where it was coming from. Midwife Maughan had a look and saw a little cut on Baby L's upper left gum and a tiny bit of blood with saliva. Midwife Maughan explained to LCM that

[217] T 27.
[218] T 30 – 31.
[219] T 46 – 47; Exhibit 5, Tab 15.
[220] T 49.
[221] T 40.
[222] T 49.
[223] Exhibit 2, Tab 5 [36].
[224] T 128 – 129; Exhibit 2, Tab 5 [37] – [41].

he had been too rough with the bottle when feeding LCM and he had to be more careful. She suggested he "needed to just calm down and just listen to what the baby was trying to say."[225] According to Midwife Maughan CTB appeared very concerned and CTB reiterated to LCM that he must be gentler when feeding the baby.[226]

149. Midwife Maughan did not make a note of this incident in Baby L's Integrated Progress Notes. She said in a note made a few days later that she verbally told the shift coordinator and also the next person she handed over to, so that they could observe and make sure LCM was using appropriate technique, but she chose not to make a written record as she "felt that the education had been given to [LCM] and that the issue didn't need to be told to the social work or make entry of it."[227]

150. Midwife Maughan explained further at the inquest that she chose not to write it down as she felt LCM had listened to her and had really taken it on board and it seemed to her that CTB was upset with him and would speak more to him about it. She also said that she felt at the time that "they were under enough scrutiny from the entire process themselves, and I felt myself that they were doing the best that they could …. and … he wouldn't do it again."[228] Midwife Maughan admitted that in hindsight it was "a silly move"[229] but at the time she was worried that if she wrote it down it would perhaps raise a red flag that wasn't required. In that context, Midwife Maughan explained that she felt it was more of a 'father crafting' issue than a sign that LCM was being deliberately aggressive towards Baby L.[230]

151. Midwife Maughan did say that she shared with a social worker the fact that LCM had appeared irritated and annoyed that day, but not about the small injury to Baby L's mouth.[231]

152. Afterwards CTB and LCM bathed the baby and took him outside for a little while before they left to get some lunch. Midwife Maughan fed LCM a bottle at 1.00 pm and there was no blood and he was happy at that time.[232]

153. Also on 13 February 2014 Ms Matters emailed Ms Fordyce, who had recently returned from leave, and advised her that Baby L would likely be ready for discharge on Monday, 17 February 2014. Ms Matters told Ms Fordyce that CTB would need to come in for a stay overnight with Baby L to show she was able to attend to all of his care needs. This is a common practice with new mothers and the decision whether to offer it can be made by a midwife or social worker.[233]

154. Ms Matters spoke to CTB and LCM later that day at the hospital and they discussed the Best Beginnings program and Ms Matters told them she would

[225] T 130.
[226] Exhibit 2, Tab 5 [42] – [47] and Tab 5.2.
[227] Exhibit 5, Tab 5.2.
[228] T 131.
[229] T 131.
[230] T 132.
[231] T 133 – 134; Exhibit 5, Tab 5.2.
[232] Exhibit 2, Tab 5 [42] – [47].
[233] Exhibit 5, Tab 18 [101], [106] and Tab 26 [15] – [16].

complete the referral at their request. Ms Matters also told CTB that she should come in and stay overnight at the hospital with Baby L for two nights prior to him being discharged to help her with her mother crafting and confidence. After the meeting Ms Matters emailed Ms Fordyce to let her know what had occurred.[234]

155. Ms Matters met CTB the next morning and CTB informed her that she was keen to participate in the Best Beginnings program so Ms Matters completed the referral and faxed it off. They also discussed CTB staying on the ward and Ms Matters confirmed it would only be her and LCM was still limited to attending within visiting hours.[235] Ms Matters did not have any further contact with CTB and LCM until after LCM's assault on Baby L the following day.

156. That afternoon an entry was made in the Integrated Progress Notes by a midwife indicating that both CTB and LCM had been caring for Baby L well and they were asking questions and enjoying their time learning about caring for Baby L.[236] Nothing of concern was noted.

EVENTS ON 15 FEBRUARY 2014

157. As arranged by Ms Matters, CTB was permitted to stay as a boarder in the maternity ward on 15 February 2014 to assist her in her mother crafting before the transition to taking Baby L home. CTB recalled that LCM had stayed the night before with his family so when she arrived at the nursery on the morning of 15 February 2014 LCM was already there and was holding the baby in the nursery. After CTB expressed some milk they put him in a portable cot and took him to a room two doors down from the nursery that had been allocated to CTB for her in-hospital stay. This was the first time that Baby L's parents had been able to take him out of the nursery.[237]

158. Before Baby L was taken out of the nursery he had been stripped and weighed by a nurse, so it was known that he was in generally good health that morning.[238]

159. Baby L and his parents spent the morning in their hospital room. They had brought some food with them, which they ate together and they also slept for a while. They eventually woke due to Baby L crying and his mother fed him and changed his nappy. The baby was still unsettled so she gave him some warm water and he eventually fell back asleep. Baby L's mother put him back into the cot and then returned him to the nursery before Baby L's parents went outside the hospital to smoke a cigarette.[239]

[234] Exhibit 5, Tab 18 [102] – [103].
[235] Exhibit 5, Tab 18 [105].
[236] Exhibit 4.
[237] Exhibit 1, Tab 20.
[238] Exhibit 1, Tab 20 [73].
[239] Exhibit 1, Tab 20.

160. It was noted that LCM had fed Baby L at about midday and he bathed and changed the baby with minimal supervision required. They had taken the baby for a walk and returned him to the nursery settled.[240]

161. Baby L's parents eventually returned to the room and both had a shower before they decided to go out and do some shopping at a supermarket. They walked past the nursery as they were leaving and CTB heard Baby L crying so she went into the nursery and nursed him back to sleep before they left.[241]

162. The supermarket was closed so they bought some food from a service station and returned to the hospital. Baby L's mother asked LCM to collect Baby L from the nursery while she warmed up some food in the kitchen that is across the hall from the nursery. She saw LCM wheel him down to the room in his cot. This occurred around 7.10 pm.[242]

163. Baby L was then alone with his father in the hospital room for a short period. In a time frame of 3 to 10 minutes LCM deliberately struck Baby L's head against a hard surface somewhere within the room or with a hard object, with considerable force. It is believed possible that LCM struck the baby's head against a wall or door frame or the floor of the room, but no specific finding has been made as to what actually caused the injuries. Baby L's father delivered at least two blows, one to the right and one to the left side of Baby L's head. These blows fractured Baby L's skull and caused severe brain injuries.[243]

164. When CTB returned to the room with the food she had prepared she found Baby L in his father's arms. He was standing just inside the door at the end of the bed. Baby L was not breathing and he was pale. She immediately noted a lump on the right side of Baby L's head, visible through his hair near his ear. Baby L's mother took the baby from LCM and rushed him to the nursery, where efforts were made to resuscitate him.[244]

165. Baby L's mother and father returned to their room. Baby L's father did not disclose what he had done and only said that Baby L had stopped breathing.[245] He was later interviewed by police and essentially admitted that while he held Baby L inside the hospital room he had 'accidentally' bumped the baby's head into the wall or door frame with enough force to cause a 'pop' noise.[246]

166. Medical staff at Bunbury Hospital managed to stabilise Baby L and x-rays were taken. They revealed skull fractures and areas of bleeding in the brain.

167. On 16 February 2014 Baby L was transferred to Princess Margaret Hospital for specialist paediatric medical treatment. On the same day he was brought into provisional care pursuant to s 37 of the *Children and Community*

[240] Exhibit 4.
[241] Exhibit 1, Tab 20.
[242] *LCM v The State of Western Australia* [2016] WASCA 164 [43] (Mazza JA & Beech J).
[243] *LCM v The State of Western Australia* [2016] WASCA 164 [43] (Mazza JA & Beech J).
[244] Exhibit 1, Tab 20; *LCM v The State of Western Australia* [2016] WASCA 164 [44] (Mazza JA & Beech J).
[245] Exhibit 1, Tab 20; *LCM v The State of Western Australia* [2016] WASCA 164 [44] (Mazza JA & Beech J).
[246] *LCM v The State of Western Australia* [2016] WASCA 164 [46] (Mazza JA & Beech J).

Services Act 2004 (WA). Application for a protection order under the Act was filed by the Department on 19 February 2014 but it did not proceed due to the baby's deteriorating condition.

168. Following investigations at Princess Margaret Hospital it became clear that Baby L had suffered a severe brain injury and the picture was suggestive of irreversible brain damage. His condition was discussed widely within the Neonatal Intensive Care Unit and with the Paediatric Intensive Care Unit specialists and it was felt there was no therapy that would be of benefit to him in terms of allowing him to recover. It was ultimately decided that he would be taken off the respirator and allowed to die peacefully. Baby L died on 24 February 2014 at Princess Margaret Hospital.[247]

CAUSE AND MANNER OF DEATH

169. Dr Moss, a Forensic Pathologist, conducted a post mortem examination on Baby L on 26 February 2014. The post mortem examination revealed bilateral parietal skull fractures as well as multiple areas of scalp haemorrhage. There was extensive subdural haemorrhage and severe brain swelling. There was a patent foramen ovale and otherwise the deceased was a normally developed male infant.[248]

170. Dr Fabian, a Neuropathologist, examined Baby L's brain and formed the opinion that the injuries were incompatible with shaking of Baby L's head and the brain injuries were caused by severe blunt force trauma. She commented that the injuries were "the most severe head or brain injuries that she had seen in an infant."[249]

171. At the conclusion of all investigations Dr Moss formed the opinion the cause of death was complications of head injury. I accept and adopt the conclusion of Dr Moss as to the cause of death.[250]

172. Dr Moss also expressed the opinion that it was unlikely the two separate areas of fracture of the skull were caused by one application of force, and the best explanation was that there were at least two impacts. The force required to cause those injuries was considerable and the injuries were all consistent with severe blunt force.[251]

173. As noted above, LCM pleaded guilty, and was convicted, of the offence of manslaughter in relation to the death of Baby L. The facts involved LCM deliberately applying force to Baby L's head, causing the head injuries that led to his death. I find that the manner of death was by way of unlawful homicide.

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[247] Exhibit 2, Tab 18.
[248] Exhibit 1, Tab 12.
[249] Exhibit 1, Tab 9, p. 45; *LCM v The State of Western Australia* [2016] WASCA 164 [48] (Mazza JA & Beech J).
[250] Exhibit 1, Tab 12.
[251] Exhibit 1, Tab 9, pp. 44 - 5.

QUALITY OF SUPERVISION, TREATMENT AND CARE

174. Under s 25(3) of the *Coroners Act 1996*, where a death investigated by a coroner is of a person held in care, the coroner must comment on the quality of the supervision, treatment and care of the person while in that care.

175. As mentioned at the outset, although Baby L was only taken into care following the catastrophic events on 15 February 2014, in my view the circumstances of Baby L's death at the hands of his father made it appropriate to consider the Department's involvement with Baby L and his parents in the lead-up to Baby L being taken into care.

176. In particular, Counsel Assisting identified a number of issues that essentially focussed on the Department's decision to allow the parents to have unsupervised contact with Baby L while he was at Bunbury Hospital and not to exercise its statutory power to take Baby L into care at an earlier stage. Issues of interagency communication and support for LCM to prepare him for fatherhood were also raised.[252]

177. Prior to considering those issues, it should be noted that after being convicted and sentenced in relation to the death of his son, LCM was diagnosed with Fetal Alcohol Spectrum Disorder (FASD), which led to a successful appeal against sentence. I consider below whether the evidence suggests knowledge of LCM's diagnosis might have changed the way in which he was managed.

Relevance of LCM's FASD

178. Despite the fact LCM was in the care of the Department for many years and Departmental staff were aware of a recorded history of alcohol and substance abuse by his mother, he was not assessed for FASD prior to Baby L's death. His lengthy involvement with the juvenile criminal justice system also did not lead to any sort of assessment for FASD until after Baby L had been convicted of manslaughter and sentenced to a term of detention. While incarcerated at Banksia Hill Detention Centre he participated in a programme for screening for FASD undertaken by the Telethon Kids Institute. As a result of that screening process LCM was diagnosed with FASD. "An essential element of this disorder is that the person has suffered a prenatal, permanent, organic brain injury as a result of maternal alcohol consumption in pregnancy."[253]

179. The organic brain injury which the deceased's father suffered before he was born was compounded by a severely deprived and dysfunctional childhood. The combined effect of the organic deficit and childhood trauma produced significant impairments in cognition, executive function, language, academic functioning and motor skills.[254] His level of impairment fulfilled a cut-off point 'for assignation of intellectual disability'.[255]

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[252] T 7.
[253] *LCM v The State of Western Australia* [2016] WASCA 164 [30] (Mazza JA & Beech J).
[254] *LCM v The State of Western Australia* [2016] WASCA 164 [91], [95] (Mazza JA & Beech J).
[255] *LCM v The State of Western Australia* [2016] WASCA 164 [97] (Mazza JA & Beech J).

180. The Court of Appeal found that LCM's powers of reasoning, logical thought and self-control were all compromised, as was his ability to deal with traumatic events. This was all in addition to the effects of his lived trauma, which itself compounded the effects of his FASD.[256] The Court of Appeal found that LCM's irrational behaviour was in part a reflection of the impairments attributable to FASD.[257] However, it was also accepted that his FASD and his traumatic life did not deprive him of the capacity to know that what he did was wrong.[258]

181. Ms Harvey, LCM's Departmental case manager from early 2011, was unaware that LCM had FASD and indicated it was never "on our radar to discuss with him."[259] It was clear from the evidence that Ms Harvey was aware that LCM had significant behavioural and psychological issues and he required a specialist report, but he was not open to engaging with the Department so it was difficult to explore further what his specific needs were. Ms Harvey was asked whether it would have made a difference if she had known that LCM had FASD and she responded that she did not know.[260]

182. Ms Rapkins observed that the fact that LCM was a child in care reassured the Bunbury case workers involved with the family, as they felt that he would have been assessed and any issues identified, including if he had FASD. In that sense, the assessment of LCM was not as rigorous as it would have been if LCM was unknown to the Department.[261] The reality was that LCM was not engaging well with the Department and they had had little opportunity to assess him in recent years.

183. Ms Rapkins further stated that if they had known that LCM had FASD it would have helped the Department's staff in terms of how they dealt with LCM. It would also have affected what they thought he would be able to achieve and would probably have raised a bigger question as to whether he had the capacity to grow once the supports and services had been put in place.[262]

184. Nothing alerted Ms Sara, LCM's Bunbury Youth Justice Services worker, to the fact that LCM showed symptoms of FASD. She had never had experience with a client with FASD previously and she only recently had training in relation to the condition, some years after these events.[263]

185. It is quite clear that not enough was known about LCM's cognitive deficits and behavioural issues to have a full understanding of how these impacted on his ability to become a father and to parent safely. While I accept that the tragic events that unfolded were unpredictable, particularly while the baby was still in what was considered to be the relatively safe environment of the

[256] *LCM v The State of Western Australia* [2016] WASCA 164 [126] (Mazza JA & Beech J).
[257] *LCM v The State of Western Australia* [2016] WASCA 164 [129] (Mazza JA & Beech J).
[258] *LCM v The State of Western Australia* [2016] WASCA 164 [141] (Mazza JA & Beech J).
[259] T 160.
[260] T 160.
[261] 210 – 211.
[262] T 210.
[263] T 82.

hospital, if more had been done to properly assess LCM the fact that he potentially posed a risk to Baby L might have become more apparent.

186. It is apparent from the evidence that there were opportunities to diagnose LCM at an earlier stage, but no steps were taken in that regard until he inadvertently became involved in the Telethon Institute project. Some of this can be explained by the fact that until recently there was less awareness of FASD amongst government agencies, although it was still known in medical communities and testing has been done for it from before LCM was born.[264]

187. In considering where matters stand today in terms of FASD diagnosis, Mr Geddes gave evidence that the Department is more aware of FASD now and provides training to staff through their Learning and Development Centre. However, Mr Geddes questioned sometimes the value of a FASD diagnosis, as opposed to an IQ and functioning assessment. He accepted that in LCM's case a diagnosis of FASD would have been another red flag and led to more identification of his functioning deficits and issues peculiar to him, that might have affected his ability to parent effectively.[265] However, Mr Geddes also suggested that a simple trauma profile would also have been effective in this regard.[266]

188. The Department of Corrective Services has also indicated that Youth Justice Services is undertaking work to improve practise in the area of recognising young people who may exhibit features consistent with FASD. The Department of Corrective Services will use information collected by the Telethon Kids Institute research study to assist in developing appropriate strategies to improve staff understanding of FASD and their ability to provide for the specific needs of youth with FASD.[267]

189. The information provided by the two Departments is encouraging in that it shows a commitment to educating staff about FASD, which is the first step towards identifying children at risk of having the disorder and will hopefully lead to better identification of their physical, behavioural and psychological needs so that the appropriate supports can be put in place.

Decision by the Department not to take Baby L into care

190. In sentencing LCM in the Children's Court, Reynolds CCJ, remarked that it was surprising that LCM's access to the baby was not conditional or supervised, given his age at the time combined with his personal history, which included "disconnection, aggression, personal violence, exposure to violence and substance abuse."[268] His Honour also expressed surprise that it had been thought that LCM was capable of properly caring for Baby L given his age and the matters personal to him.[269] These comments were made prior to LCM's diagnosis of FASD, so they were based upon what the Department knew of LCM's background at the time.

[264] Exhibit 2, Tab 21, pat 3(a), p. 3.
[265] T 228 – 230.
[266] T 230.
[267] Exhibit 2, Ta 21, Part 3(a).
[268] Exhibit 1, Tab 9, p. 43.
[269] Exhibit 1, Tab 9, p. 44.

191. There was expert evidence before Reynolds CCJ that suggested that the offence was caused, at least in part, by frustration and feelings of jealousy on LCM's part due to the attention Baby L was receiving from CTB. Baby L's father felt, in effect, like he was competing with Baby L for CTB's attention and affection.[270] This behaviour had not been identified by anyone involved with the couple prior to these events, although it was known that they had a dysfunctional relationship and LCM relied heavily upon CTB.

192. An independent clinical review instigated by WACHS found "there was a failure to appreciate the unpredictable nature of this troubled teenager. The opportunity to develop protective measures was not fully explored."[271]

193. It was explained during the inquest that part of the problem with assessing LCM and gaining a full understanding of his needs and abilities was due to his failure to engage with the Department. LCM's case worker, Ms Harvey, observed that throughout the period of years that she managed his care she had difficulty engaging with him. The relationship was dominated by a pattern of LCM ceasing contact and then engaging in criminal offending and being incarcerated. He would then re-engage with the Department and the Department would obtain a placement for him but once released to the placement LCM would abscond and engage in further criminal offending. A stable suitable long term placement was unable to be sourced for LCM. A number of attempts at obtaining placements with relatives were made but only two suitable caregivers were identified, LCM's aunt and maternal grandmother, and both of those options were trialled but ultimately failed due to LCM's behaviour.[272]

194. Ms Harvey made multiple attempts to enrol LCM in programs aimed at working with students disengaged from the education system. She also linked LCM with an Aboriginal Youth and Family Support Worker who assisted in attempting to engage LCM in education services, but these attempts failed. Ms Harvey also attempted to link LCM to drug and anger management counselling but he declined the offers.[273] Ms Harvey commented that with children in care, "we can only offer services to them"[274] and can't force them to do anything.

195. Between 2011 and 2014 LCM was on numerous community based orders (CBO's) imposed by the Children's Court for multiple offences. Ms Harvey's understanding was that LCM's engagement in his CBO's was also limited.[275] Ms Harvey prepared numerous reports to inform the court about LCM's situation and the reports highlighted issues of unstable accommodation, lack of engagement in work or education and escalating anti-social behaviour.[276] Ms Harvey also shared information with LCM's Youth Justice officers to help them understand a bit more about him and his social situation.[277] Nevertheless, there were many gaps in the information and it

[270] Exhibit 1, Tab 9, pp. 37, 52.
[271] T 141; Exhibit 5, Tab 26, Attachment 11.
[272] Exhibit 5, Tab 24 [113] - [115].
[273] Exhibit 5, Tab 24 [117] – [119].
[274] T 151.
[275] Exhibit 5, Tab 24 [120].
[276][276] Exhibit 5, Tab 24.
[277] T 151 – 152.

appeared that no one from the Department or Youth Justice was ever able to establish a good rapport with LCM.

196. Ms Harvey did, however, have at least some understanding of the troubled relationship between LCM and CTB and she properly raised those concerns with her Bunbury colleagues and her local superiors in an email. In the email Ms Harvey stated that she would be concerned about this baby given LCM's behaviour/history and the fact his relationship with CTB had been highly volatile in the past.[278]

197. While Ms Harvey's email does not limit her concerns to potential indirect harm to the baby, it was clear during the inquest that what was taken away by the main parties involved was a concern that Baby L might be hurt accidentally in the midst of violence between LCM and CTB. None of the people directly involved in the Signs of Safety meetings ever thought that Baby L would be the target of direct violence by one of his parents, despite LCM's history of violent behaviour.

198. It was put to Ms Fordyce, the Department's case worker who was managing the Signs of Safety meetings at the end, that LCM or CTB harming the baby wasn't even on her radar, and she responded, "It should have been, but it wasn't'."[279]

199. Ms Fordyce indicated that she had felt at the time that the hospital was a safe place for Baby L, and she was more worried about his safety when he went home. She had believed that they had more time in which to investigate further, and perhaps have another meeting, which could have led to a decision at some point that Baby L could not go home with his parents. The event that occurred in Bunbury Hospital was not something that Ms Fordyce ever anticipated.[280]

200. On 27 February 2014 the Department completed an Internal File Review on Baby L's death and a report was prepared for Cabinet. The review was prepared on the basis of the Department's virtual file only and staff were not interviewed. The review identified that there were delays in pre-birth planning and that the rigour in mappings, assessment and safety planning and inter and intra office case management collaboration could have been better. Although these failings were identified, the review concluded that there was no information to suggest that there was a direct correlation between any of these issues and the event that led to the death of Baby L.[281]

201. Nevertheless, it was accepted on behalf of the Department that earlier referral to pre-birth planning would have allowed the Department, CTB and other significant stakeholders to identify concerns, focus on safety planning and determine whether a protection order was required for Baby L in a more timely manner. It would have enabled the Department to form better judgments about whether CTB's protective capacities mitigated the risks

[278] Exhibit 5, Tab 24 [73], Attachment N.
[279] T 182.
[280] T 184 - 185.
[281] Exhibit 5, Tab 25 [117] – [119] and Attachment 2.

posed by LCM to CTB and their baby and the apparent positive steps being taken by LCM to deal with some of his issues.[282]

202. It was also acknowledged that the pre-birth planning process would have benefited from further information regarding LCM's background and history by involving his Cannington case worker, Ms Harvey, and Youth Justice worker, Ms Sara, in the mapping meetings. Further, the Department recognised it would have been beneficial for a co-worker from one of the Bunbury Office's Children in Care Teams to have been assigned to specifically focus on LCM and his needs, as had been requested by Ms Harvey.[283] The lack of a co-worker appointed to LCM made it difficult to know what gains LCM had really made since his dealings with Ms Harvey and commencing parenthood.[284] However, it was pointed out that LCM's transience made that slightly problematic as it created some uncertainty about where he would live long-term, which at the time meant that transfer was discouraged to allow the situation to become clearer.[285] The other reason why no co-worker was appointed appears to have been due to caseload issues.

203. Mr Andrew Geddes, the Department's Executive Director of Country Services and Therapeutic Care indicated that at the time of Baby L's death there were workload management issues impacting on the South West District and the Bunbury Office. The South West District Office was one of the busiest districts in the State, resulting in a significant increase in the number of contacts the Bunbury Office had to manage. This increase was partly due to population growth in the Southwest, with Bunbury being the second largest city in the State. The predominant issues for families in the area associated with the Department are identified as amphetamine use, domestic violence and mental health issues.[286]

204. In 2014, at the time of Baby L's death, the increasing number of contacts were managed by a large single Duty Intake, Assessment and Intervention Team. This adversely affected response times. The structure of the District has since been reviewed and new structure was implement on 3 March 2015. There is now a central Duty Team that manages incoming calls for the whole District and Bunbury now has a separate Assessment Team. Mr Geddes indicated that it has given Department staff a greater opportunity to have intense involvement with a family and try to increase their capacity and ability to provide care for their children.[287]

205. Mr Geddes also provided a copy of the Department's revised practice guidance in relation to the transfer of cases and the allocation of case workers for children in the care of the CEO. It was comprehensively reviewed and revised after Baby L's death and creates timelines and processes for how these matters are to be handled. It allows some flexibility that perhaps was not there previously.[288]

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[282] Exhibit 5, Tab 25 [128] – [129].
[283] Exhibit 5, Tab 25 [130] – [134].
[284] T 223.
[285] T 213 – 215.
[286] Exhibit 5, Tab 25 [123].
[287] T 216; Exhibit 5, Tab 25 [124].
[288] Exhibit 5, Tab 25 [135].

206. The Department has also strengthened its Casework Practice Manual since the death of Baby L to include pre-birth planning specifically for children in the CEO's care, as LCM was at the time.[289]

207. Ultimately, although these various issues have been identified it was suggested by Mr Geddes that it was not clear that earlier pre-birth planning and the involvement of LCM's case worker and the Department of Corrective Services in planning would have resulted in a different decision being made by the Department as to whether or not to bring Baby L into care. LCM's criminal history consisted mostly of property-related offences and, despite staff suspicions, CTB and her family were not open about the existence and extent of violence in her relationship with LCM. There was also no evidence of LCM ever having been violent or aggressive to young children or Baby L.[290]

208. At all times, the Department's concerns were the risk of incidental harm to Baby L or a lack of maturity on the part of his parents to manage parental responsibilities. It was never anticipated that LCM would be directly violent to Baby L and it was submitted that the precise circumstances in which Baby L was critically injured by his father were not foreseeable by the Department.[291]

209. Mr Geddes suggested that if the Department had pursued statutory action to take Baby L into care prior to the events on 15 February 2014 it was not clear that it would have been successful through the court process and if the Department is not successful with such an application then it has longer term implications in the context of the relationship with the family and there is less safety at the end because of the strained relationship between the Department and the family.[292]

210. The Community Development and Justice Standing Committee conducted an inquiry into the events surrounding Baby L's death and released a report in March 2016.[293] The purpose of the review was to identify any systemic issues rather than attributing blame to individuals. Two recommendations were made at the conclusion of the review:

> *Where there is insufficient information about a case and there is potential for a dangerous outcome, the Department for Child Protection and Family Support should take a precautionary approach; and*
>
> *The Department for Child Protection and Family Support should review its methods of maintaining contact with highly vulnerable and transient youth to ensure that every possible avenue for contact is pursued. It should direct sufficient resources to monitoring the location of particularly troubled children.*

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[289] T 216; Exhibit 5, Tab 25 [136].
[290] Exhibit 5, Tab 25 [138] – [40].
[291] Exhibit 5, Tab 25 [141].
[292] T 226.
[293] *Red flags, white flag response? The Department for Child Protection and Family Support's management of a troubled boy with a baby*, Report No 11, Community Development and Justice Standing Committee, Legislative Assembly, Parliament of Western Australia, March 2016.

211. In line with the first recommendation, following Baby L's death the Department strengthened existing practice guidance for assessing child protection concerns when a child is hospitalised and may be in need of protection. Departmental staff are now required to assess whether parent/caregiver contact requires restrictions and/or supervision, and work with the hospital staff to implement arrangements to safeguard and/or promote the wellbeing of the child.[294]

212. In addition, to ensure that sufficient information is obtained, lines of communication been the various relevant agencies have been improved.

213. Ms Sara, from Youth Justice Services, gave evidence that communication between Youth Justice and the Department had improved since these events and she had personally noted that her relationship with the Departmental staff had improved.[295]

214. Since Baby L's death there have been a number of practical changes to how WACHS South West identifies and manages children and pregnant women at risk. Ms Matters now chairs a collaborative meeting, known as the 'Babies at Risk' meetings, held via video conference between the Department's case workers and social workers and midwives from WACHS South West. The meetings allow an open discussion about pregnant women open to the Department and those identified by hospital staff as being of concern. All of the women and unborn babies discussed at these meetings are entered onto a 'Neglect Concern Register' that is maintained by WACHS Child Health Nurses and it is common now for child health nurses to attend the final pre-birth planning meeting with a pregnant woman identified as at risk.[296] There are also now monthly 'Children at Risk' meetings chaired by the Department in a similar vein that are attended by relevant agency workers.[297]

215. The meetings have been described as "incredibly beneficial"[298] in improving communication between the two agencies. Ms Matters, the Senior Social Worker at the hospital, agreed that communication with the Department had improved since 2014, attributing the difference in recent times to the 'Babies at Risk' meetings.[299] Ms Matters noted that in this case, CTB would not have been included in a 'Babies at Risk' meeting as the Department did not let the hospital know about the pregnancy. However, it is hoped that the meetings are a way to ensure that a similar case is not missed.[300]

216. Ms Matters agreed that in hindsight it would have helped in planning to know more about LCM's history, and she believed it would have been helpful for CTB to be made aware of that too as there were probably parts of his history that she did not know.[301] In this regard, Ms Matters commented that it would have been helpful for hospital social work staff to have been invited to the Department's internal mapping meeting after the Code Black incident

[294] Exhibit 1, Tab 8.1.
[295] T 81.
[296] Exhibit 5, Tab 18 [109] – [113].
[297] T 90 – 91; Exhibit 5, Tab 18 [114].
[298] T 140.
[299] T 90 - 91.
[300] T 108.
[301] T 95.

so that they could have heard more about LCM and his history of violence and understood the Department's concerns, so the hospital staff could take that into account when making their own decisions about lifting the ban on LCM.[302]

217. Nevertheless, as Ms Matters pointed out, it would be difficult to enforce the ban from the ward long term without any clear violence to staff or the baby and with no violence restraining order or other court order in place.[303] Ms Matters emphasised that as far as she was aware at no time had LCM been violent or aggressive towards his baby.[304]

Decision by the Department and Hospital to allow his parents unsupervised contact, particularly after the Code Black

218. Following the Code Black incident the decision not to take statutory action to take Baby L into care was made by the Department, and then it was left to the hospital to lift the maternity ward lockdown.

219. An independent clinical review suggested the decision to allow LCM back onto the Maternity Ward should have been made by a multidisciplinary team at a more senior level. Although this review did not appear to have been brought to the attention of the relevant management at the time of the inquest, I was advised by Ms Yvonne Bagwell, the Coordinator of Nursing and Midwifery at Bunbury Hospital, that the hospital had already implemented a similar procedure.[305] Ms Matters also indicated that they have tightened up their processes at the hospital and are more likely to involve management now in such decision-making and document the process better now, although it was suggested by witnesses that better documentation of the de-escalation of the Code Black would not have affected the outcome in this case.[306]

220. In terms of the decision to allow LCM unsupervised contact with Baby L after the Code Black incident, as I have noted above in the witness accounts, it was generally thought at the time that the violence had been directed at LCM's mother, with whom he had a troubled history. Even on the alternative version involving CTB, there was never any suggestion that he had harmed Baby L or been violent to anyone near the baby. The decision to limit LCM's access to visiting hours was more to do with having additional staff around in case of an incident involving LCM and another adult than any suggestion he might be aggressive towards the baby.

221. In those circumstances, staff from the Department made it clear they had little grounds for seeking a restraining order against LCM and the hospital had no basis for restricting his access any further.

222. The only known incident where LCM used any physical force against Baby L was the undocumented incident a couple of days before where Midwife

[302] T 101 – 102.
[303] T 101 – 103.
[304] T 105.
[305] T 142.
[306] T 103 – 104, 113 – 114, 140, 143; Exhibit 5, Tab 26, Attachment 11.

Maughan saw LCM behaving in an agitated manner[307] in the ward on 13 February 2014 and subsequently identifying that Baby L had a small wound in his mouth that was probably caused by LCM feeding him too roughly. In hindsight, this may have been a sign of his escalating behaviour and it was a matter that should properly have been documented by Midwife Maughan in the Integrated Progress Notes. Midwife Maughan explained her reasons for not doing so and admitted that in hindsight her decision not to document it was a mistake.[308] She was worried it might raise a red flag that wasn't required, but in hindsight that red flag may have been proven to be correct.[309] Nevertheless, it is difficult to see how anyone could have predicted the extreme violence that occurred a few days later from that incident.

223. Ultimately, I accept that the exact events that occurred on 15 February 2014 could not have been easily predicted and there was arguably not a sufficient basis for the Department to take action based upon what was known at the time. Nevertheless, there were warning signs that were not properly heeded by those involved, largely due to a lack of real understanding and knowledge about LCM and his increasing violence and lack of ability to regulate his emotions. Some of this information was withheld by the families of LCM and CTB, for various reasons, and some of this information was missed due to problems with communication between various agencies and individuals due to LCM's move from Perth to Bunbury and staff taking leave. There were missed opportunities by the Department to prioritise Baby L's safety and wellbeing as a result.

224. The approach recommended by the Community Development and Justice Standing Committee is that where there is insufficient information about a case and there is potential for a dangerous outcome, the Department for Child Protection and Family Support should take a precautionary approach.[310] I have no doubt that the individual staff members involved in this case, both from the Department and Bunbury Hospital, will do so in the future as it was apparent at the inquest that many of them were deeply traumatised by the tragic death of Baby L at the hands of his father.

225. The lesson that must be learnt from these sad events is to prioritise communication at an early stage, so that pre-birth planning can be done effectively and fulsomely. In this case, extensive pre-birth planning might have enabled a more accurate picture of LCM's ability to parent to have been realised. This may have helped CTB and her family to have a better understanding of what was best for Baby L, as well as the other people involved in the decision-making.

[307] Exhibit 2, Tab 5 [36].
[308] T 131.
[309] T 132.
[310] *Red flags, white flag response? The Department for Child Protection and Family Support's management of a troubled boy with a baby*, Report No 11, Community Development and Justice Standing Committee, Legislative Assembly, Parliament of Western Australia, March 2016.

CONCLUSION

226. The death of Baby L in February 2014 was an event that shocked the Western Australian public and was deeply traumatic for not only CTB and extended family on both sides, but also all of the individuals who were involved with the young family for his short life.

227. This coronial investigation is not the first inquiry into these tragic events and various recommendations have been made and implemented since Baby L's death and now. In those circumstances, I do not propose to make any further recommendations. However, this inquest has emphasised the need for early pre-birth planning where, as in this case, it can be clearly identified that an unborn baby may be at risk. Early planning allows for more opportunities for good communication between the relevant parties, which will allow for better calculation of risk and more opportunity to put in place safety networks. Where such early planning cannot, for whatever reason, be undertaken, then those involved should take a cautious approach to assessing risk, to ensure we protect some of the most vulnerable members of our community.

S H Linton
Coroner
25 June 2018