



MAGISTRATES COURT of TASMANIA

CORONIAL DIVISION



**FINDINGS, RECOMMENDATIONS and COMMENTS of Coroner
Olivia McTaggart following the holding of an inquest under
the *Coroners Act* 1995 (Tas) into the death of:**

BJAY ADAM JOHNSTONE

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Record of Investigation into Death (With Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Olivia McTaggart, Coroner, have investigated the death of BJay Adam Johnstone with an inquest held on 12, 13, 14, 17, 18, 19, 20, 21, 24 and 25 August 2015 in Devonport; 27, 28, 29 and 30 October 2015 in Burnie; 18, 19, 20 and 21 January 2016; 24 March 2016; 1, 6, and 14 April 2016; and 24 June 2016 in Hobart.

Appearances

Counsel Assisting	Ms Lakshmi Sundram
Child Protection Services	Mr Paul Turner
Tasmania Police	Mr Mark Miller and Ms Rebecca Munnings
Mission Australia	Mr Todd Kovacic
Youth, Family and Community Connections	Mr Matthew Verney
Glenhaven Family Care	Ms Leanne Topfer
Suellen Shadbolt	Mr Robert Phillips
Fleur Atkin	Ms Philippa Morgan
Simon Johnstone	Unrepresented
Hellen Dykstra	Unrepresented
Ashley Richelme	Unrepresented

Introduction

Preliminary matters

BJay Adam Johnstone was born on 14 October 2012 and died on 28 November 2012. BJay died as a result of traumatic head injury at the age of 45 days. Specialist medical evidence, including that of the forensic pathologist who conducted the autopsy, was that the pattern of injuries on BJay's body was characteristic of abuse of the most severe kind. The main injuries he sustained were a severe brain injury, fractured skull, multiple rib fractures, and fractures to both femurs and right pelvis.

Under section 24(1)(a) of the *Coroners Act 1995* a coroner must hold an inquest if it appears to the coroner that the death occurred in Tasmania and the coroner suspects homicide. Homicide is not defined in the *Coroners Act*. Under section 153(1) of the *Criminal Code* the definition of "homicide" is "*the killing of a human being by another*". Under section 153(2), "*killing*" is "*causing the death of a person by an act or omission but for which he would not have died when he did, and which is directly and immediately connected with his death*".

On the basis of the medical opinion and the other evidence in the investigation indicating that the injuries were non-accidental in origin, I suspected that BJay's death occurred as a result of homicide. Therefore, an inquest was mandatory pursuant to the *Coroners Act*.

The functions of a coroner are set out in section 28 of the Act. The provision is set out below:

“(1) A coroner investigating a death must find, if possible –

(a) the identity of the deceased; and

(b) how death occurred; and

(c) the cause of death; and

(d) when and where death occurred; and

(e) the particulars needed to register the death under the Births, Deaths and Marriages Registration Act 1999.

(f)

(2) A coroner must, whenever appropriate, make recommendations with respect to ways of preventing further deaths and on any other matter that the coroner considers appropriate.

(3) A coroner may comment on any matter connected with the death including public health or safety or the administration of justice.”

In relation to section 28(1)(e), neither the *Births, Deaths and Marriages Registration Act 1999*, nor the regulations made thereunder, provide for which particulars must be found. As observed by Coroner Cooper in *Mansell 2016 TASCDC 001*, this issue requires legislative attention.

The requirement of a coroner pursuant to section 28(1)(f) to find the identity of any person who contributed to death was removed on 21 April 2015. I am therefore not required to make this formal finding. However, the finding of how death occurred will necessarily entail an examination and finding as to the person or persons responsible for inflicting the fatal injuries upon BJay; see *Keown v Kahn and Anor* [1999] 1 VR 69 per Callaway J at para 16.

Terminology

In this finding, the following abbreviations are used:

“DHHS”	Department of Health and Human Services.
“CPS”	Child Protection Services, a division of Children and Youth Services, part of DHHS.
“the Act”	<i>Children, Young Persons and their Families Act 1997</i> .
“the Mersey”	Mersey Community Hospital.
“CHAPS”	Child Health and Parenting Service, a division of Children and Youth Services, part of DHHS. The organisation provides home visits for infant health checks by qualified child health nurses.

“ECM”	Extended Care Midwife, being a registered midwife employed by the Mersey to provide home midwifery visits after a birth.
“SW”	Social worker.
“CPIS”	Child Protection Information System, being the electronic system used by CPS in its statutory functions.
“RHH”	Royal Hobart Hospital.
“CBIS”	Community-Based Intake Service under Part 5B of the Act.
“Gateway”	Gateway Services, a CBIS operated by Mission Australia, providing a referral service for children and their families to receive support in areas of need.
“IFSS”	Integrated Family Support Services, being a partnership of nine non-government organisations, the lead partner being Mission Australia, that are utilised in the Gateway system to provide support to children and their families in areas of need.
“Glenhaven”	Glenhaven Family Care, an IFSS organisation.
“YAFF”	Youth and Family Focus Inc. (now Youth Family and Community Connections), an IFSS organisation.
“CBTL”	Community-Based Team Leader, a CPS worker with the primary role of liaison with Gateway and IFSS.
“IDM system”	the electronic information data management system used by Tasmania Police.
“MOU”	Memorandum of Understanding.
“TRF”	Tasmanian Risk Framework, being the process and documentation by which CPS conducts the risk assessment in respect of a notification.

Summary of the facts

BJay was the only child of Fleur Atkin (“Ms Atkin”) and Simon Adam Johnstone (“Mr Johnstone”). At BJay’s birth, Mr Johnstone was 23 years of age and Ms Atkin was 20 years of age. Ms Atkin and Mr Johnstone commenced their relationship in Victoria, moving to Tasmania in early 2012. Mr Johnstone’s mother and brother lived in Tasmania. Ms Atkin had no family or connections in Tasmania. Mr Johnstone had suffered a traumatic childhood that included physical abuse by his father, his mother’s partners and witnessing severe violence to his mother. He had an extensive history of child protection interventions, ultimately being subject to a guardianship order until the age of 18 years. Ms Atkin also suffered a traumatic childhood in Victoria that included physical abuse by her mother. She was also subject to child protection intervention. The short relationship between Mr Johnstone and Ms Atkin before the

birth of BJay was marked by homelessness, drug use and family violence perpetrated by Mr Johnstone upon Ms Atkin.

Ms Atkin attended the Mersey for antenatal care when pregnant with BJay. In the course of Ms Atkin's antenatal care two separate notifications by nursing staff were made to CPS in respect of her unborn baby due to the couple's homelessness and cannabis use. At BJay's birth CPS workers attended the hospital. They assessed that it was appropriate for BJay to live with his parents if the family lived with Mr Johnstone's mother, Hellen Dykstra ("Ms Dykstra"), at her two bedroom unit in Railton.

Therefore, after three days in hospital, BJay was taken home. He lived at the unit at Railton with his parents, grandmother and uncle. BJay's uncle was Ashley Richelme, the brother of Mr Johnstone.

Between the date of his birth and the date of his subsequent admission to hospital, a period of 19 days, severe injuries were inflicted upon BJay. During that period, Ms Atkin, Mr Johnstone and BJay were seen by CPS workers, CHAPS nurses, ECMs, and IFFS workers. BJay was also taken to a general practitioner on one occasion.

On 2 November 2012, Ms Atkin and Ms Dykstra took BJay to the Mersey with serious concerns about his condition. Due to the severity of his injuries, he was transported to the RHH the following day. There he underwent tests, treatment and monitoring. However, his injuries were so severe that he could not survive.

BJay died on 28 November 2012.

The inquest and the issues

The inquest was conducted between 12 August 2015 and 24 June 2016 over 23 hearing days. There were 44 witnesses called to give evidence. There were 91 documentary exhibits tendered, including voluminous medical and CPS records.

The issues for examination at inquest fell into two distinct areas.

The first issue involved how BJay died and the circumstances that led to him receiving the injuries discovered upon presentation to the Mersey.

After BJay's death, Mr Johnstone was charged with wilfully ill-treating a child under section 178 of the *Criminal Code*, involving several particulars of ill-treatment of BJay from his birth on 14 October 2012 until 2 November 2012. He was also charged with three counts of common assault against Ms Atkin occurring between 1 October 2012 and 28 October 2012. He pleaded guilty in the Supreme Court to all charges. On 23 December 2013 Chief Justice Blow sentenced him to a period of two years and six months imprisonment backdated to 3 March 2013 with a non-parole period of 18 months. In passing sentence, the Chief Justice stated:

"However, this case does not concern the fatal injuries. The authorities have been unable to establish who inflicted those injuries, but Mr Johnstone has admitted to ill-treating the child in various, less serious, respects before his hospitalisation."

The inquest specifically focussed upon those living in the home with BJay as the evidence indicated that the fatal injuries were inflicted in the home environment by one or more of those family members.

Secondly, the inquest examined the role of a number of organisations involved with BJay during his life, the role they played in protecting him from harm, and whether his death could or should have reasonably been prevented. Those organisations, and the main issues examined, were as follows:

1. CPS - The adequacy of the response to the antenatal and subsequent notifications until his admission to hospital on 2 November 2012. The issues examined included the assessment of risk to BJay, referral to Gateway and intended closure of the notifications.
2. Gateway - The acceptance of the referral from CPS and risk assessment procedures in respect of the family.
3. IFFS (Glenhaven and YAFF) - Awareness of risk to BJay, the scope of their expertise and reporting to CPS.
4. Tasmania Police - The adequacy of the response to a telephone call taken from a citizen of the United Kingdom by the Police radio room on 29 October 2012 to report a concern that BJay was subject to abuse in his home, and the subsequent actioning of the report for investigation.

As will be seen, there was a comprehensive failure of decision-making, action and systems in taking proper steps for BJay's protection. This failure lies primarily with CPS, which had the opportunity and power to remove BJay from his parents at birth. Nonetheless, deficits in action by Gateway intake and Tasmania Police also resulted in lost opportunities to protect him.

It is necessary in the course of this finding to consider the adequacy of decisions and actions of individuals, some in key positions, within the above organisations. However, I do not consider that it is appropriate to apportion responsibility for the multitude of failures between one or more individuals. For the very large part, those individuals undertook their tasks in good faith whilst working in a difficult environment and frequently within systems not conducive to sound decision-making. Therefore, where possible, my intention is to avoid unnecessary personal criticism. The ultimate purpose of my comments and recommendations is for the improvement of systems and practice so as to prevent other deaths of vulnerable infants and children.

The standard of proof in coronial inquiries is the civil standard of the balance of probabilities. However, where the findings may reflect adversely on an individual, such as in this inquest, the standard is to be applied in accordance with the principle in *Briginshaw v Briginshaw* (1938) 60 CLR 336. In that case, Dixon J (as he then was) stated:

"...reasonable satisfaction is not a state of mind that is attained or established independently of the nature and consequence of the fact or facts to be proved. The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding are considerations which must affect the answer to the question whether the issue has been proved to the satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences..."

Similarly, in *Chief Commissioner of Police v Hallenstein* [1996] 2 VR 1 Hedigan J said at page19:

“The identification of appropriate standards of proof and satisfaction is important, a matter that at all times must be borne in mind by any coroner who has to consider findings of contribution which must not lightly be made and only be made when there has been established the necessary degree of satisfaction of mind.”

I apply the above principles in this finding in relation to the standard of proof.

I am not, under the *Coroners Act*, permitted to make a finding or comment that any person is guilty of an offence or crime. A coroner may not charge or commit a person for trial in relation to any suspected offence or crime, no matter what the evidence at an inquest.

Chronological account of the evidence

I now set out and discuss the evidence chronologically.

The death of BJay must be seen in the context of the traumatic childhood years of Ms Atkin and Mr Johnstone. Details of their early circumstances, including their CPS involvement, were included in the documentary evidence. There was limited evidence at inquest regarding Ms Atkin’s childhood compared to that of Mr Johnstone. Although the chronology therefore contains less information in respect of Ms Atkin, her childhood abuse and neglect impacted most considerably upon her psychological development.

Much of the evidence went unchallenged during the inquest. Where reasons for a particular finding are required, they are included. I also incorporate into the chronology, where appropriate, my reasoning and conclusions where I have identified a deficit in action and/or a potential opportunity to have prevented BJay’s death.

Mr Johnstone was born on 22 July 1989 to Hellen Johnstone (now Dykstra) and John Smith.

Ms Atkin was born in Victoria on 11 January 1992. The correct names of her parents were not evident from the material provided.

In 1997 Mr Johnstone first came to the attention of CPS as a 7-year-old boy as a result of notifications made by his school about his exposure to family violence and physical abuse. An investigation was conducted by CPS whereby it was ascertained that Mr Johnstone was living with Ms Dykstra and one Tony Pyke. It was further ascertained that Mr Pyke was extremely violent and threatening towards Ms Dykstra and that he regularly assaulted her in front of the children. She sustained broken bones and bruising on several occasions.

CPS records indicate that Mr Johnstone had witnessed extreme and repeated threats of violence against his mother, including threats that she would be killed. It was recorded that Mr Pyke had physically and psychologically abused Mr Johnstone on numerous occasions. The records further indicate that Mr Johnstone was without food or adequate clothing at times, exposed to alcohol and drug abuse by the adults caring for him, and did not attend school regularly.

As a result of these first notifications, CPS placed Mr Johnstone in foster care for a period of approximately two months whilst Ms Dykstra was in hospital recovering from an assault inflicted upon her by Mr Pyke. Mr Johnstone was then returned to the care of his mother.

In 2000, CPS received a second notification in respect of Mr Johnstone, aged 11 years, when Ms Dykstra attempted to end her life. CPS investigated the notification and determined as follows: that there was a complex history of sustained abuse of Mr Johnstone; that he was exposed to extreme violence, including family violence; that he did not regularly attend school; that he suffered ADHD and was prescribed medication to manage the condition; that he had significant delays in his learning and social skills; that he had a long history of physically assaulting peers and adults; and that Ms Dykstra was unable to protect her children or herself.

CPS again placed Mr Johnstone in foster care before returning him to Ms Dykstra. Whilst in foster care, it was noted that Mr Johnstone frequently assaulted and bullied other children, both in the school and in the foster care environment; that he had a fascination with fire and fire lighting; that his behaviour was reactive, impulsive and aggressive; that his IQ was borderline at 76; and that his attachments had been insecure.

From March 2000 to October 2000 Victorian CPS ("VCPS") was involved in protective intervention with Ms Atkin and her family. Such involvement was due to allegations that Ms Atkin's mother was extremely abusive towards Ms Atkin. There were also concerns raised that Ms Atkin and her siblings were not properly fed.

From 15 January 2001 to 5 February 2003 Ms Atkin was subject to a protective order made by VCPS, as it was alleged that Ms Atkin's mother would hit, kick and punch her, as well as throw her against a linen press. There were also continued concerns regarding environmental neglect. The evidence suggests that these orders did not result in foster placements.

In about May 2001 Mr Johnstone commenced living with his father, Mr Smith, primarily due to his mother leaving the State because of violence exhibited by Mr Johnstone to his mother and younger sister. Prior to this time Mr Smith had not seen Mr Johnstone since he was three months old. Mr Johnstone received no extended family support. However, issues relating to violence by his father, neglect, school non-attendance caused further CPS involvement.

In May 2002 Mr Johnstone was placed with a family in foster care pending further assessment of risk.

In June 2002 a medical report was written by Dr Christopher Bailey, paediatrician, stating that Mr Johnstone suffered ADHD and engaged in antisocial behaviour.

On 15 July 2002 a 12 month Care and Protection Order in respect of Mr Johnstone was made in the Devonport Magistrates Court. The affidavits in support of the application noted the total lack of family interest in Mr Johnstone, his pattern of violence and absconding together with the other serious behavioural and risk issues previously outlined. CPS thereafter developed a case plan to manage Mr Johnstone.

In July 2002 when Mr Johnstone was almost 13 years of age, a Guidance Assessment was completed by psychologist Ms Rebecca Downy. The assessment noted the following: that his IQ was well below average at 78; that he had aggressive behaviour noted to be clinically significant; that he exhibited antisocial traits; that his memory was low and he suffered black

outs; that he was socially ostracised by his violent behaviour; that his social behaviour was maladaptive and pathological; that he had extreme difficulty in being able to interact; and that he used violence in interactions.

Ms Downy's assessment emphasised the role of Mr Johnstone's traumatic experiences and painted a bleak picture of his prospects for a well-adjusted and happy future.

In June 2003 a psychologist, Ms Susan Hyslop, prepared a report for CPS concerning Mr Johnstone. At this time he was 13 years and 10 months of age. Ms Hyslop assessed Mr Johnstone's ADHD condition as significant. She stated that his verbal IQ was 62, indicating a mild intellectual disability. She reported that Mr Johnstone's communication skills were brief and that he might experience difficulty keeping up with his peers in a wide variety of situations that require age-appropriate thinking and reasoning abilities.

On 23 July 2003 when Mr Johnstone was nearly 14 years of age, a Care and Protection Order was made by the Court in respect of Mr Johnstone until he reached 18 years of age. This order granted custody and guardianship to CPS. He was then placed in foster care.

Between August 2003 and November 2003 there was further VCPS intervention in respect of Ms Atkin. It was noted in the VCPS documentation that Ms Atkin had been diagnosed with Oppositional Defiance Disorder and other mental health conditions that were unspecified on the records.

In January 2004 CPS received a notification that Mr Johnstone had sexually assaulted a 7-year-old girl living in the same household. He was then placed in a group foster home and the allegations were reported to police. From this point his accommodation and schooling became more unstable, and he started to offend on a regular basis.

In January 2004 Ms Hyslop prepared a report regarding Mr Johnstone. She stated that, instead of communicating his wishes and needs, he would likely deal with problems by becoming silent, in turn leading to uncooperative and aggressive behaviours. His difficulties in managing anger and lack of insight as to how his behaviour affected others were also noted by Ms Hyslop.

On 26 April 2005 Mr Johnstone committed the offence of aggravated armed robbery and was sentenced to 13 months detention, serving an actual detention period between 27 April 2005 and 15 September 2005.

On 30 June 2005 a notification to VCPS was made in respect of Ms Atkin that she was found by police in a main street dressed in pyjamas and slippers. The subsequent application by VCPS noted an escalation in her criminal behaviour, influence of poor associates, inhalation of substances, her mother's emotional abuse (due to suffering family violence) and inability to manage her behaviour.

Relevantly, the records state that Ms Atkin had been emotionally damaged and varied greatly in her presentation. At times she would present as quite young for her age and very childish in her actions. At other times she would show significant insight and acted in a manner more appropriate for an older adolescent.

In April 2006 a Youth Justice pre-sentence report was prepared concerning Mr Johnstone in respect of numerous further offences of assault and dishonesty. The author formed the opinion that he was a high risk criminal offender, had no empathy and that he required radical intervention. He received a detention order of 8 months for this offending and, in August, his earlier suspended detention order was activated.

On 24 April 2007 Mr Johnstone was released from Ashley Youth Detention Centre.

In May 2007 a pre-sentence report concerning Mr Johnstone indicated that he was disengaged from society and lacked any respect for the law.

Mr Johnstone subsequently continued offending and lived in different places in unstable accommodation. There is no evidence that he ever had employment of substance. Mr Johnstone's offending between 2005 and 2009 includes aggravated armed robbery, burglary and stealing charges, unlawfully setting fire to property and motor vehicle offences.

It appears that, in respect of Ms Atkin, VCPS maintained orders until she turned 18 years of age in November 2010, with Ms Atkin living in various placements, including with her sister. She undertook some studies at TAFE.

In 2009 when Ms Atkin was 17 years of age she met Mr Sam Shreuder, and, at the age of 18 years, married him. The marriage ended after 18 months in late 2011.

In 2010 Mr Johnstone, whilst in Tasmania, reengaged in contact with his mother through Facebook. He then travelled to visit her in Queensland for a short period.

In 2011 Mr Johnstone moved to Victoria. He lived in a motel in Warnambool and met Ms Atkin who was also living in the motel, having separated from Mr Shreuder. They both subsequently lived in a house with a couple named "Lester" and "Jess" in Warnambool. They then moved into the house occupied by Ms Atkin's mother.

In 2011 Ms Dykstra, Mr Johnstone's mother, moved from Queensland to Ulverstone and settled in Railton.

Pre-Birth period (2012)

In early 2012 Ms Atkin and Mr Johnstone arrived in Tasmania from Victoria. At this stage Ms Atkin was already pregnant with BJay. The relationship was abusive from its inception, with Mr Johnstone regularly inflicting physical violence upon Ms Atkin. Upon arrival in Tasmania they had no permanent accommodation. The couple originally lived with Ms Dykstra, but due to disagreement, they then "couch-surfed" with various friends until the birth of BJay.

On 18 June Ms Atkin attended her first antenatal consultation at the Mersey with Nurse Gina Hollows. Ms Atkin and Mr Johnstone attended the appointment together. On that day a referral was made to social worker Ms Cheryl Hite by antenatal staff in relation to their issues of homelessness and pregnancy. It was also mentioned in the referral that the couple had fled from possible violence in Victoria.

On 19 June SW Hite met with Ms Atkin. She told SW Hite about leaving Victoria quickly and implied that drugs may have been involved. SW Hite did not recall any reference to the issue

of family violence. She noted that Ms Atkin was quite shy and needed encouragement to engage, but when encouraged she did respond.

On 26 June Mr Johnstone, Ms Atkin and Ms Dykstra attended the Devonport Community Health Centre, where they met with SW Hite. This was the first time that SW Hite had met Mr Johnstone. At that appointment Ms Hite observed that both Mr Johnstone and Ms Atkin appeared 'sluggish'. Mr Johnstone confirmed that both he and Ms Atkin had used cannabis that day. SW Hite noted that Ms Atkin was less forthcoming in talking and was quite tearful during the appointment, saying that she was unwell and felt homesick. Mr Johnstone was leading the conversation. SW Hite felt that neither parent engaged on this occasion, and there was very little interaction between them. At this appointment Ms Dykstra stated that she suffered from bipolar disorder and that her relationship had recently ended because of this. SW Hite noted that Ms Dykstra was very engaged in the process.

On 29 June Ms Atkin presented to the hospital for an antenatal appointment with Nurse Hollow who observed nothing unusual in Ms Atkin's presentation.

On 13 July Ms Atkin attended an antenatal consultation with Nurse Judith Taylor. A scan was conducted which showed Ms Atkin to be 25.2 weeks pregnant. Ms Atkin told Nurse Taylor that she was smoking two bongs a day. A discussion between Ms Atkin and Nurse Taylor concerning lack of housing also took place. A message was left by Nurse Taylor to social worker Ms Heather Osborne to assist Ms Atkin. However, SW Osborne did not become involved at that stage.

On 10 August the couple attended the Mersey for an antenatal appointment and were seen by Nurse Barbara Salter. The pregnancy was then at 29.2 weeks gestation. Nurse Salter noticed that both parents behaved abnormally, exhibited little eye contact and were giggling inappropriately. Ms Atkin told Nurse Salter that she was using cannabis during the pregnancy. Nurse Salter noticed a bruise to Ms Atkin's right cheek, but did not question her about what caused the bruise due to the potential to place Ms Atkin at risk whilst Mr Johnstone was in the room. Nurse Salter did consider the possibility of family violence. She did not record her suspicions in her notes. Nurse Salter gave evidence that now, if family violence is suspected, the standard practice is to request that partners leave the room whilst appropriate questions are asked to ascertain the existence of family violence.

At 5.09pm on the same day Nurse Salter, in the presence of Nurse Taylor, telephoned CPS to make an "unborn baby notification". She used the landline in the nurse's room to make the call to the after-hours CPS number and spoke to a staff member of CPS. Both Nurse Salter and Nurse Taylor were of the view that the couple's homelessness and drug abuse posed a risk to the unborn baby which necessitated a CPS referral. Both nurses were also sufficiently concerned on this occasion to leave a message with the social worker in addition to CPS.

The evidence indicates that, if the information in the telephone call had been correctly actioned, CPS would likely have generated an "unborn baby alert". In such case, an alert would be forwarded by CPS to relevant birth hospitals and other involved organisations. If correctly actioned, the information from the call would have been recorded on CPIS. It would then have been assessed by CPS Intake to determine whether the notification would be passed to the CPS Response team for further investigation or closed at the Intake stage without further substantive involvement of CPS.

However, Nurse Salter's information was not recorded on CPIS nor was Nurse Salter contacted again the following day for further details by a CPS worker. There was no evidence at inquest from CPS that it had received or recorded this notification. I find that there was nothing done in response to it.

On 28 August SW Hite again met with Mr Johnstone and Ms Atkin for a pre-arranged appointment at the Mersey. She noted that their presentation was flat, and that no effort had been made by them to follow up housing avenues.

On 7 September both Mr Johnstone and Ms Atkin presented to their antenatal clinic appointment under the influence of cannabis. During the consultation Nurse Taylor observed their behaviour to be erratic, non-compliant and aggressive on occasions. They both presented with a glazed appearance and were unable to concentrate on the conversation. Ms Atkin told Nurse Taylor that she had used cannabis that morning. Tests revealed that BJay had not grown since 10 August and was growing 4 weeks behind a baby's normal in-utero rate. Therefore an urgent scan was scheduled.

On 12 September the scheduled scan was conducted. Ms Atkin was then referred to an immediate consultation with a doctor, at which Nurse Taylor was also present. In the consultation room Ms Atkin became very abusive, yelling and screaming. Mr Johnstone was called into the consultation room to calm her. When Nurse Taylor left the room, she encountered a security officer who had been called by the administrative assistant in response to the incident.

There was evidence about this incident being a "Code Black", being a category of hospital alert where the safety of a person is at risk. I accept, as indicated by Nurse Taylor, that the level of Ms Atkin's behaviour did not satisfy that criterion. In fact, Nurse Taylor ultimately dismissed the security officer but accepted that it was appropriate for the administrative assistant to seek the presence of security on the basis of the abusive language coming from the consultation room. It appears, from the testimony of various witnesses, that this incident was mistakenly assumed to be a Code Black called in relation to the behaviour of Mr Johnstone. I find that there was no Code Black called in respect of Mr Johnstone at any relevant time.

On 21 September SW Hite received a new referral from the antenatal clinic regarding Ms Atkin and her lack of housing. At this time, SW Hite formed the belief that a CPS notification was appropriate, although did not submit one as she believed that it had already been made and she would not be able to add anything to the referral. However, due to the ongoing risk factors of lack of housing, drug use, and need for multiple supports, she contacted Mission Australia to assist Ms Atkin and Mr Johnstone. Mission Australia is the lead organisation in Gateway Services and accepts referrals to assist families with specific needs. SW Hite also made a further social work appointment. It is plain that she recognised the inability of the couple to assist themselves and the risk factors surrounding the birth of the child.

On 25 September SW Osborne took over as the social worker of Ms Atkin and Mr Johnstone as a result of a referral from SW Hite.

On 27 September SW Osborne met with Ms Atkin and Mr Johnstone at the Mersey. She gave evidence that there was nothing out of the ordinary about either of them or their interaction

with each other. SW Osborne also stated that she was aware of a CPS notification at this time, presumably because of Nurse Salter's notes in the hospital records. On the evidence, it is likely that both SW Hite and SW Osborne would have made notifications to CPS had they not believed that CPS were already taking action upon the notification of 10 August.

On 1 October Mr Johnstone assaulted Ms Atkin by grabbing her by the upper arms with his hands, squeezing them forcibly, shaking her and telling her to "get fucked". Mr Johnstone was convicted and sentenced for this assault. However, there was no complaint made by Ms Atkin at the time, and this episode of violence only came to light after BJay's death. I have not included uncharged episodes of violence by Mr Johnstone to Ms Atkin in this chronology. However, I am satisfied that the violence was regularly inflicted throughout this period and was mostly not the subject of charges. I am not able to ascertain precise dates for these incidents, and I will deal separately with them in a further section of the finding.

On 4 October Ms Osborne contacted Ms Atkin due to a missed midwife's appointment. Ms Atkin indicated that she missed the appointment due to lack of transportation. She attended the following day, with the records indicating that she was swearing and anxious.

At 4.45pm on Friday 12 October Nurse Taylor contacted CPS as she was concerned that Ms Atkin was being admitted to give birth on 14 October and there still had been no social supports put in place. She gave evidence that she spoke with a person called Michelle (surname unknown) from CPS, who informed her that there had been no record of the notification by Nurse Salter to CPS on 10 August. Nurse Taylor advised CPS about the parents' drug abuse and behaviour. She noted that they had presented on 10 August with slurred speech, unsteady on their feet and unable to follow the flow of the consultation regarding their baby's general health and the need for an early birth. She also expressed concerns that as soon as the baby was born, the parents would attempt to leave the hospital and that the baby may suffer from possible drug withdrawal issues. She was informed by Michelle that CPS would follow up this notification on Monday. On this same day, Nurse Taylor also telephoned Gateway to determine whether the organisation had been contacted to support the parents. Like SW Hite, the evidence of Nurse Taylor indicated strong concerns regarding parental coping skills and risk to the unborn baby.

CPS worker Robin Bull gave evidence that on 12 October nurse manager Maureen Pendell telephoned her on Ms Bull's mobile telephone. This may have been after Nurse Taylor's call referred to above. Nurse Pendell also expressed concerns that the earlier notification had not been acted upon. Ms Bull checked CPIS but could find no record of the earlier notification that Nurse Pendell indicated had been made. Ms Bull and Nurse Pendell had another conversation that day in which Ms Bull recorded details of the notification.

I find on the evidence that the CPS notification made by Nurse Salter, with Nurse Taylor, had in fact been overlooked by CPS and no record of it was made. This error by CPS had the effect of a reduction in the opportunity for investigation by two months in the crucial pre-birth period. This should have involved a strategy, based upon properly considered risk, for BJay's immediate protection upon his birth. As further discussed, even if the notification had not been overlooked, it would most likely not have been investigated.

In the notification of 12 October the following information was provided to CPS, by either Nurse Taylor and/or Nurse Pendell, regarding Ms Atkin and Mr Johnstone, and therefore risk factors to the unborn baby:

- They had fled Warrnambool in Victoria before arriving in Tasmania.
- They had presented for clinic appointments unbathed, in dirty clothing and under the influence of drugs.
- They had presented unable to follow discussion regarding the need for an early birth, having slurred speech and unsteady on their feet.
- They had missed several clinics and specialist appointments throughout the pregnancy.
- Concerns that they would leave the hospital with the baby early and the baby may suffer drug withdrawal effects.
- That they had nowhere to live.

The notes of the above notification were entered into CPIS on Monday 15 October, the day after BJay's birth and three days after the notification. Given the crucial importance of this system in the operations of CPS, the notification should have been recorded immediately.

At this point, it is appropriate to mention some relevant provisions of the Act and associated areas of CPS practice within its framework.

Pursuant to section 10B of the Act, the Tasmanian Government has responsibility for promoting and safeguarding the wellbeing of children and, if required, assisting families in fulfilling their responsibilities for the care, upbringing and development of their children.

Section 10E provides that, in performing functions or exercising powers under the Act, the best interests of the child must be the paramount consideration.

Section 4 of the Act, defines the meaning of "at risk" and states, *inter alia*:

(1) For the purposes of this Act, a child is at risk if –

(a) the child has been, is being, or is likely to be, abused or neglected; or

(b) any person with whom the child resides or who has frequent contact with the child (whether the person is or is not a guardian of the child) –

(i) has threatened to kill or abuse or neglect the child and there is a reasonable likelihood of the threat being carried out; or

(ii) has killed or abused or neglected some other child or an adult and there is a reasonable likelihood of the child in question being killed, abused or neglected by that person; or

(ba) the child is an affected child within the meaning of the Family Violence Act 2004; or

(c) the guardians of the child are –

(i) unable to maintain the child; or

(ii) unable to exercise adequate supervision and control over the child; or

(iii) unwilling to maintain the child; or

(iv) unwilling to exercise adequate supervision and control over the child; or

(v) dead, have abandoned the child or cannot be found after reasonable inquiry; or

(vi) are unwilling or unable to prevent the child from suffering abuse or neglect.

As a matter of practice, the CPS Intake team receives notifications in respect of a child or children. Intake workers use the TRF and Risk Factor Warning list guidelines in this process. These guidelines are set out in the Child Protection Manual that governs CPS practice in Tasmania.

The TRF provides a comprehensive guide to information-gathering, analysis and judgment regarding the impact and risk of abuse and/or neglect to children. The TRF is used to carry out an initial assessment of risk. Information is gathered from the notifier and other sources to make a judgment about immediate safety issues and the need for further detailed assessment of the situation. The assessment is recorded on CPIS.

If the notification is assessed as serious and requires further assessment it is referred to the Response team for further investigation, risk assessment and action. At Response level, the TRF is used more fully and the investigation is conducted in greater detail in order to determine risk response. Again, the usual course is that a risk assessment is recorded in CPIS. If orders seeking the removal of the child are then considered appropriate, there is consultation with the Court Application Advisory Group ("CAAG") within CPS as to the type of order that should be sought. The CAAG comprises experienced CPS workers who provide advice and support in respect of court applications under the Act.

Various powers under the Act are available to CPS in respect of the involuntary removal of a child from his or her parents where the level of risk and best interests of the child render that course necessary, having regard to the completed risk assessment. These include applications by CPS to the Magistrates Court for a warrant to remove the child to a place of safety, assessment orders and care and protection orders.

Under section 17A of the Act CPS may also refer a risk notification to a CBIS, being Gateway, if satisfied that the CBIS is an appropriate organisation to take action in respect of the notification. This type of referral involves the CBIS accepting the referral and the family agreeing to accept support services upon a voluntary basis. Upon satisfaction of these conditions, CPS will usually close its notification without further action. This type of referral by CPS necessarily applies to notifications where risk to the child is assessed as sufficiently low that the child may continue to reside with his or her family.

Returning now to the notification of 12 October, CPS was therefore obliged to fully assess risk to the unborn baby pursuant to the provisions of the Act. It was then obliged to take the measures necessary to protect him from that assessed risk, depending upon its degree.

Hospital period after birth

At 2.43am on 14 October 2012 BJay was born at the Mersey at 38 weeks gestation. Ms Atkin's labour was uncomplicated and relatively swift. BJay weighed 2630g, being on the

lower end of the normal spectrum. His Apgar scores were normal. He was a healthy baby in all respects.

On the morning of BJay's birth, Nurse Olga Wilson spoke with Ms Atkin about the importance of supporting BJay's head when lifting him and the potential to cause injury if the head was not properly supported. At this time Mr Johnstone was in the room, but not engaging in the conversation. In regards to feeding BJay and changing his nappy, Ms Atkin undertook these tasks correctly. Nurse Wilson gave evidence that BJay was being monitored closely for the effects of Ms Atkin's cannabis use during pregnancy. However, she stated that the results of that monitoring indicated that there was no concern.

On Monday 15 October SW Osborne visited Ms Atkin and Mr Johnstone in hospital. At 11.22am she telephoned CPS to notify of the birth of BJay. I note that no CPS workers had already attended the hospital despite the notification of the birth the previous Friday.

At 2.55pm Cheryl Eberhardt and Ms Bull, CPS workers, attended the Mersey and spoke to Ms Atkin and Mr Johnstone and conducted enquiries for the initial assessment of the notification of 12 October. Ms Atkin provided Ms Eberhardt with a significant amount of information. This included: that she had a child protection history in Victoria, that she came to Tasmania because she was punched in the stomach by a male, and that she and Mr Johnstone had only been in a relationship for a month before she became pregnant. She confirmed the use of marijuana, but said that she wanted to cease its use. She denied being the victim of family violence. She refused to provide CPS with names of those with whom she had been living.

Mr Johnstone and Ms Atkin said that they had made arrangements to live with Ms Dykstra in her unit.

Therefore, at 3.22pm Ms Eberhardt and Ms Bull went to Ms Dykstra's address to conduct an inspection for suitability but no one was present.

At 4.00pm Ms Eberhardt also spoke with Ms Dykstra by telephone regarding her attitude to the family staying with her and the support she could provide. Ms Dykstra indicated that she was willing to have them. On that basis, a home visit was scheduled for the next day for CPS to assess the suitability of the home environment proposed for BJay.

At about 4.10pm SW Osborne spoke with Ms Eberhardt and indicated the need for support for the family. Ms Eberhardt said that the family would be referred to Gateway.

As part of the assessment on this date CPS also arranged to receive Ms Atkin's records from VCPS. Documentation was received several days later but there is no indication that it was considered in the assessment of risk to BJay. Moreover, the only document received by CPS was a 14 page report and summary, far less than what I would have expected as a full child protection file containing Ms Atkin's extensive history.

By this stage, on 15 October, the notification of 12 October was electronically recorded in CPIS. A risk analysis was conducted and approved by two CPS workers on this day, although it is unclear as to what time this assessment was made. The assessment noted that CPS considered the harm consequence to BJay as *concerning*, the harm probability as *likely* and future risk as *high*. BJay was given a priority rating of two. On this basis the notification was

referred to the Response team to further investigate the notification and to make a full assessment of risk in accordance with the TRF.

On 16 October CPS cancelled the scheduled visit to Ms Dykstra's unit due to the need to execute a warrant in regards to another child, being an urgent matter with a priority one rating. CPS did not reschedule this visit prior to BJay being discharged from the hospital. Further, no attempt was made by CPS to delay BJay's departure from hospital until satisfied that the proposed home environment was safe. A CPS worker did not personally meet with Ms Dykstra before BJay departed hospital to assess her suitability as a responsible and protective person, who could alleviate the risk to BJay that was apparent from the notification and assessment. By this stage CPS should have been aware that material information may well have been obtained regarding Ms Dykstra from CPS records.

On this same date, Ms Atkin went to the toilet in her hospital room, leaving Mr Johnstone and BJay in the room alone. When she came out of the bathroom she observed Mr Johnstone holding BJay tightly around the throat and then throwing him down onto the bed. After BJay's death, Mr Johnstone was charged and convicted of this assault upon BJay. At the time, however, no person in authority was aware of this occurrence and it was not reported by Ms Atkin.

Between 14 and 16 October bruising was noticed on BJay by Ms Atkin whilst they were in hospital. Ms Atkin stated that she confronted Mr Johnstone over the bruising, but she did nothing further and no one else was notified about the injury.

On 17 October Ms Atkin and BJay left hospital to live with Ms Dykstra with the knowledge and assent of CPS. Nurse Mandy Glann spoke with Ms Atkin about making an appointment to see her upon discharge, but no appointment was made at that stage.

On the same day, being 17 October, Ms Eberhardt made a referral to Gateway via an email to the CBTL, Leah Steven. Ms Steven was the CPS worker then in the community-based role. Notwithstanding the referral, the CPS notification remained open and requiring investigation. As further discussed, the referral to Gateway was premature in light of the level of risk to BJay and the extent of the unknown information. The operative MOU between CPS and Gateway requires immediate transfer of case responsibility from CPS to Gateway in the event of a referral. The MOU does envisage some scenarios whereby the CPS case will remain open despite Gateway having accepted the referral. This was the situation in respect of BJay's notification. Importantly, the MOU provides that, in this category of cases, case responsibility will remain with CPS until it becomes a closed case.

Therefore the obligation of CPS was to maintain case responsibility. However, the referral to Gateway had the effect of significantly diluting CPS responsibility, and signified the premature commencement of the process of closure of the notification.

BJay's 19 days at home

On 18 October 2012, the day after BJay was brought home, CPS workers, Ms Bull and Kellylee Munting, conducted a home visit at Ms Dykstra's address. Ms Munting had no prior involvement in the notification and was briefed by Ms Bull in the car on the way to the unit. Their evidence was that nothing was amiss. BJay was asleep in a capsule. They noted that

Ms Atkin and Mr Johnstone did not appear affected by substances and engaged well. Ms Dykstra told them that she would not permit drug use in the unit. Ms Atkin indicated that she would not consume cannabis. The CPS workers noted that Mr Johnstone and Ms Atkin were occupying one of the two bedrooms. There was a bassinet and portacot for BJay. They noted that Ms Atkin was happy to answer questions and said she would accept voluntary referrals to support organisations and home visits by the midwife.

There is no indication that at this time CPS was aware that BJay's uncle, Ashley Richelme also lived in the house and slept in the lounge room. This was critical information in assessing risk to BJay, being another adult living in the house and having regular contact with BJay.

On 18 October the family were discussed in the scheduled Gateway allocation meeting and assessed as appropriate to refer to IFSS organisations to assist with risk issues. Present at that meeting was Ms Leah Steven, the CBTL who supported the referral to IFSS. The CBTL is an important position in CPS. The role is a crucial liaison between CPS and IFSS in the monitoring of risk to children referred by CPS into the Gateway system. Kate Huett, Gateway intake worker, was also present at the meeting. In preparation for the meeting, Ms Huett noted that the risk factors surrounding the family included their youth, drug use, relationship stress, instability of housing, isolation, few supportive role models and childhood involvement and trauma with CPS.

At the allocation meeting, an assessment of risk to BJay was required to enable Gateway to determine whether it would accept the referral or not. Gateway was at liberty not to accept the referral. As will be discussed further, reasons why the referral might not be accepted by Gateway could involve the risk to the child assessed as being too high for cessation of CPS involvement; or a lack of an appropriate IFSS organisation to address the required needs of the family.

In determining risk, Gateway intake used a document called the Common Assessment Framework ("CAF"), being a different document and risk assessment process than that TRF used by CPS. Where the referral to Gateway is from CPS, the CAF is partly completed by CPS and partly by Gateway workers. The CAF is a comprehensive risk assessment tool when used to its fullest extent. However, in this case the CAF document was incomplete and was inadequate to properly inform those present at the allocation meeting, and those subsequently involved, regarding the true extent of risk.

Having accepted the referral, the resolution of the meeting was that social workers Diana Boyd of YAFF and Mark Greeny of Glenhaven were allocated to work with the family. The two-worker model of referral was unusual and was due to the number of risk factors surrounding the family and aggression shown by Mr Johnstone and Ms Atkin toward other services.

The following day, 19 October, Gateway closed its file and ended involvement as the IFSS workers had been tasked to work with the family.

On 19 October Nurse Glann, ECM, attended a home visit to BJay and his family. She gave evidence that there was nothing in either parent's behaviour which stood out during this visit to raise concern. She examined and weighed BJay unclothed and did not note bruises on any part of BJay's body. Nurse Glann said that looking for abnormalities, such as bruising, was part of her role. She gave evidence that in her years of nursing and seeing many babies she

cannot recall ever finding a baby bruised. I accept her evidence in this regard. All other professional evidence in the inquest was to the effect that bruising on a newborn infant is an extremely rare occurrence.

On 21 October Nurse Suellen Shadbolt, ECM, attended the home address for a midwifery visit. Before the visit, Nurse Shadbolt was aware of allegations of drug use by BJay's parents and the involvement of CPS. She observed a bruise, a little smaller than one centimetre, to the middle of BJay's left cheek. Upon Nurse Shadbolt asking about the bruise, Ms Atkin stated that it occurred as a result of a vomiting or choking episode where she had panicked and leant BJay forward to support his head as he vomited; and it was this action that had caused the bruising. In evidence at the inquest, Nurse Shadbolt stated that Ms Atkin said that she was not sure when it occurred. The vagueness of Ms Atkin's explanation and unusual incident description should probably have triggered further questioning. However, Nurse Shadbolt accepted the explanation.

Apart from the bruise, Nurse Shadbolt gave evidence that there was nothing untoward about the visit. In her affidavit, she stated that she completely undressed BJay and did not recall seeing any bruising or marking on BJay's body. She further stated that he moved as would be expected for an infant of that age and seemed "*fine and healthy*". He had also gained weight. In evidence at the inquest, Nurse Shadbolt said that she could not definitively recall whether she completely undressed BJay. Her evidence was that if she weighed a baby clothed, her practice was to separately weigh an equivalent set of the baby's clothes and record the clothes weight. She said she would then record the results of the "clothes weigh" in the Infant Care Pathway document. In that way, an accurate naked weight would be obtained. In this case, Nurse Shadbolt did not record a "clothes weigh" in the documentation.

I am satisfied that, in accordance with the documentation and her initial affidavit made when her memory was fresh, she did remove all of BJay's clothes. If there had been any bruising to his body, she would have observed this whilst he was naked and recorded it. Her observations about the bruise she did observe on his face were recorded in the Infant Care Pathway document.

As Nurse Shadbolt accepted Ms Atkin's explanation for the bruise to BJay's cheek, she did not make a notification to CPS.

Section 14(2) of the Act requires, *inter alia*, a "prescribed person" in the course of their work to inform CPS if they believe or suspect, on reasonable grounds, or know (a) that a child has been or is being abused or neglected or (b) that there is a reasonable likelihood of a child being killed or abused or neglected by a person with whom the child resides. A "prescribed person" is defined in the Act, and includes a variety of professional persons having contact with the child. A registered or enrolled nurse is a "prescribed person".

Ms Sundram submitted that Nurse Shadbolt was obliged by the above provision to inform CPS of the bruise. Both Mr Phillips and Mr Turner submitted that under section 14(2) the obligation to report the bruising only arose where Nurse Shadbolt actually possessed the requisite state of mind. In my view, the provision requires the fact of formation of the belief or suspicion. It is not intended to penalise those prescribed persons who ought to have had the state of mind but who, in fact, did not. Nurse Shadbolt gave genuine evidence. I accept that she did not form the requisite belief or suspicion that would give rise to the obligation.

Aside from any obligation under section 14, Mr Phillips submitted that Nurse Shadbolt should not be criticised for not contacting CPS regarding possible risk to BJay, given the otherwise normal circumstances of the visit and the fact that the explanation given for the bruise was not fanciful. I observe, however, that Nurse Shadbolt was an experienced registered nurse, a bruise on a baby is a rare occurrence, and the explanation given by Ms Atkin as to how the bruise happened may not have withstood close analysis. Being aware that CPS was involved, it would have been prudent for her to contact CPS after her visit to report her observation. It cannot be determined whether a notification at this stage relating to the bruise would have changed the course of CPS action.

On the following day, 22 October, Ms Atkin was assaulted by Mr Johnstone whilst she was holding BJay. The assault involved Mr Johnstone strangling her until she lost consciousness. She dropped BJay in the course of the assault. Again, Ms Atkin did not make a complaint until after BJay's hospitalisation. Similarly, no person assisting the family was aware of this incident at any relevant time. Mr Johnstone was subsequently charged and sentenced.

In the morning of 23 October, IFSS workers Mr Greeny and Ms Boyd attended the home together for their first visit. An initial assessment was conducted with the family. It was noted that Mr Johnstone was not particularly engaging with the workers on this visit.

At 2.35pm that day Nurse Suzanne Luke, a Registered Nurse with CHAPS, attended for a home visit for approximately 90 minutes. During the visit she observed Mr Johnstone shouting and making loud crying noises at BJay, and leaning over him so that their faces were only 30 centimetres apart. During these actions, BJay was crying and it appeared to Nurse Luke that Mr Johnstone was attempting to drown out the sound of BJay's cries. She also observed that Mr Johnstone was shaking his head vigorously at BJay and poking out his tongue. He continued such behaviour for about two minutes. Nurse Luke gave evidence that she told Mr Johnstone to stop his behaviour, and had to raise her voice due to the level of his noise. She said that Mr Johnstone ignored her, gave her a hostile look and continued his behaviour.

Nurse Luke has been a registered nurse and midwife since 1976. She gave evidence that she considered that the behaviour of Mr Johnstone was not nurturing, was abnormal and unlike any she had previously encountered. She formed the view that the behaviour was designed to torment BJay. She stated that Ms Atkin was silent throughout Mr Johnstone's interactions with BJay and did not move.

When BJay was undressed, Nurse Luke noticed a large bruise on his posterior left thigh and a smaller narrower bruise on his right thigh. She also observed bruising on BJay's cheek near his nose. She noted that the bruise on his left thigh measured 10cm long and 5cm in width, and covered the whole area from buttock to knee. The bruise on the right thigh was on an angle and was a finger width in thickness. She stated that the bruises were grey in colour, which indicated to her that they were fairly fresh. She questioned Ms Atkin and Mr Johnstone about how BJay received the bruises. Ms Atkin told her that she had accidentally poked BJay in the cheek when she turned him over when he was vomiting a "couple of days" previously.

Mr Johnstone told Nurse Luke that the bruises to both thighs were a result of an incident early on the previous Sunday morning, being two days before her visit. He told Nurse Luke that he was walking down the hallway in the dark holding BJay and had run into a door. Nurse Luke gave evidence that she had only rarely seen bruising to small infants and had never seen

bruising of such severity as that upon BJay. Nurse Luke gave evidence that she found it difficult to accept the explanation as she would have expected the bruise to be on Mr Johnstone's forearm rather than BJay's thigh because Mr Johnstone stated that he had BJay's head in the crook of his arm and his hand under his thigh. The other, smaller thigh bruise was unexplained by Mr Johnstone.

Nurse Luke provided a detailed affidavit and gave high quality evidence regarding her observations throughout her visit. Her memory was excellent. Of relevance, she formed the view that Ms Atkin was under the control of Mr Johnstone, demonstrated by Ms Atkin remaining silent and allowing Mr Johnstone to speak for both of them when they were together. She concluded that Ms Atkin was frightened of Mr Johnstone. Towards the end of Nurse Luke's visit she told Mr Johnstone that the formula that he was about to give BJay was not suitable for a newborn and that it would be better if BJay was breastfed. Nurse Luke stated that Mr Johnstone ignored her. Ms Atkin did not intervene. Nurse Luke concluded in respect of this incident that Ms Atkin was not in a position to intervene.

Nurse Luke said in evidence that she considered that if she talked to Ms Atkin about the bruising, Mr Johnstone would have retaliated after she left. Upon leaving, Nurse Luke had strong concerns about the safety of both BJay and Ms Atkin.

Nurse Luke made a notification to CPS late the same day upon returning to her workplace. She informed CPS about the size of the bruises and the behaviour she observed whilst in the house and indicated that she was concerned about the baby. She described BJay's bruising as "severe" to the CPS worker taking her report. She said that she also told CPS that she did not agree with the explanation provided by the father as to how the bruises were caused.

In actual fact Mr Johnstone had already told Ms Atkin in respect of the large bruise to the leg "*/ punched him because he wouldn't shut up*". Ms Atkin did not disclose this statement until after BJay was hospitalised. Mr Johnstone was subsequently charged and sentenced for this act.

On the morning of the following day, 24 October, CPS worker Leilani Brooke, who had been passed Nurse Luke's message the previous day, telephoned Nurse Luke and recorded in CPIS details of the visit by Nurse Luke, and her concerns relating to BJay. The manner in which the note was written down played both the concern conveyed by Nurse Luke and the seriousness of a report from a professional notifier of bruising on a newborn infant.

At 11.10am Ms Brooke sent an email to Ms Eberhardt and Ms Laine Willis (CPS Response Team Leader) referring them to Nurse Luke's notification in respect of BJay that she had recorded in the system. The email forwarded by Ms Brooke was couched in moderate terms. Although it referred to an extensive bruise to BJay's thigh, the notes did not significantly emphasise the possibility of the bruise being caused by deliberate abuse. It may well be that Nurse Luke did not convey her view in particularly strong terms at that stage. However, such extensive bruising on an infant should have caused CPS the highest degree of concern notwithstanding the fact that the notifier may have used moderate language in the notification.

The notification taken from Nurse Luke recorded in CPIS also noted the crowded nature of the accommodation, inappropriate formula, the parents missing cues from BJay who was hungry, and difficulty with breastfeeding. The notification further recorded Mr Johnstone presenting as immature and mimicking BJay's cry and not responding to advice, Ms Atkin referencing her

traumatic childhood, Ms Dykstra having OCD and bipolar disorder and discouraging visits of the CHAPS nurse. Even if Ms Brooke did not convey the severity of the situation as described by Nurse Luke, the notes contained more than sufficient detail to warrant immediate action to protect BJay.

At 1.45pm on the same day, CPS workers Ms Eberhardt and Ms Bull conducted an unannounced home visit as a result of the notification. All occupants at the home were present and were told that the reason for the visit was the report of bruising to BJay's thigh. Ms Dykstra and Mr Richelme became angry at the workers, stated that the visit was not warranted, and continued to speak in a raised voice throughout the visit.

Ms Eberhardt stated in her affidavit that Mr Johnstone and Ms Atkin were calm and gave the same explanation of the origin of the bruise on BJay's thigh as previously given to Nurse Luke. Ms Atkin said that they were happy to work with CPS and were going to purchase a night light to prevent such an incident occurring again. The workers saw Ms Atkin take BJay out of his bed. He was sleeping, appeared healthy and was wrapped appropriately. At about this point, Ms Dykstra, who continued to be hostile, told the workers to "*fuck off*".

Ms Eberhardt said in evidence that she formed the view that it was unnecessary to sight the bruising to BJay because she believed that it was accidental. She stated that it did not occur to her that Ms Dykstra's hostility was an attempt to cover up abuse to BJay. She also stated that the hostility was not a factor in the decision not to view the bruising. Although she was aware of the notification that there was bruising to the left cheek, it appears that Ms Eberhardt did not come sufficiently close to BJay to view any bruising on his face. At the visit, Ms Eberhardt and Ms Bull advised Ms Atkin and Mr Johnstone that if engagement occurred with CPS and if no risks were assessed then the matter would be closed.

There was no direct contact by Ms Eberhardt or Ms Bull with Nurse Luke to personally discuss her observations from the previous day. If there had been, the behaviour of Mr Johnstone and his apparent control over Ms Atkin may have caused them to question the safety of BJay. Similarly, they may have ascertained the true extent of Nurse Luke's doubts about the veracity of the explanation of the bruising given by the parents. As it was, they accepted the explanation for the bruising without further requirements. A clear-headed consideration as to the purported mechanism of injury should have immediately led them to the conclusion that it was inconsistent with the position of BJay's bruising. There was no decision to return to the home to sight the bruising, to obtain medical advice or to further scrutinise the explanation of Mr Johnstone and Ms Atkin.

At about 2.53pm Ms Eberhardt spoke to Ms Steven by telephone and indicated that the explanation for the bruising was plausible. In her notes recorded on CPIS in respect of this telephone call Ms Eberhardt stated "*it was agreed that the CPW (child protection worker) would write a letter of support to Housing and keep the case active for the next fortnight to ensure that the family engage and there are no identified risks for Bjay*". Therefore, subject to family "engagement" CPS evinced an intention to imminently close the case.

On 25 October Ms Steven, in turn, telephoned Mr Greeny and told him about the notification concerning bruising to BJay and informed him that CPS accepted the explanation given by the parents for the bruising. Mr Greeny then emailed Ms Boyd and conveyed to her the notification regarding a "significant" bruise on BJay but that CPS Response had visited and were "happy"

with the parents' explanation. Ms Boyd and Mr Greeny were not informed that the original notifier, Nurse Luke, was sceptical of the explanation regarding the bruising. There was nothing in the contact by CPS to the Gateway workers at this point to give Mr Greeny or Ms Boyd reason to be hesitant in relation to ongoing risk or that they were to proceed in a way other than to "engage" Mr Johnstone and Ms Atkin and assist them with the issues of housing and drug use. As further discussed, it was not the responsibility of the IFSS workers to assess risk to BJay, particularly when CPS was still investigating an open notification.

At 5.09am on 26 October BJay was taken by Ms Atkin and Ms Dykstra to see Dr Sergei Kisselev in relation to discharge coming from his eyes. Dr Kisselev took a swab for analysis by pathology. He gave evidence that, during the consultation, an examination of BJay was performed by him with no note of any rash, bruising or other abnormalities. Dr Kisselev produced his notes of the consultation but had no independent memory of seeing BJay. The notes were brief but, relevantly, indicated that the skin contained no rash and that both testicles were descended. In evidence, Dr Kisselev stated that in accordance with his invariable practice for infants under the age of 12 months, he performed a thorough examination and would certainly have noticed a large bruise. He gave evidence that his usual examination includes observing the entire body of the child, using a stethoscope to the front and back of the baby, looking at the baby's motor function, and testing the range of motion of joints.

It is difficult to determine on the evidence whether the leg bruising observed by Nurse Luke on 23 October would likely have been present or clearly visible at the time of this consultation three days later. As Nurse Luke described it as mostly grey in colour, it could therefore have still been visible and yellow at the time of the consultation. Ms Dykstra stated in her affidavit of 17 January 2013 that when they took BJay to Dr Kisselev, BJay had bruises on his face. She was hoping that the doctor would notice the bruising and "*do something about it*". She did not go into the consultation with Ms Atkin. Ms Dykstra's evidence is credible for the reasons set out further in this finding.

I accept Dr Kisselev's evidence that if he had noticed bruising he would have been concerned and taken appropriate further steps to contact the authorities. I find that Dr Kisselev examined BJay substantially as per his normal practice. There were likely to have been remnants of the bruise to the leg and/or cheek. However, for some reason not able to be determined, he did not detect bruising. His focus was not upon allegations of abuse and the bruises may have been obscured by jaundice. One or more bruised areas may have been deliberately shielded from his examination by Ms Atkin.

On 26 October, at a time after the consultation with Dr Kisselev, Mr Johnstone was trying to feed BJay with a bottle but BJay would not accept it. Mr Johnstone reacted by forcibly pushing the bottle into BJay's mouth, causing damage to his upper lip, and tearing the flesh between the lip and the jaw (medically termed the *frenulum*). This caused profuse bleeding and the injury was still evident when BJay was admitted to hospital. Mr Johnstone pleaded guilty to this act of ill-treating BJay, which came to light only after he was hospitalised.

Shortly before 2.00am on 29 October Ms Katherine Bond made a telephone call from her residence in the United Kingdom to Tasmania Police. The call was taken by Sergeant Robert Schiwy of Radio Dispatch Services. In that call, Ms Bond sought to relay to him concerns for BJay's safety after Ms Dykstra had posted on Facebook that BJay had sustained fresh

bruising. There will be further analysis of police action subsequent to this call. The call is transcribed below:

POLICE: Tasmania Police, Sergeant Schiwy.

CALLER: Hi, I'm calling from the UK. I-I have a worldwide mental health page on Facebook. I would like to report somebody who is talking about their son abusing his baby. Basically she's talked about three times now about having bruises on him.

POLICE: M'mm, and this in Tasmania is it?

CALLER: Yes, he lives in Railton – Railton, Tasmania. She volunteers at the RSPCA in Tasmania she says. From Ulverstone. I don't know [indistinct word(s)] no, no that's from Ulverstone, but she lives in Railton but I don't know of her address but I have her name.

POLICE: Yes, her name is?

CALLER: Her name is Hellen Dykstra – DYKSTRA. But she's spoke three times now about the baby being bruised –.....

POLICE: Her baby?

CALLER: Not her baby, no, her son's baby. She has- her son is an adult and is living with her. And she's spoken twice before of the baby having bruises, one on his cheek and one somewhere else, on his arm, and you know myself and the other members of the group said that that's – you know that's not right, it's not normally – you don't accidentally bruise a child –

POLICE: So this Hellen –.....

CALLER: And then –.....

POLICE: Excuse me, this Hellen –.....

CALLER: I'm sorry?

POLICE: Sorry, so this Hellen, her adult son he lives at Ulverstone with her. Has a son, an infant son I presume –.....

CALLER: Yes. Yes. They were homeless and so she homed them – her son and his girlfriend I think after they had the baby. They were living with her in her house with the baby –.....

POLICE: In Ulverstone?

CALLER: No, in Railton –.....

POLICE: In Railton, sorry, and its DYKSTRA her name is?

CALLER: Yes. Yes –.....

POLICE: Do you know the son's name at all?

CALLER: I have no idea about her children at all but she says on the post in Facebook, she says she has a situation four 0 and she'll accept any advice, and as you know I have one of my two sons living with me, one does have a girlfriend and a newborn here as well. The newborn BJay, who is under Child Services by the way, has had a bruise on him and that puts the Child Protection on the scene, but now he has more bruises and a split lip inside the mouth, and he –.....

POLICE: When was the last –.....

CALLER: He [indistinct word(s)] – sorry?

POLICE: When was the last post?

CALLER: The last post was seven hours ago. That was a post from seven hours ago – be quiet I'm on the phone [speaking to someone in background] yes, I'm going to get you dressed in a minute, we've been very lazy today, [indistinct word(s)] –.....

POLICE: Your first name?

CALLER: Sorry? [someone speaking in background]

POLICE: Your first name?

CALLER: Sorry?

POLICE: Your first name?

CALLER: Sorry?

POLICE: Barry?

CALLER: Oh, my name is Katherine, Katherine with a K, Katherine Bond –.....

POLICE: No worries.

CALLER: And you've got my phone number –.....

POLICE: No I haven't.

CALLER: Oh. Oh, okay, well my phone number is – in England – 0121 –.....

POLICE: 0121 yep.

CALLER: 439 –.....

POLICE: Yep –.....

CALLER: 4415.

POLICE: No worries. What I'll do is I'll put that on an information sheet to be acted on when they do something on it.

CALLER: Okay. I was very concerned. I think a lot of the ladies in the group are really concerned about the baby, you know she seems very ineffectual and seems more – more worried about protecting her son than she does her grandson.

POLICE: Yep. Now what you've told me I'll put on what they call an information sheet and I'll put it up to be actioned on tomorrow in the morning.

CALLER: Okay.

POLICE: No worries –.....

CALLER: Okay. Brilliant. Thank you –.....

POLICE: Thank you Katherine. Bye.

CALLER: Thank you very much. Bye.

POLICE: Bye.

Ms Bond presented as an articulate and rational person. She gave the police officer a coherent narrative and was most concerned about the possibility of intentional harm being inflicted upon BJay.

The information contained in Ms Bond's call was immediately processed by Sergeant Schiwy into an electronic report using the IDM system. Through further police processes, the report was allocated for investigation to Senior Sergeant Stuart Wilkinson of Devonport Criminal Investigation Branch ("CIB") that same day. He then immediately allocated the investigation to Constable Bobby Gray who, due to a heavy workload at that time, did not take any steps to investigate before BJay's hospitalisation with fatal head trauma.

None of the four police officers dealing with the report made contact with CPS to report the call or seek to verify or obtain information. CPS was therefore not aware of Ms Bond's report whilst BJay was at home.

I deal with the deficits in the police response further in this finding. As will be discussed, it is likely that BJay suffered further severe head trauma in the last few days before his hospitalisation. If police had contacted CPS, it is possible that CPS may have taken further action to remove BJay from the home. There should have been a notification to CPS during the morning of 29 October by an officer from the Devonport station.

At 11.30am on 30 October Mr Greeny and Ms Boyd attended for their second home visit. During the visit Ms Boyd was unable to produce a reflex response from BJay and noted a tiny bruise on his cheek. When she asked about the bruise, Ms Atkin told her that BJay had slept on his dummy and that it had bruised his face. Ms Boyd gave evidence that the explanation was plausible given the position and size of the bruise. Ms Boyd gave evidence that her concerns about BJay's sluggishness were alleviated when he fed from the bottle.

Ms Boyd, the IFSS worker tasked primarily to interact with Ms Atkin, gave evidence that she was aware of the previous report of bruising to BJay. She said, however, that she would not have unwrapped BJay to examine him as she was aware that CPS had already been to the home and were still involved.

Ms Boyd stated that Ms Atkin was very concerned about the involvement of CPS and the prospect of BJay being taken into care. Ms Atkin also expressed criticism of the CHAPS nurse (Nurse Luke), with Ms Dykstra agreeing and saying that she would not let that nurse back into the house. Ms Boyd suggested that they ask for a different CHAPS nurse. At this visit, Mr Greeny noted that Mr Johnstone was mostly occupied with tattooing tools in a box. Upon leaving an appointment was made for Ms Boyd and Mr Greeny to re-attend on 6 November 2012.

After the home visit, Ms Boyd expressed to Mr Greeny her ongoing concerns regarding BJay's lack of "awakeness" and non-existent baby sounds. She also expressed to Mr Greeny the lack of interest and commitment by Ms Atkin and Mr Johnstone in respect of suggested appointments.

It might be thought that after this home visit the IFSS workers should have held serious concerns about BJay's safety sufficient to make immediate contact with the CBTL to relay to CPS. However, I make no criticism of them. They had been reassured by CPS as to BJay's safety, the risk responsibility remained with CPS and they were not trained medically or in analysis of risk.

At midday on 30 October Ms Atkin telephoned CHAPS requesting whether she could attend another nursing centre with BJay as the nurse who made the last home visit was "quite rude". Nurse Luke took Ms Atkin's phone call. She gave evidence that Ms Atkin was actually referring to the home visit conducted by herself on 23 October 2012 after which she made a CPS notification. Nurse Luke acceded to the request and arranged for Nurse Taylor to see Ms Atkin and BJay at the Sheffield Centre. I find that Ms Atkin did not wish to have Nurse Luke returned to the home because Nurse Luke was suspicious of the origin of the bruise and made a notification to CPS.

On this same day, Mr Johnstone applied hard pressure with his thumb to an area near BJay's left eye which caused bruising. Ms Atkin witnessed this incident but did not disclose it until after BJay's hospitalisation. Mr Johnstone was subsequently charged and sentenced in respect of this act of ill-treatment.

Two days later, on 1 November, Mr Johnstone assaulted Ms Atkin by slapping her to the left side of her face. This arose after an argument when both were in their bedroom. Ms Atkin was lying on the bed when Mr Johnstone scuffed her by the front of her jumper with one hand and slapped her to the right side of her face with the other. Ms Dykstra came into the bedroom at that point. BJay was in his rocker in the lounge room. Ms Atkin did not make a complaint about this assault at the time. Mr Johnstone was subsequently charged and sentenced for this assault.

The next morning, Friday 2 November, Mr Johnstone and Mr Richelme left the house to go fishing. They returned at about midday. Upon their return, Ms Atkin, Ms Dykstra and BJay went shopping in Devonport, returning at a time before 4.00pm. Ms Atkin stated in a

subsequent affidavit that at about 4.30pm she and Mr Johnstone began arguing in their bedroom as Mr Johnstone accused her of spending an additional three dollars on cigarettes. Ms Atkin stated that she began packing her bags to leave Mr Johnstone and told him she was taking BJay with her. BJay was in his bassinet at the time. It came to the attention of Ms Atkin that one of BJay's eyes was abnormally dilated, and she took him to Ms Dykstra.

Ms Dykstra observed that both of BJay's eyes were rolling, the top of his head swollen, and that he was limp, pale and unresponsive. In her affidavit made the following day, she stated: "*I just told them to grab everything and we were going to the hospital. I said something was desperately wrong and it could be brain damage*". Between 6.00pm and 7.00pm Ms Dykstra and Ms Atkin took BJay to hospital. Mr Johnstone declined to join them.

Before 4.00pm the same day Mr Greeny had a telephone call with Ms Steven, CBTL, regarding the prospect of CPS ceasing involvement with BJay.

Therefore, Ms Steven immediately emailed Ms Eberhardt in the following terms:

"The family have been allocated two IFSS workers Di from YAFF and Mark from Glenhaven (going with a team approach as many concerns needed addressing as soon as possible). The family have met with workers and all appears positive. The family have asked Mark if he could contact CPS and find out how long we will keep it open and if there is anything else they need to do for CPS. I have explained to Mark I will email him the details and will CC you in so you can add if need be. The IFSS workers seem positive about the experience so far so if you wanted you could likely close it".

At 4.30pm Ms Steven, having discussed the case with Ms Eberhardt, emailed Mr Greeny advising of several matters which she permitted Mr Greeny to discuss with Ms Atkin and Mr Johnstone. Relevantly, her email to him noted as follows:

- That Ms Eberhardt was ready to close the matter and would do so in the following week on the condition that the parents continued to engage with Gateway and accept family support.
- That CPS was confident that the family wished to do everything possible to ensure that BJay was safe and well cared for.
- That if the family wished to ensure that CPS had no future concerns then they should take various steps. These steps included making a plan with the Gateway workers to stop drug use; not leaving BJay with a drug affected parent; getting their own stable housing; ensuring that they have everything BJay requires (including food and clothing); and ensuring that they meet all Child Health requirements.

The email also recommended that the family undertake the following, less concrete, steps to avoid further CPS intervention:

- Ensure that BJay is not exposed to violence, yelling or screaming;
- Continue to bond with BJay;
- Follow through their commitments;

- Ensure that BJay's best interests are considered first above the interests of anyone else.

Both Ms Steven and Ms Eberhardt suggested in their evidence that CPS may have kept open the notification for several more weeks. However, the evidence clearly indicated that prompt closure was intended within the week of the email of 2 November. The emails, in particular, indicate that CPS took the view that the notification would be imminently closed leaving the IFSS workers to assist the family.

Hospitalisation Period

At 7.10pm on 2 November BJay was admitted to the Mersey with severe injuries. CPS was unaware of the admission and unaware of BJay's condition. At this time CPS was of the view that its intervention was no longer required.

Dr Martin Koolstra, emergency physician, examined BJay upon his arrival at the Mersey. Dr Koolstra noted bruising to BJay's left eye, bruising to the cheek, a torn frenulum and an absence of spontaneous movement. In the presence of Dr Koolstra, BJay suffered two seizure episodes during which he became placid and bradycardic (slow heart rate). He noted that the seizures were less than a minute in duration and spontaneously resolved without the need for intervention. He stated that the injuries he observed on BJay were horrific in nature, were not consistent with any normal childhood disease or accidental injury, but were consistent with deliberate abuse. In his report for the inquest, he stated:

Of major concern to me was the accompanying history from BJay's mother and grandmother. They alluded to BJay being thrown up and down to settle him when he was crying and he would not settle. They also alluded to the father being volatile, possibly drug affected and violent towards BJay's mother and possibly toward him when they were not in the room. BJay's grandmother was urging his mother to tell the truth about what had been going on. My general impression was that BJay was definitely not safe and needed admission for protection as well as further work after his injuries. I also had a concern for the safety of BJay's mother.

Dr Koolstra formed the belief that there was intracranial pathology and took the unusual step of ordering a CT scan of an infant.

At 11.10pm on 2 November Senior Sergeant David Chapman and Senior Constable Scott Poke of the Devonport CIB were called to attend the hospital by Dr Koolstra. Thereafter, police commenced an investigation into the cause of BJay's injuries.

Shortly before 4.00am on 3 November, BJay was transported by emergency airlift to the Neonatal and Paediatric Intensive Care Unit at the RHH as a result of his injuries. There, he underwent MRI scans of the brain and spine and a chest x-ray.

At 1.00am on 3 November police officers attended 15 Leake Street and spoke to Mr Richelme, who stated that he did not know the origin of BJay's injuries but had noticed bruising.

At 2.30am on 3 November Mr Johnstone participated in an interview for 24 minutes with police that was video recorded. In essence, Mr Johnstone told police that he may have engaged in

unintentional practices that caused minor injuries to BJay. However, he did not know how the serious brain injuries were caused, and he was not responsible for them.

At about the same time, Ms Atkin provided a brief statutory declaration to police in which she stated that she noticed a bruise beneath BJay's left eye the previous Tuesday when she woke at 8.00am. She said that, on the same day, Mr Johnstone had pushed the bottle into BJay's mouth, causing a split to the inside of the mouth. In the same statutory declaration she also stated that:

- That the previous Sunday she had grabbed BJay's cheeks with her thumb and forefinger to stop him choking on his vomit which caused bruising to his face;
- That Mr Johnstone does get grumpy with BJay but when he does she removes BJay from him;
- That Mr Johnstone would on occasions throw BJay into the air and catch him, after which she told Mr Johnstone that he should not do that.

At 10.00am on 3 November Dr Chris Williams, Staff Specialist in the Paediatric Intensive Care Unit at RHH, examined BJay. He observed that BJay was an abnormally quiet infant exhibiting little spontaneous movement with a swollen skull, full fontanelle and palpably splayed suture. He also saw the same external injuries as noted by Dr Koolstra. He indicated that the radiology suggested the presence of severe traumatic brain injury, occurring on more than two occasions and bilateral posterior rib fractures.

At 4.00pm on 3 November Dr Chris Williams spoke to Ms Atkin regarding the cause of the severe trauma. Ms Atkin gave significant information to Dr Williams regarding BJay but told him that she knew of no injuries which had occurred to BJay that would have caused his severe head trauma.

On 5 November Dr Chris Williams assessed BJay's brain injuries as profound, such that, if he survived, he would be unlikely to be able to ever talk, see, feed, walk or toilet. He also noted that the radiology revealed a skull fracture, multiple rib fractures, pelvis and bilateral femur fractures.

At the time of treating BJay, Dr Williams had had 26 years of experience as a paediatrician and had worked with child protection cases for much of this time. He stated in his report written a week before BJay's death that the injuries to BJay represented one of the most severe cases of child abuse that he had encountered in his career.

On the same day, 5 November, Ms Atkin swore a further detailed affidavit in which she stated that, in making her first statement, she had feared for her own safety and that of BJay and so had not given police full details at that time. In her new affidavit, Ms Atkin spoke of being a victim of violence at the hands of Mr Johnstone. She also described the various ways in which Mr Johnstone would treat BJay violently. The violence that she described in this affidavit became the basis for the charges against Mr Johnstone. However, she did not allege or describe that there was any incident that might have caused BJay's head trauma.

That evening Mr Johnstone was charged with causing grievous bodily harm to BJay and ill-treating a child and he appeared in the Hobart Court of Petty Sessions where the charges were adjourned until a later date.

On 6 November Ms Atkin told RHH Nurse Jenny Ryan that she should have left the relationship earlier but she was threatened by Mr Johnstone that he would “*put her down a mine shaft*”, and she thought that BJay would be safe if she stayed. This was the first of several statements made to the nurses, the credibility of which I will discuss further in this finding.

On the same date, CPS decided, finally, to apply for an assessment order in respect of BJay.

On 7 November BJay underwent neurosurgery, being a burr-hole operation in order to drain fluid from his brain and release pressure. Although the operation was successful, he remained neurologically abnormal and required nasogastric tube feeding.

On 8 November 2012 a four week assessment order was made by a magistrate, with custody of BJay granted to the Secretary.

On 13 November BJay was transferred to the Paediatric Ward of the RHH under the care of Staff Specialist Consultant Paediatrician, Dr Michelle Williams.

On the same day Ms Atkin told Nurse Jane Carrick that Ms Dykstra knew what was going on but kept quiet; and also that she (Ms Atkin) was told by Mr Johnstone that nothing would happen if she went to the police.

On 16 November Nurse Lucy Copping heard Ms Atkin say to BJay “*he can't hurt you in here, don't worry.*”

On 19 November EEG testing on BJay showed abnormal results, with frequent periods of electrographic seizures, consistent with loss and damage of underlying brain tissue.

On 21 November Ms Atkin said to Nurse Yasmin Palfreyman that she would “*take the beatings*” instead of BJay and talked about being punished.

On 22 November Ms Atkin disclosed to Nurse Copping that Mr Johnstone had banged BJay's head on a brick wall and that she would try to get to BJay first when he was crying so Mr Johnstone would not hurt him.

On 23 November Ms Atkin was assessed by a psychiatrist, Dr Andrea Boros-Lavack, as competent to make medical decisions for BJay. It is noted that Dr Michelle Williams, even after this assessment, gave evidence that she believed that Ms Atkin did not have the capacity to make end of life decisions regarding BJay. Dr Williams stated in her report for the inquest that BJay's care was complicated at times due to Ms Atkin's emotional lability, aggressiveness, strong opinions on care, and her apparent difficulty in understanding information given to her about BJay's condition. Dr Williams' observations about the behaviour and demeanour of Ms Atkin at the RHH are corroborated by the other evidence of health care professionals and southern CPS workers.

On the same day, an ultrasound revealed further increases in the size of BJay's ventricles. There was extensive specialist discussion concerning further treatment, including advice from

a neurosurgical team at the Royal Children's Hospital in Melbourne. The overwhelming medical opinion was that no surgical treatment was likely to be of any benefit and that BJay's prognosis was very poor. Given his fractures and head injuries, he required analgesia prior to movement from his crib. His seizures became worse and there was increasing spasticity of his lower legs. There was consultation with the RHH palliative care team to ensure that BJay's pain and seizure management was optimised.

On 25 November Ms Atkin spoke to a Dr Charlton at the RHH. In that conversation she disclosed threats of suicide. She referred to the incident in hospital that had occurred shortly after BJay's birth and stated that she wished that she had taken BJay to the toilet with her and that it was "*all her fault*".

On 29 November 2012 BJay died at the Royal Hobart Hospital as a result of a respiratory arrest caused by his seizures, secondary to his brain injury.

The medical evidence of the timing and mechanism of BJay's injuries

Medical evidence

The medical evidence enables me to find that BJay suffered the following injuries:

- a) A fractured skull extending across two plates;
- b) A severe brain injury, including injury to the eyes;
- c) Fractures of left distal femur and corner fracture of the right distal femur;
- d) Posterior fractures to the eighth, ninth and tenth ribs on the right side;
- e) Posterior fractures to the fifth, sixth, seventh, eighth, ninth, tenth and eleventh ribs on the left side;
- f) A fracture of the right superior pubic ramus (pelvis);
- g) A torn frenulum, facial bruising and bruising under the right thigh.

The evidence regarding the timing and possible causes of the above injuries came principally from the following medical specialists: Dr Martin Koolstra (emergency physician), Dr Chris Williams (paediatric intensivist), Dr Michelle Williams (paediatrician), Dr Alison Thomas (radiologist), Dr Donald Ritchey (forensic pathologist), and Dr Guy Bylsma (ophthalmologist). Whilst their individual evidence focussed upon their respective areas of specialty and/or treatment of BJay, there was no essential disagreement between them on any important issue. They all gave evidence that BJay's injuries were characteristic of non-accidental or inflicted origin. This conclusion was not challenged by any person involved in the inquest, including Mr Johnstone, Ms Atkin or Ms Dykstra.

The more difficult factual issues for determination focussed upon when each injury occurred. The age of BJay's injuries is discussed below, with particular reliance upon the evidence of Dr Allison Thomas. Dr Thomas was not involved in BJay's treatment but gave expert evidence in interpreting the radiology.

Rib fractures

Dr Thomas gave evidence that, in terms of ageing rib fractures, groupings of “*less than 2 weeks*”, “*2 to 4 weeks*” and “*4 to 6 weeks*” are used. The age category of an injury is assessed by the degree of bony healing seen on the radiology. She gave evidence that the left rib fractures were more than two weeks old at the time of taking the first x-ray on 3 November 2012. Therefore the fractures occurred between 14 October and 20 October, being in the first 6 days of BJay’s life.

Dr Thomas gave evidence that three fractures to the right ribs were more recent than the fractures to the left ribs by about one week. She gave those fractures an age grouping of less than two weeks. I am satisfied that BJay did not suffer any further injuries once he was admitted to the Mersey on 2 November as there was no opportunity for trauma to have occurred there. Therefore the right rib fractures occurred between 23 October and 2 November 2012.

In summary, the multiple bilateral rib fractures suffered by BJay occurred approximately one week apart. The left sided fractures may have occurred in hospital after his birth or in the first few days of his arrival at home.

Dr Thomas and Dr Ritchey gave evidence that the mechanism of the rib fractures was one of compression, with the body being squeezed inwards from both sides, or alternatively squeezed from both the back and the front.

Fractured pelvis

An x-ray conducted on 3 November 2012 showed a fracture of the right superior pubic ramus. Dr Thomas noted that features of the fracture, including the lack of callus formation, indicated that the fracture was less than two weeks old. This would indicate that the fracture occurred between 20 October and 2 November 2012.

The femur fractures

An x-ray of BJay’s legs taken on 6 November 2012 revealed a metaphyseal lesion of the left distal femur, also known as a “bucket handle fracture”. Dr Thomas was able to determine that this injury was less than one week old. Therefore, this fracture occurred between 30 October and 2 November 2012. Dr Thomas also observed a corner fracture of the right distal femur which could not be aged.

Skull fractures

The skull x-ray revealed a minimally displaced fracture of BJay’s parietal bone (at the top of his head) which crossed the suture (the fibrous portion between the bone plates). Dr Thomas gave evidence that this type of injury is not able to be aged as skull fractures do not heal by callus formation.

Brain injuries

Dr Thomas stated that there were at least two separate instances by which intra-cranial injury was caused. In this regard she gave detailed, technical evidence as to the interpretation of the radiology. She concluded that BJay suffered at least one high velocity head injury that occurred more than two weeks before the scan of 3 November, necessarily being between 14 and 20 October. Secondly, she concluded that he suffered another high velocity head injury between 3 and 7 days before the scan, being between 27 October and 31 October 2012.

The features noted by Dr Thomas supporting her opinion of at least two severe head injuries included evidence of mixed age subdural collections of blood, widespread ischaemia that was both old and acute, and the occurrence of the process of liquefactive necrosis (being the prolonged process of loss of brain tissue that commences at least 48 hours following significant brain insult). In giving her evidence regarding those features, she relied upon the clear distinction between the appearance of the more recent blood and ischaemia shown upon the scan contrasting with the differing features of the older blood, older ischaemia and cavitation occurring with respect to the earlier insult (or insults) that occurred before 20 October 2012.

Dr Thomas explained that the scans do not enable further determination as to whether separate insults occurred to the brain on different dates within the two specified time categories. She could not therefore rule out that within either of these two time periods, multiple brain insults may have occurred.

Both Dr Thomas and Dr Ritchey gave evidence that cavitation had occurred in BJay's brain. Cavitation is a process that may occur subsequent to a brain injury. After an insult to the brain, the brain tissue may become ischaemic. Ischaemia occurs in this context when the swelling of the brain tissue prevents sufficient blood circulation. The brain tissue then becomes infarcted (death of the tissue). Once infarction has occurred, the dead tissue is removed through an immune system response, leaving a hole which is filled with cerebro-spinal fluid.

Dr Ritchey gave evidence that, in BJay, this process of cavitation had resulted in there being very little brain matter remaining in the brain. He observed at autopsy that what remained of BJay's brain was in fact a thin rind of residual scar tissue containing a large volume of cerebro-spinal fluid. He explained that the fluid was taking the place of the original brain matter; and that in the period since the occurrence of the trauma, the cells had taken away the dead tissue. Dr Ritchey gave evidence that a dead part of the brain can never regenerate itself.

The mechanism of injury

On the medical opinion at inquest the most likely cause of BJay's broken ribs is at least two episodes of an adult squeezing the thorax of BJay. However, there may have been many more than two occasions of compression and consequent injury, given the number of ribs involved, particularly on BJay's left side. Both Dr Ritchey and Dr Thomas gave evidence of "shaken baby syndrome" in the context of abuse of infants, involving a pattern of multiple injuries. They gave evidence that "shaken baby syndrome" is characterised by fractured ribs caused by holding the baby with both hands and squeezing forcefully.

In relation to the fractures of the femurs, Dr Ritchey, Dr Chris Williams and Dr Thomas said that such injuries occur as a result of gripping, twisting or pulling the legs with great force. Dr Thomas noted that less commonly these injuries may occur during shaking when indirect acceleration/deceleration forces are applied to an infant's limbs. All three doctors gave evidence that this type of injury does not occur in the normal handling of a young infant.

The medical experts indicate that the mechanism of the pelvic fracture would be the imposition of great force of abduction to the right leg and pelvis, involving the legs being pushed or pulled apart forcefully. Again, such violent force applied to an infant is inconsistent with normal handling.

The injuries that caused BJay's death were those to his brain. The medical evidence was that BJay's severe head injuries may have been caused by shaking him, delivering heavy blows to him or propelling him into a solid object. Dr Ritchey stated that throwing a baby forcefully onto a bed could also cause such injury to the brain with little observable scalp injury. Dr Thomas gave evidence that brain injury may be caused by the crushing of the head by an adult whose hands are either side of the head. She said that as both sides and all lobes of BJay's brain were affected, the pattern would also sit with "shaken head". Again, repetitive shaking would not leave bruising to the scalp. At inquest there was no evidence of bruising to BJay's scalp.

The medical experts were not able to determine any specific points of impact upon BJay's head. Dr Ritchey explained that upon an injury occurring, the whole brain or different parts of it may be impacted by rapid acceleration into the bony skull. It is not therefore possible to determine a corresponding external impact point from examining affected areas of the brain.

In Dr Thomas' opinion, the fact that a fracture was seen to both plates across the suture line indicated that BJay had suffered two separate impacts or one crushing injury to the skull. Dr Chris Williams also indicated that the skull fracture is suggestive of blows with severe force.

Apart from evidence from those in the household, there are several objective pieces of evidence, outlined earlier, which may indicate the occurrence of a head injury. They are:

- a) On 23 October 2012 BJay's head circumference was measured by Nurse Luke at 34.5 centimetres. In his submissions, Mr Turner submitted that an abnormal increase from 32 centimetres measured at birth is indicative of head swelling due to trauma sustained. If the measurements are accurate I accept it would indicate abnormal pathology. However, the evidence of Dr Michelle Williams emphasises the difficulty of placing reliance on recorded figures for head circumference. In her experience, such measurements are prone to inaccuracy. I cannot make such a finding due to the margins for error in measurement. In any event, on the evidence of Dr Thomas, I can be satisfied that a very severe brain injury occurred before 20 October 2012.
- b) A phone video taken whilst BJay was at home at a time close to his hospitalisation. Dr Chris Williams was told that this video was taken on 1 November, which seems likely. Both Dr Chris Williams and Dr Michelle Williams (who also viewed the video in court) gave evidence that BJay's movements were abnormal, consistent with seizure activity, indicating that head trauma had occurred.

- c) Ms Boyd seeing BJay with no reflex response and sluggish on 30 October during her home visit. I find that BJay's presentation on this occasion was a manifestation of his severe brain injury.

Upon all of the above objective evidence concerning BJay's injuries, I am satisfied that BJay suffered, at the very least, two severe episodes of head trauma causing brain injury – the earlier being in the first six days of his life on or before 20 October; the latter being between 27 and 31 October. However, on the evidence I am not able to make any finding as to which episode of severe head trauma or combination of multiple episodes of head trauma within the two different age categories would have caused BJay's death. The earlier injury or injuries at the minimum would have resulted in permanent and serious disability if he survived. The later injury or injuries may have been more or less significant in terms of BJay's cause of death. Perhaps both sets of injuries independently would have resulted in BJay's death. On the medical evidence, this is not something that can be known.

Assessment of the evidence of the persons of interest

Having assessed the medical evidence relating to the timing and possible mechanism of each of BJay's injuries, I now turn to consideration of the evidence of those residing in BJay's household, as it was in that environment that he suffered most of those injuries.

Before considering the quality of the evidence of the persons residing in the household, two matters arising at inquest require discussion and determination, these being drug use and family violence in the household. These issues provide an understanding of the household environment and credibility and context of the evidence.

Drug use in the household

Ms Atkin adamantly denied the use of cannabis after BJay's birth. Her evidence is in direct conflict with all other credible evidence, particularly that of Mr Richelme and Ms Dykstra. Mr Richelme gave evidence that he would use \$25 worth of cannabis per day, while Mr Johnstone and Ms Atkin would use \$75 worth of cannabis between them. He gave evidence relating to the childlike effect of cannabis upon Ms Atkin and the fact that Mr Johnstone would be agitated and fidgety before smoking cannabis. He said that Mr Johnstone and Ms Atkin would smoke cannabis in the kitchen or lounge room, about four "bongs" throughout the day, and would leave BJay in the bedroom whilst smoking cannabis. Ms Dykstra gave similar evidence about the extent of cannabis usage of Ms Atkin and Mr Johnstone. Ms Dykstra herself used cannabis. She gave evidence that Mr Johnstone and Mr Richelme called Ms Atkin a "bong pig" due to the extent of her usage of and need for cannabis.

Ms Dykstra gave evidence that Mr Johnstone and Ms Atkin would constantly fight over drugs and money and that Mr Johnstone would become "crabby" when they did not have cannabis. Mr Johnstone also gave evidence, consistent with that of Ms Dykstra and Mr Richelme, about his use of cannabis. The evidence of all three was open and forthright regarding cannabis use. I find that the cannabis use in the household during BJay's life, and the manner in which it was consumed, was as described by them. Ms Atkin's denials in the face of overwhelming evidence are one example of her somewhat desperate need to be seen as a good mother and to be perceived in a better light.

I find that much of the daily lives of all occupants of the household revolved around buying and using cannabis. The time and energy, as well as effects of such significant cannabis use placed BJay's welfare at risk.

Mr Johnstone gave evidence that he used "ice" on occasions but that he had reduced the quantity of his consumption upon returning to Tasmania. There was no direct evidence concerning Mr Johnstone's use of ice from any other person. On the basis of Mr Johnstone's own evidence, I find that he used ice at times after the birth of BJay.

Family violence by Mr Johnstone

There was compelling evidence that Mr Johnstone inflicted severe violence upon Ms Atkin. Mr Johnstone agreed in evidence at inquest that he was physically abusive to Ms Atkin and that he knew both his mother and Ms Atkin were fearful of him.

The history of violence and family violence by Mr Johnstone requires attention in this finding. An awareness of his psychosocial development and behaviours from the time of his childhood are crucial in understanding his relationship with BJay and also his evidence. I have already set out in the chronology the psychological evidence of Mr Johnstone's aggression and maladaptive behaviours as a child. The picture presented by the assessments, CPS documents and other evidence is one of a severely dysfunctional child with sociopathic traits, seemingly due primarily to insecure attachment and experience of severe trauma as a child. The evidence of his psychological makeup as he entered his teenage years indicates that these traits were entrenched and virtually incapable of remediation.

Mr Johnstone provided extensive and, at times, seemingly emotional evidence about his childhood and the physical and psychological abuse to which he was subject. Ms Dykstra substantiated his evidence of childhood abuse.

Mr Johnstone, in his evidence at inquest, agreed that he was the only aggressive and violent person in the house. Whilst he challenged the specific allegations and manner in which he inflicted violence upon Ms Atkin, he conceded that he would hit Ms Atkin and that their relationship was abusive. He also agreed that Ms Atkin would have been scared of him.

Ms Dykstra gave evidence that Mr Johnstone had been violent towards her during his childhood. She recalled two specific incidents. The first occurred when Mr Johnstone was around the age of 6 years and he set alight the bed in which she was sleeping. The second occurred when Mr Johnstone was around 7-8 years, when he held a knife to her throat because he was angry at her. He then stabbed her in the stomach and twisted the knife. Ms Dykstra recalled that Mr Johnstone's violence was also directed at his sister and described instances of physical violence towards her. She said that Mr Johnstone left to live with his father due to the danger that he posed to her and her daughter.

Ms Dykstra stated that, as an adult living in her home, Mr Johnstone still scared her and that he was aggressive. She said that Mr Johnstone was able to contain his anger for a limited period of time, possibly "a couple of days". She described that when his brow furrowed, she knew that the anger was setting in. Mr Johnstone would then often display his anger by slamming or breaking objects onto the floor or tables. She stated, in particular, if no drugs

were available to him he would throw down items such as glasses or crockery that were within his reach or in his hands. It was apparent that Ms Dykstra's fear of her son was real.

Ms Atkin gave detailed evidence regarding Mr Johnstone's violence and abuse. The credibility of Ms Atkin's evidence regarding Mr Johnstone's violence towards BJay requires close scrutiny. However her narrative regarding the violence to which she was subjected by Mr Johnstone was, in my view, compelling. She provided details of specific incidents and her narrative was oriented as to both sequence and place. Ms Dykstra's evidence, as discussed below, regarding the physical beatings of Ms Atkin by Mr Johnstone in the house corroborates her evidence.

I set out the following summary of Ms Atkin's evidence regarding the violence by Mr Johnstone, which for the most part, I accept. The full extent of Ms Atkin's evidence on this matter did not appear in her early statements. The evidence of Ms Natalie Hankin, family violence counsellor, was that victims of family violence may not make immediate disclosure, instead revealing the extent of the abuse over a long period of time.

Ms Atkin gave evidence that the relationship between her and Mr Johnstone began fairly quickly and that she was living in a motel in Warnambool when she met him, just prior to Christmas in 2011. They moved in with another couple, Lester and Jess, and were only in the house for about 2-3 weeks before she discovered that she was pregnant. At this stage, Mr Johnstone would beat her and accuse her of sleeping with Lester. He also accused her of sleeping with Sam, her former husband. She indicated that Mr Johnstone did not need to hide his violence as Lester engaged in the same behaviour towards Jess.

Ms Atkin described severe, gratuitous violence by Mr Johnstone that included beatings with his fists, knees and feet, as well as nearby objects. She also gave evidence that he had held knives against her throat. She said that when they moved into Ms Atkin's mother's residence the violence escalated even though Mr Johnstone knew that she was pregnant.

Ms Atkin gave evidence that Mr Johnstone forced her to move to Tasmania. To do so, he placed a belt around her throat and hung it on the wardrobe. He then put a knife to her throat and told her that if she did not leave with him he would kill her mother, family and friends. Her move to Tasmania was made three days after this event with Mr Johnstone making her climb out of the bedroom window whilst the two occupants of the house were sleeping. Ms Atkin stated in evidence that Mr Johnstone had been beaten by Lester, who had started to assault Mr Johnstone as the beatings towards Ms Atkin were, in his opinion, becoming too violent.

Ms Atkin gave evidence that upon their arrival to Tasmania the violence and beating by Mr Johnstone continued and escalated to daily occurrences. The people she was living with tried to assist, by either saying something to Mr Johnstone or hiding implements that could be used as weapons. She stated that Mr Johnstone would make her sit in a chair in the corner of the lounge room, requiring her to seek permission to leave, including to go to the toilet. She stated that if she left the chair without permission she would "cop a beating". The assaults in Tasmania, she said, became more severe than in Warrnambool. She gave evidence that, on 10-20 occasions, Mr Johnstone would beat her for not consenting to sexual intercourse, and subsequently force her to have sexual intercourse with him, including anally.

Ms Atkin also credibly described Mr Johnstone's threats to her life. She said that one of these was while they were flying into Tasmania. Mr Johnstone pointed to bush land and stated that there were mine shafts in the area where he could throw her and that she would not be found because no one would be looking for her. She said he repeated this same threat on many occasions and she had a genuine fear that he would act upon the threat. Mr Johnstone denied this threat but admitted that he had heard such a threat issued by others, presumably in his past. I find that he did make such threats to Ms Atkin.

Ms Atkin gave evidence that, as soon as she arrived home with BJay from the hospital, Mr Johnstone began to assault her. She described a daily occurrence of being taken into the bedroom by Mr Johnstone and the door shut behind them. She said that he would throw her around, punch her, knee her, kick her and even get his knives out and hold them against her throat. He would accuse her of having slept with Lester, and assert that BJay was not his child. As discussed further on, it was in this bedroom setting that BJay also suffered violence at the hands of Mr Johnstone.

Ms Atkin described notable assaults by Mr Johnstone. For example, she said that on the day she took BJay to the hospital Mr Johnstone assaulted her by throwing her against the wall and started to punch her to the stomach and chest area. She stated that prior to BJay being born Mr Johnstone gave her the "biggest beating of her life" because she questioned whether he was going to beat his son once born.

There was corroboration of Ms Atkin's evidence by Ms Dykstra in some important respects, particularly the violence perpetrated by Mr Johnstone in the bedroom setting. It was apparent that the issue was discussed only minimally by Ms Atkin with Ms Dykstra. Equally, further discussion was not encouraged by Ms Dykstra, herself a victim of family violence.

In the affidavits of 3 November 2012 Ms Dykstra indicated that, before Ms Atkin and Mr Johnstone came to live with her, she was aware that Mr Johnstone had been violent towards Ms Atkin and she thought that it might stop if they lived under her roof. Ms Atkin had showed her bruises on her arm, shoulder and face and told her that Mr Johnstone abused her. Ms Dykstra stated that Ms Atkin almost always had bruising on her face – on her cheeks, either side of the mouth, around her eyes and temples. She confronted Mr Johnstone about this. After confronting him, she noticed that the bruising to Ms Atkin's face stopped but that she remained with bruising on her body.

Ms Dykstra believed that the violence by Mr Johnstone was serious, describing the level as 8 out of 10. She had seen bruises on Ms Atkin after hearing them fighting in the bedroom. She did not actually see physical violence. Ms Dykstra said that she believed that serious violence was occurring to Ms Atkin in the bedroom every second day. She described the look on Ms Atkin's face when she followed him into the bedroom, and that she knew it was a lot worse than Ms Atkin was telling her. She said that Ms Atkin would leave the bedroom "scrunched up" and trying to make herself "invisible" so that she would not have to explain what occurred.

Ms Dykstra said that Ms Atkin was petrified of Mr Johnstone and that he controlled the relationship. She said in evidence "*I'd say she was going through domestic violence inside the bedroom, as was BJay. I think Simon was just giving them both a horrible rotten life.*" Ms Dykstra said that her usual response would be to take Ms Atkin outside for a cigarette and coffee and speak to her. However, she stated that Ms Atkin was limited in her disclosures

about what happened. She said that Ms Atkin's fear of Mr Johnstone extended to being frightened of spending money.

No action was taken by Ms Dykstra to assist Ms Atkin or prevent her son's violence. Ms Dykstra herself was a victim of family violence, was scared of her son and clearly reluctant to accept him as the perpetrator of serious family violence. Her failure to take steps to protect Ms Atkin, and consequently BJay, whilst living in her home may be explained by these factors, but it ultimately deprived BJay of a critical safeguard.

Mr Richelme gave evidence at inquest. He stated that he observed the bruising on Ms Atkin and knew she was being hit by Mr Johnstone. However he did not contact anyone because he said it was "her choice". He stated that he had tried to speak to Mr Johnstone about his abuse of Ms Atkin but Mr Johnstone did not respond. He stated that he never saw Mr Johnstone being violent to anyone in the household, nor was Mr Johnstone, to his own mind, dominant or aggressive in the household. He did not see Mr Johnstone have any explosive outburst of anger after BJay was born. However, he said that Mr Johnstone would control his temper in his presence because Mr Johnstone was afraid of him due to incidents in the past where Mr Richelme had reacted violently to Mr Johnstone. This would appear to be a plausible explanation as to why Mr Richelme would not have been aware of the family violence inflicted upon Ms Atkin to the same extent as Ms Dykstra.

I note that there was no evidence from Ms Dykstra or Mr Richelme that Ms Atkin was aggressive or violent whilst BJay was residing in the house. I accept the evidence of Ms Dykstra where it conflicts with Ms Atkin's evidence. Ms Atkin's evidence in general terms was prone to exaggeration and overstatement. However this does not mean that the substance of it is incorrect.

I find that Mr Johnstone was the perpetrator of both extreme physical violence and emotional abuse upon Ms Atkin. I find that before BJay's birth, Mr Johnstone treated Ms Atkin substantially in the way that she described in evidence. Her evidence of this period was given frankly, without histrionic effect and as if recounting genuine experiences. After BJay's birth, I find that Mr Johnstone assaulted Ms Atkin primarily in the bedroom approximately every second day, using various forms of violence. He also controlled her emotionally, financially and sexually. Without adequate coping skills or support in Tasmania and subjected to threats of death, she felt unable to extricate herself from the relationship.

Ashley Richelme

Ashley Richelme was the paternal uncle of BJay and lived in the unit. He slept in the lounge room. On 4 November 2012 Mr Richelme swore an affidavit at the request of the investigating officers. He also gave evidence at inquest.

In his affidavit, he said that he did not see anyone hit BJay, see him fall, or strike any object. He noticed no bruising on BJay, except one bruise on his left eye about two days before he was taken to hospital. Being concerned, he asked Ms Atkin and Mr Johnstone how it happened. Mr Johnstone told him that he did not know how it happened and Ms Atkin "*just lowered her head, saying nothing*".

Mr Richelme deposed to Mr Johnstone and Ms Atkin having a very unstable relationship, being unprepared for the birth and parenthood. He stated that they argued heavily and regularly. As previously discussed, he believed Mr Johnstone was violent to Ms Atkin.

Mr Richelme said he did not spend any time with BJay alone and did not ever see anyone intentionally hurt BJay. He stated that he remembered Mr Johnstone and Ms Dykstra speaking about an incident where Mr Johnstone was carrying BJay and accidentally knocked BJay's head on the doorway and Ms Dykstra had sounded concerned. From the guarded manner of his evidence, it is likely that Mr Richelme was suspicious and concerned about the incident but not prepared to intervene.

In his evidence for the inquest, Mr Richelme was at pains to emphasise to the court that he was rarely at home, stating "*if I wasn't at work I was at a friend's place, if I wasn't at a friend's place I was asleep*". He said that he had limited involvement with BJay or in his brother's relationship with Ms Atkin. He stated that his memory was poor due to medication that he was taking, as well as previous drug use and a head injury. Further, he stated that he was deaf in one ear and could not hear the specific content of the arguments between Mr Johnstone and Ms Atkin. I observe that he appeared to have no difficulty hearing and responding to questions in the courtroom.

Mr Richelme stated that he became concerned about BJay's wellbeing after a while but could not recall the time when those concerns commenced. He noticed that BJay was not feeding properly and choking on the milk as if he could not swallow correctly. At that time, however, he did not believe that Mr Johnstone was hurting BJay. I am doubtful that he did actually hold this belief, rather a state of mind approaching denial and wilful disinterest. After BJay was admitted to hospital, Mr Richelme said he asked Mr Johnstone what happened, to which Mr Johnstone did not respond.

Mr Richelme gave evidence that he would have considered bringing to the attention of people coming to the house the fact that BJay had a bruise if he was aware of bruising at the time they visited. However the strong flavour of his evidence was that he resented persons in authority being in the house. I do not accept that he would have taken this action.

Under cross-examination, Mr Richelme denied knowledge of any details of the matters to which Mr Johnstone was convicted and served time in prison. It appeared that his determined failure to inform himself of these matters may have been his manner of dealing with the extremely confronting situation of violence perpetrated by his brother upon his infant nephew. He stated that he tried "*a couple of times*" but could not extract information from Mr Johnstone, saying "*you can't get blood out of a stone, can you?*" He also gave evidence that Mr Johnstone would not respond at all to regular accusations by Ms Dykstra that Mr Johnstone had killed BJay.

Although Mr Richelme tended to downplay the opportunities he had to observe any violence to BJay, I accept his evidence that he was not present in the household for much of the time. This is supported by the evidence of Ms Dykstra. His evidence was generally uncooperative but not necessarily untruthful on any important point. I am satisfied that he did not witness any violence to BJay but was suspicious, at least from the time of the CPS visit on 24 October, that his brother was perpetrating such violence. When he saw the bruise to BJay's face in the days before his hospitalisation, he must have then known that it was the case.

I am satisfied that Mr Richelme did not inflict any injuries upon BJay. He was not alone with BJay at any stage and had no motive to hurt him.

Despite his best attempts to present as disinterested, both in respect of the inquest proceedings and in the home environment in which BJay was residing, Mr Richelme expressed some concern for the welfare of Ms Atkin and BJay. At the very least, he was aware that BJay was at risk by virtue of parents who were ill-equipped for an infant, in an abusive relationship and were focussed upon their cannabis use throughout the day. He took the view, though, that matters associated with Mr Johnstone, Ms Atkin and BJay were not his problem.

As the only one in the household with influence over Mr Johnstone, Mr Richelme was in a strong position to confront his brother in an attempt to protect Ms Atkin and therefore BJay. It is most unlikely, however, that any amount of discussion with Mr Johnstone could have prevented his episodes of rage stemming from his dysfunctional psyche. Mr Richelme could have contacted the police with a view to having them intervene to protect Ms Atkin and BJay. He had the capacity to confidentially notify CPS with his concerns. Another notification may have changed the CPS response. Mr Richelme would never have contemplated taking such steps. Considering the vulnerability of Ms Dykstra, Ms Atkin and BJay, he should have done so.

Hellen Dykstra

Ms Dykstra swore three affidavits in the investigation, two of which were sworn on 3 November 2012 and one after BJay's death on 17 January 2013. She also gave evidence at inquest and made a further statement to police on 30 October 2015 subsequent to her inquest evidence. She stated in her affidavit of 3 November as follows:

“About a week after BJay's birth they came to live with me. Since that time they have both been continuously fighting, both verbally and physically. Within about two days I realised that Fleur had no idea how to look after a baby. She refused to bath the baby in hospital and also when they came to live with me. She had no idea how to prepare his bottles or to prepare him for a feed.

Simon was very inexperienced with handling the baby as well. Within a few days I noticed bruising on one side of BJay's cheek and then the other and then on both sides of his cheeks, underneath the cheekbones. I asked Fleur how he was getting the bruises and she looked at Simon and didn't say anything. She looked at me and I knew then that Simon was doing it. I told Simon if you mark the baby once more I would report him. Simon didn't respond to me.

Towards the end of last week they were trying to give BJay a bottle and I lent over as Simon was feeding him and saw blood coming from the side of his mouth where the teat is.

Simon was pushing the bottle into BJay's mouth and twisting it.

I took BJay from Simon and had a look at his mouth. They told me that BJay had a milk pimple on the outside of his top lip but there was no blood coming from outside his lip. I lifted BJay's lip up and noticed that the bit of skin connecting his lip was torn.

I then gave them the new rules of the house and that was that BJay was not to be taken into their room during the day to be fed at any time. I told them that the bassinet was to go into the living room and that was where he was to be fed and changed. This seemed to work well for a couple of days and then I found out through Fleur that when I was asleep or taking Ashley my other son to work, things were happening."

Ms Dykstra went on to state in her affidavit that Ms Atkin told her that Mr Johnstone was abusing her, had strangled her and that she had blacked out whilst holding BJay. She said Ms Atkin told her that she would hold BJay in front of her so that Mr Johnstone could not hit her. She said that Mr Johnstone admitted abusing Ms Atkin. She said that she first noticed bruising on BJay's face at the hospital when he was born. The bruises on BJay's face did not go away "the whole time" and this led her to believe that either Ms Atkin or Mr Johnstone were still inflicting these bruises. When she asked Ms Atkin about them, she did not respond. In the days before taking BJay to hospital she saw that BJay had a fat lip with bruising and redness to his eye.

Ms Dykstra stated that at 2.00pm on 2 November, before taking BJay to hospital, she heard Mr Johnstone and Ms Atkin in their bedroom arguing very loudly with BJay also in the bedroom. In her affidavit she described this incident:

"Fleur raced into me and asked me to look at BJay. She said one eye was dilated and one wasn't. When she brought him in I noticed that both eyes looked funny.

I reached and felt for the soft spot on the top of his head. It was firm to the touch and slightly raised. BJay was limp and pale and unresponsive and his eyes were rolling."

Ms Dykstra said that she believed that BJay may have suffered injuries whilst in the bedroom with Ms Atkin and Mr Johnstone on that occasion. However, she stated in her later affidavit that she had been concerned about BJay all day, in particular that he would not feed. She said that Ms Atkin told her that Mr Johnstone did not want to come to hospital with them.

In evidence at inquest Ms Dykstra was a complex witness. Her mannerism and presentation changed from an account denying Mr Johnstone's involvement and portraying hostility to Ms Atkin to a more genuine and emotional account implicating her son as the perpetrator of BJay's injuries.

At the beginning of her oral evidence she presented as a combative witness, who sought to give the impression that she had nothing of value to add to the inquest. She would not answer questions directly, was argumentative with the questioner and contradictory with her answers from one question to the next. It is also noted that her evidence was derogatory towards Ms Atkin, at one stage calling her a "fucking bitch" under her breath in open court during her evidence. Wherever possible she would cast Ms Atkin as being responsible through what appeared to be an irrational thought process. An example was her evidence that Ms Atkin killed BJay because she did not do anything to protect BJay; and that whilst Mr Johnstone may have inflicted the injuries, Ms Atkin inflicted "the pain" by not leaving.

The evidence provided by Ms Dykstra in this part of the inquest was driven by an apparent desire to paint Ms Atkin in a poor light and not fully accept Mr Johnstone's involvement or fault, even in the face of his conviction for ill-treating BJay. She said that Mr Johnstone only indirectly hit BJay because Ms Atkin was holding him up as a shield. This part of Ms Dykstra's evidence was heavily tainted by her fear of implicating her son, her anger and guilt, and her own inability to come to terms with her son having inflicted terrible injuries upon her grandchild whilst living in her home under her supervision.

After giving evidence of this flavour until the morning adjournment of the inquest, Ms Dykstra's evidence changed dramatically. Upon returning to the witness box, she indicated that she had not been entirely truthful to the court and had been withholding information. Her presentation altered significantly. She became very emotional and remorseful, and expressed her conflict between protecting her son and speaking up on behalf of her grandson.

It was most apparent that she felt guilt and regret about the plight of BJay and her own role in it. She blamed herself for not reporting the danger to BJay to the authorities and said that she could have saved him. Her presentation in this section of her evidence was forthright and sincere. She appeared to be making a genuine attempt to recall events and to provide the evidence to the best of her ability. She spoke of her observations and knowledge of Mr Johnstone's abusive behaviour towards BJay, much of which she had not previously disclosed. She answered the questions put to her intelligently and without argument. Her demonstrations of Mr Johnstone's violent actions using a doll were powerful. She also corroborated a large proportion of Ms Atkin's evidence.

As the day progressed Ms Dykstra moderated some parts of the evidence relating to Mr Johnstone's actions towards BJay, but the substance of her evidence remained firm. It is noted that Ms Dykstra also provided a statement to police after the inquest, which accorded with her inquest evidence without retraction. Ms Dykstra had clearly made a decision to provide to the inquest as much information as she was able after withholding it for a lengthy period.

I accept the submissions of Ms Sundram that the second part of Ms Dykstra's evidence and her subsequent further written statement are credible and should be accepted. Her affidavits made after BJay's hospitalisation were more limited in content, reflecting her difficulty in acknowledging that her son could be responsible for infliction of such injuries upon her grandson.

I therefore accept the evidence of Ms Dykstra given in the second part of her testimony. It is well stated in her subsequent statutory declaration and is crucial evidence in this inquest. I have therefore decided to take the step of reproducing the contents of this document, as follows:

I was present when my son Simon Adam Johnstone could not handle when BJay, his son, would start crying. This was when Simon, Fleur and BJay with (sic) living with me at 15 Leake Street, Railton in July 2012. Simon would get angry and start singing to drown the crying out. It was in a deep angry tone and I would then get upset and tell Simon to cut it out because it was annoying.

I have made this statement today as I left some information out in my first statement as I was being protective towards my son. On two occasions whilst they lived with me I observed Simon put pressure onto BJay's head. On one occasion I watched Simon holding BJay in his arms and the baby was crying because he didn't want to have a bath. Simon used his free hand to press BJay's head up against the shower screen. I don't know why he did this but BJay stopped crying. I do remember Simon saying, 'You will have a bath whether you like it or not,' A couple of weeks later I again heard BJay crying and observed Simon holding him and doing the same thing which was using his free hand to press BJay's head against the bedroom wall. Again BJay stopped crying, Simon knew that he should not be doing this to the baby.

I would always hear both Simon and Fleur arguing and yelling at each other in the bedroom. I would be able to hear the sliding doors banging and BJay screaming but never saw anything because the bedroom door was always shut. The usual reason for their arguing was over their lack of money and lack of drugs. They both smoked cannabis daily in the kitchen of my house. This arguing was daily as they always required cannabis. They would purchase their cannabis from their friends 'Mat and Tiff' and used \$50 a day in cannabis cones. They lived in Devonport but where exactly I don't know, I don't know their full names. It (sic) yelling was very loud and if we had people living nearby, which we don't, they would have heard it.

During the 6 weeks that all three of them lived with me I was in disbelief that my son Simon was such a bad father to BJay. I knew deep down that Simon was hurting BJay and Fleur but didn't want to believe it. I didn't directly witness a lot of it but there was no other explanation for the injuries to both of them. I feel that if Simon doesn't get help he may kill or seriously injure someone in the future.

Simon's normal pattern of behaviour when BJay started crying was to get angry and slam doors and cupboards. I noticed that BJay started to get small bruises on his cheek and I asked both Simon and Fleur to leave the bedroom door open as I believed that Simon might be causing the bruises. They did listen to me and on most occasions after that the door was left open.

Fleur told me that she was carrying BJay out to the kitchen during the night and hit his leg on the open bedroom door. I then purchased a night light so that this would not happen again. However I then noticed that the leg and face bruising on BJay was still occurring so I felt that Fleur's reason was probably a lie and in fact Simon was causing it. I was living alone for about 8 years and when Simon and Fleur arrived it was all very overwhelming as I lived a pretty quiet lifestyle and now people were visiting the house and life was busy.

On about the third day after BJay came home from the hospital I observed Simon place the whole of his palm over BJay's face to stop him from crying, attempting to muffle the sound. It didn't work so he handed the baby to Fleur. There was a little bit of pressure but not enough to injure the baby. BJay was not feeding properly when he first came home and so cried a lot. Simon would do this thing with his palm over the babies (sic) face daily. The baby would try to cry but couldn't, I think Simon was covering his mouth so he couldn't breathe. If Simon did this in front of somebody he would tell them it was to quieten BJay down. If this didn't work Simon would yell at BJay and tell him to shut up.

When Simon held BJay he would cradle him in one arm with his little head pushed into the crook of his arm. He would also place BJays head between his elbow and his ribs and hold him tightly. I felt it was too tight but Simon told me he liked to feel secure. My opinion was that Simon held BJay this (sic) was to squeeze his head whenever he started to cry. In fact I saw him do this on a number of occasions. I remember on one occasion that Simon was holding BJay in the (sic) manner and squeezing him to (sic) tight. I tried to take BJay from Simon but he refused to let me. Simon would carry BJay around for half the day like this on most days and when he did BJay was silent. I would often tell Simon to relax his grip on BJay. I did not see deliberate pressure applied on BJay but clearly there was pressure in the way that he cradled him.

A week before they took him to hospital they were bathing BJay I went in and looked at him and he looked lethargic. When they put him down he would not lie like a newborn baby he would lie down with his arms and legs out straight. It didn't look right and I felt there must be something wrong with him. His proportion of his head to his body, to me, seemed enlarged. I mentioned this to them and they said that they could not see what I saw. Simon told me that he has always looked like this.

About a week and a half before I took BJay to hospital I was walking down the hallway past his bedroom door and observed Simon standing up holding BJay in front of him with both his hands. He was holding BJay around his waist when for no reason Simon just let go and dropped BJay onto a mattress on the floor. BJay was not crying and when Simon dropped him he fell approximately a meter and a half. BJay landed on his back and immediately started crying. I was just shocked. I am afraid of Simon's responses and so did not confront him on what I had just seen. I told Fleur and stated that he can't do this and it was wrong. She listened to me but it went in one ear and straight out another.

I spoke to Simon and Fleur on a number of occasions about their arguing however nothing changed. I noticed quite often that Simon would start pressing or pushing down with his fingers onto BJays crown cap. I asked him what he was doing and he said it felt freaky. He would do this a couple times a day if we didn't stop him from doing it.

A couple of weeks after I observed Simon push BJay's head against the shower screen. I walked into the bedroom to place some clothes in a cupboard. I observed Simon holding BJay's head up against the wall. Simon realised that I had entered the room and pretended to be showing BJay the roses out of the window. It was clear to me that Simon had pushed BJay's head against the wall. I had heard BJay crying before I entered the room. BJay's bassinet was near that window so I presume Simon had picked him up to stop him from crying. It was clear to me that Simon was being nasty to BJay.

In the first week or two that BJay came home from hospital I took Ashley, my other son, to work and left Simon, Fleur and BJay alone at the house. When I got home I noticed that there was large bruising on BJay's leg, I think it was his left. I asked Simon what had happened and he told me that he was holding BJay and he had run into a wall.

I observed on a daily basis Simon feed BJay with a bottle, he would place the bottle in BJays mouth firmly and then with more force than he should of used he would twist the

bottle around in BJay's mouth. He justified this to me by saying that BJay was a lazy drinker. I also observed Simon grabbing BJay's legs, when he was lying down, and pushing them up against his chest, Simon would the (sic) spin BJay's legs outward and bring the legs back down. I noticed that BJay cried when Simon was doing this to his legs, but not a normal cry. I thought he was crying because it hurt. I considered it was rough and when I asked why he was doing it he stated that the clinic nurse had told them to do it to help BJay deal with constipation. I felt they were being too rough on him and told them not to do it.

I (sic) one occasion I observed Simon pick up BJay around the waist with both his hands and through (sic) BJay in the air and them (sic) catch him. Fathers do this to toddlers not infants as they do not have the neck muscles to hold their head straight. I told Simon this was inappropriate and he did not do it again. However I did see Fleur do it once as well.

On another occasion I observed Simon holding BJay against him with one arm around BJay's waist. He was not giving any support to BJay's head which was flopping about. The week before I took BJay to hospital I noticed that he had more bruising, around both his eyes, his cheeks and his leg. BJay was not feeding, he was quiet, BJay's poos and urine were not frequent.

On another occasion I observed Simon standing in the kitchen cradling BJay and attempting to feed him with a bottle. BJay was crying and Simon got annoyed and with force shoved the bottle into his mouth. He then moved and hit BJay's head on the wall. I am not sure whether he did this on purpose or not.

One evening Simon was feeding BJay in the lounge room when Simon brought BJay to me and said that he was throwing up blood. I saw a reasonable amount around the corner of his mouth and when I was removing this with a flannel I observed that the small amount of skin between the lip and the upper gum was torn away. Simon did not seem too worried about this and showed no emotion.

When BJay would start crying Simon would get a furrowed brow (sic) and I knew he was getting angry. He would keep the anger bottled up for a time and then he would go to the bedroom and I would hear the yelling. He always took BJay to the bedroom with him. Simon would not show violence in front of me, he would always do it in the bedroom. Fleur would always go into the bedroom with him when he was angry and I thought she must have had a miserable life. Fleur would come out of the bedroom scrunched up like she had been punched. I would take her out into the backyard for a coffee and a smoke and I would ask her if Simon was hitting her because I also saw bruises on her. The exact same bruises as BJay. She never told me that she was being hit by Simon. Simon completely controlled Fleur as he has a controlling personality.

On one occasion I took Fleur to Devonport to shop for things for BJay and she spent all of her money. On the way back home she was petrified of what Simon would do and say to her for spending the money. I calmed her down and when we got home Simon went off. He took Fleur up to the bedroom and I could hear a lot of yelling about drugs. Fleur was trying to do the right things for BJay but just didn't know what she was doing.

I also observed Simon holding BJay on another occasion with both his hands around the baby's waist and shaking him from side to side in a vigorous way. Simon was singing nursery rhymes and playing a game but BJay was too young and his head was not being supported. I told Simon he should not do it and he stopped doing it. This occurred in the lounge room of the house and BJay was about three weeks old. Simon was angry with BJay and Fleur when he was doing this because they were crying. When Simon noticed I was watching he stopped being so rough with BJay.

During this time I was taking BJay shopping with me and was placing him into a car capsule when I thought I heard a click. I put it down to BJay having a clicky hip. I can't remember him crying at this time. I can't remember exactly when this was but it was after the nursery rhyme incident in the lounge room.

When BJay was about 2 weeks old I was getting worried about his bruises and I placed a post on Facebook in a Bipolar group that I am a member of. I stated that I wanted to put BJay in my room so I could look after him. I was then told by the person who ran the group that they were legally obliged to kick me out of the group so I didn't get to see what the responses were.

I was getting worried about the bruises on BJay and asked Simon and Fleur to put BJay's cradle in my room so I could monitor him. They would not do this even after I asked two or three times.

On the day I took BJay to hospital Fleur brought BJay to me and I observed his eyes were flickering and one was dilated and fixed. Prior to this happening Simon and Fleur had been having one of their biggest arguments yet. It again was over lack of money for drugs, from memory they only had \$25 left and they needed cash to buy the cannabis and they didn't have enough to purchase it. BJay was completely non responsive so I put him in his capsule and Fleur and I took him to hospital.

When I arrived at the hospital I went in and told the booking nurse that child protection should be contacted and informed of what had happened. I then left as I had to go home and get Ashley to work. On the day before I took BJay to hospital I went to the Sheffield online centre and reported the mistreatment of BJay to who I thought was Child protection. However I mucked it up and sent it to another government department. I am aware that they have a record of this and I think it was Department of Human Services.

Simon has always had a violent streak whilst growing up. Simon attempted to set my bed on fire when I was asleep when he was aged approximately 5 or 6. I have no idea why he tried to do this but he found a lighter and tried to set my mattress alight. I woke up smelling smoke and he ran out. When Simon was aged 7 or 8 I would not let him watch SBS as he wanted to watch South Park. He got upset and grabbed a steak knife from the kitchen and came back and held it against my throat. He then stabbed me in the stomach with the knife which has left a scar to this day. When he was twisting the knife in my stomach he was smiling at me. It caused a small wound that made me bleed. I smacked him for this and sent him to his room, he was banned from TV for a period of time.

Simon was fast and strong and I did not feel comfortable going to sleep with him still awake. I would always make sure he was asleep first before I went to bed. I was that uncomfortable that I sent him to live with his father, John Smith, in Devonport. My daughter Naomi who was younger than Simon was treated horribly by him. He once put a pillow over her head when she was 18 months old, Simon was two and a half. He was quite jealous of her and still is because he feels that she got everything and he got nothing.

When Simon gets angry he tends to throw things about, cups, glasses, and crockery. There are dents in the walls in my kitchen area from him throwing things. This would happen every second day.”

In evidence at inquest Ms Dykstra spoke of further noteworthy conduct by Mr Johnstone towards BJay.

Firstly, she observed both Mr Johnstone and Ms Atkin manipulate BJay's legs in what she perceived to be an unnatural manner. She describes that both parents would push BJay's legs up to his rib area and then split the legs when they would bring them down. She gave evidence that she observed this movement to be done “a bit rough” and told them both to stop it. She said that what she found disturbing was that both of them would open BJay's legs to a distance she believed was too wide for a baby. When she questioned them about this action they said a clinic nurse told them to do this because of BJay's constipation. Both Ms Atkin and Mr Johnstone accepted that they engaged in this practice but said that they were gentle with BJay, and did it because they were told to do so. I doubt, in the circumstances, that this action was sufficiently forceful to cause the femur and pelvic fractures described by the medical witnesses. The action may have not been performed skilfully or as gently as advised, but the evidence and demonstrations given by Ms Dykstra and Ms Atkin satisfy me that this practice was not overly forceful or malicious and was intended, at least by Ms Atkin, to assist BJay.

Secondly and importantly Ms Dykstra gave detailed evidence at inquest about the practice of Mr Johnstone entering into the bedroom when he would inflict violence upon Ms Atkin and, she believed, BJay. Her evidence on this point was compelling and is summarised in her statement set out above. At inquest she was firm that BJay would be left in the room alone with Mr Johnstone after Ms Atkin had come out having been assaulted. I do not accept Ms Atkin's evidence that she took BJay out of the room with her and did not leave Mr Johnstone alone with him. Ms Dykstra described in detail the manner in which Mr Johnstone would then continue making very loud noise in the bedroom that would drown out BJay's cries and all other sounds. She gave evidence that she would not have heard BJay being assaulted in the bedroom, even if his head was banged onto a wall. Ms Atkin's evidence corroborates Ms Dykstra's evidence, although I prefer Ms Dykstra's evidence that it occurred approximately every second day rather than more frequently, as Ms Atkin stated.

Ms Dykstra's evidence of the volume of Mr Johnstone's noise over BJay's cries is consistent with the observations of Nurse Luke regarding him mimicking and tormenting BJay with loud noise. I find that Ms Dykstra believed that Mr Johnstone was inflicting violence upon BJay whilst he was alone with him in the bedroom in a state of uncontrolled anger. For the reasons that follow, I find that her belief was correct.

Fleur Atkin

Ms Atkin's initial statement to the police was made at 11.25pm on 2 November 2012, in which she provided limited information regarding BJay's injuries. She said that the bruising around BJay may have been caused by her wiping his eye. She said that Mr Johnstone pushed the bottle into BJay's mouth causing a split to the inside of the mouth, without further details being given regarding the force or intention. She said that Mr Johnstone did get "grumpy" with BJay but when he did she removed BJay from him. She also stated that BJay's facial bruising was caused by her grabbing his cheeks to stop him choking on his vomit. She said that Mr Johnstone would throw BJay in the air and catch him but no one had shaken BJay.

Ms Atkin made a subsequent statement to police on 5 November whilst BJay was still hospitalised. In that statement she said that, in making her initial statement, she feared for her own safety and that of BJay. She spoke of being a victim of violence at the hands of Mr Johnstone. She also described various ways in which Mr Johnstone would treat BJay violently.

In her statement, Ms Atkin provided comprehensive descriptions of the violent incidents, none of which she subsequently retracted to any significant extent. Most of these were the subject of the charges against Mr Johnstone but it is appropriate to set out Ms Atkins' evidence of the incidents described in this early statement. These are as follows:

- On 16 October 2012 Mr Johnstone assaulted BJay and herself in hospital. Ms Atkin was washing her hands in the toilet when she heard BJay's heavy crying suddenly stop. She ran out of the bathroom and saw Mr Johnstone sitting on the foldout bed holding BJay around the throat with his body lifted off the bed. She saw him throw BJay down onto the fold out bed fairly hard. As she approached the bed, Mr Johnstone pushed her with both hands to her chest and she fell backwards off the other side of the bed, before getting up and taking BJay with her out of the room.
- Mr Johnstone had, on numerous occasions, threatened to kill her and throw her down a mine shaft and in recent times, he had assaulted her by holding knives to her throat.
- When she questioned Mr Johnstone about the bruising to BJay's leg, Mr Johnstone told her that he punched BJay in the leg because "he wouldn't shut up". Ms Atkin tried to cover the bruise so that the midwives would not see it when they weighed BJay.
- Mr Johnstone placed his fingers down to the knuckle in BJay's throat on three or four occasions to stop him crying. When Ms Atkin intervened to pull Mr Johnstone's hand away, Mr Johnstone would then hurt her.
- On more than one occasion, Ms Atkin observed Mr Johnstone place his hand over BJay's nose and mouth to stop him crying. One time he did this with such force that BJay stopped breathing and moving.
- On 22 October 2012 Mr Johnstone ran at her whilst she had BJay in her arms and placed both his hands around her throat and squeezed so hard she was not able to breathe. In that process she lost consciousness and dropped BJay. When she regained consciousness BJay was lying on the floor on his back, crying. Mr

Johnstone, at the time, suggested to Ms Atkin that she had had a seizure but several days later admitted that he had strangled her.

- Between Tuesday 23 October and Monday 29 October 2012, at a time between 3.00am and 7.30am, Mr Johnstone stood in front of BJay, who was on the couch crying. He yelled “*shut up*” and “slammed” his hand over BJay’s face, covering his mouth, nose and eyes. When she went to remove Mr Johnstone’s hand and pick up BJay, she noticed his chest was not moving, his body was no longer moving and his eyes were closed. He eventually recommenced his breathing.
- On 24 to 25 October 2012 Mr Johnstone and Ms Atkin were arguing. As the argument became heated he punched her once with his right fist to her nose and mouth area causing her nose and lips to bleed with some of the blood dripping on BJay.
- On Friday 26 October 2012 Mr Johnstone forcibly pushed the bottle into BJay’s lip causing the top of BJay’s head to hit the wall behind him and his lip to bleed. When Ms Dykstra walked in and asked what happened to BJay’s lip, Mr Johnstone stated he did not know.
- On 30 October 2012 Ms Atkin saw Mr Johnstone pulling his right thumb away from BJay’s left eye as she walked into the room. When she asked about the redness around BJay’s eye, Mr Johnstone said that he did not know how it happened. The redness became bruising.
- On Thursday 1 November 2012 Mr Johnstone grabbed Ms Atkin by the front of her jumper and slapped at the right side of her face with his hand. This occurred after another argument. When Ms Dykstra came into the bedroom to ask what had occurred, Mr Johnstone stated that they were “just arguing”.
- At about 4.30 pm on Friday 2 November 2012 Mr Johnstone and Ms Atkin were arguing in their bedroom. Ms Atkin started to pack her bags to leave, stating that she was taking BJay with her. Mr Johnstone picked up a full-size, wooden cricket bat from the bedroom and hit her across the left arm, left elbow and ribs, stating that she was not going to take his son anywhere.
- On several occasions she witnessed Mr Johnstone pick up the cricket bat and swing it above BJay’s head because he would not stop crying. She had not seen him hit BJay with the cricket bat.
- On three or four occasions Ms Atkin witnessed Mr Johnstone picking up BJay by grabbing hold of the top of his jumpsuit near his neck, lifting him off the mattress or couch by 30-40 cm and letting him drop onto the surface. He did this because he was not able to handle him crying. As a result of picking up BJay in this manner, three jumpsuits near the shoulder were ripped and one was stretched.
- Mr Johnstone was extremely rough with BJay in the way he wrapped him, pulling the blanket so tightly across BJay’s chest that it would become red and he would have trouble breathing. On one occasion Mr Johnstone ripped the blanket along the seam due to it being pulled so tightly.

The statements made by Ms Atkin to, or in the presence of, the various nurses at the RHH also involved allegations of violence to BJay and herself by Mr Johnstone. In particular, I note that she told Nurse Copping that Mr Johnstone had banged BJay's head on a brick wall, something she had not previously disclosed.

On 11 November 2013 Crown counsel, Ms Allison Shand, interviewed Ms Atkin between 8.15am and 11.05am, as part of her conduct of the prosecution of Mr Johnstone. At that stage Mr Johnstone had been committed for trial on one charge of causing grievous bodily harm and one charge of ill-treating a child. Ms Shand swore an affidavit relating to her interview of Ms Atkin. In this interview, Ms Atkin did not resile from her statements made previously to police but told Ms Shand of further serious incidents of violence by Mr Johnstone towards BJay that she had not previously disclosed.

Ms Shand's evidence was clear and precise, and indicated a thorough knowledge of the matter and good memory of the interview. Her contemporaneous notes, typed on her laptop computer, were detailed and I accept those as a full and accurate account of the representations by Ms Atkin, as well as her associated demeanour during the interview.

Importantly, the additional incidents conveyed by Ms Atkin to Ms Shand were as follows:

- That Mr Johnstone would slam BJay on the bench when he would get his bottle. Ms Atkin said she saw this happen 3-4 times with impact to BJay's head.
- Mr Johnstone would "*flip out*" by screaming, yelling and hitting BJay when he started crying. He would hit him mostly with his hands to the head and stomach area. He would punch, slap and use pressure.
- On one occasion Mr Johnstone slammed BJay onto the bench; the impact was to the top centre back of his head.
- On the day before his hospital admission Mr Johnstone threatened to hit BJay with a cricket bat.
- Mr Johnstone twisted BJay's leg once or twice, having done the same thing with the baby of a girl with whom Ms Atkin used to live.
- Mr Johnstone would throw BJay in the air as if he was playing catch with him.
- Mr Johnstone shook BJay on numerous occasions trying to get him to be quiet.

Ms Shand stated that Ms Atkin was polite and responsive but, in her opinion, she was motivated by wishing to see Mr Johnstone prosecuted for causing the death of BJay and therefore was willing to suggest that Mr Johnstone was responsible for violence when in fact she did not have such knowledge. Ms Shand indicated that there were occasions when she asked Ms Atkin if she had seen certain acts or could explain certain injuries but Ms Atkin said that she had not seen them occur and was just guessing. Ms Shand noted that Ms Atkin appeared to dramatise her own role in rescuing BJay from Mr Johnstone's violence. Overall, Ms Shand assessed Ms Atkin as an unreliable historian on the important matters that were being considered by her.

Ms Atkin's evidence at inquest was fairly consistent with what she had previously told police, Ms Shand and the nurses. She did, however, give specific details of an incident of BJay being thrown onto the kitchen bench at night by Mr Johnstone, which is discussed further below.

In general terms, the manner and content of Ms Atkin's evidence appeared somewhat self-serving, conflicting and involved persistent attempts to paint herself in a positive light. This is exhibited by a number of features of her evidence:

- Her refusal to acknowledge her own drug use after the birth of BJay. This topic has already been discussed.
- Her evidence that she wished to stay in hospital and was not confident to leave when she was discharged was not supported by the evidence of the hospital nurses.
- That she watched BJay all the time and only let him out of her sight when she was either on the toilet or in the shower. This is another example of a self-serving statement attempting to portray herself as a protective mother. I do not accept that Ms Atkin was with BJay all the time, particularly given Ms Dykstra's credible evidence that Mr Johnstone would regularly be alone in the bedroom and other areas of the house with BJay.
- That she disclosed to Ms Dykstra everything that was happening. I do not accept that she did so. I find that there was not significant communication between Ms Atkin and Ms Dykstra. Specifically, Ms Atkin was intent upon hiding the violence by Mr Johnstone. Further, Ms Dykstra did not like Ms Atkin and would have made her dislike apparent. The relationship between the two was complex - both traumatised individuals, both fearful of Mr Johnstone and both reluctant to speak of the violent happenings in the household.
- That she regularly disagreed with evidence given by Ms Dykstra apparently for the sake of disagreement, even when the substance of her own evidence was similar.

The above points clearly indicate Ms Atkin's propensity to embellish parts of her evidence to the point of clear contradiction with other credible evidence, seemingly for the purpose of portraying that she was a good mother and alleviating her own guilt.

There are reasons for not accepting the evidence of Ms Atkin without corroboration. However, her evidence is not to be rejected without full examination. I have found the assessment of her credibility to be a very difficult exercise. BJay, in fact, suffered severe injuries consistent with incidents such as those that she described. Mr Johnstone's propensity for violence and the fact of his concessions all militate towards incidents of the type described by Ms Atkin as having occurred. In making this comment, I include the more severe incidents alleged on later occasions by Ms Atkin that would likely have caused damage to BJay's brain. These would include Mr Johnstone slamming BJay's head onto the kitchen bench and violently shaking him.

Ms Atkin's manner of giving evidence was not conducive to a favourable assessment of credibility. Her emotional lability and difficulty in behaving with decorum in court did not assist

in this regard. Her presentation was generally attention-seeking, child-like, histrionic and self-focussed. However, the whole of her evidence was not in this category. In some respects she showed good understanding, maturity and ability to articulate her thoughts. There was nothing about her evidence at inquest, including her demonstrations with the doll, that suggested callousness towards her child. Although I perceived that she wanted to love and care for BJay she was simply not psychologically equipped to do so adequately.

Exposure to severe family violence may impact upon a victim's ability to reflect honestly upon their own role as well as disclosing what took place. This evidence was provided by Natalie Hankin, counsellor with Family Violence Counselling Support Services ("FVCSS"). Ms Hankin had been Ms Atkin's case worker since BJay's hospitalisation.

Ms Hankin gave evidence that, in presenting to FVCSS, many victims of family violence present as being disempowered, fearful and lacking control over their lives with limited knowledge of their options and responses to family violence within Tasmania. She said that many women present as conflicted, struggling to understand their partner's abusive behaviour while still maintaining an emotional attachment with their partner and a hope that the relationship dynamics could change.

Ms Hankin gave evidence that the disclosures of family violence made by Ms Atkin could be considered extreme in terms of those cases dealt with by FVCSS. She was of the view that Ms Atkin has been continuously affected by the perceived threat that Mr Johnstone will find and hurt her and her family. She said that it is important not to underestimate the impact of the fear held by Ms Atkin and how that was likely to have impacted upon her capacity to provide information, which initially might have been limited.

Ms Hankin's evidence provides a useful background regarding disclosures made by victims of family violence and a plausible reason why disclosures about violence to BJay were not all made immediately to police by Ms Atkin. Ms Hankin observed that Ms Atkin's disclosures and recollections of events in her life to FVCSS have been reasonably consistent throughout her engagement although provided in "bits and pieces", based on Ms Atkin's thoughts at the time and not as a full narrative.

In addition to the views of Ms Hankin, Ms Atkin's evidence concerning Mr Johnstone's violence is also supported in many parts by other witnesses and is generally consistent with medical opinion. These are all factors that lend credibility to her account, particularly that she saw Mr Johnstone shaking BJay violently and banging his head upon a hard wall or kitchen bench. However, the extent to which Ms Atkin was prone to both denial and exaggeration in her evidence does detract considerably from her credibility. In those circumstances I must be extremely cautious of accepting her evidence and give the *Briginshaw* standard its full effect in light of the nature of the allegations.

I therefore cannot be satisfied that Mr Johnstone was violent to BJay in the manner and by the acts recounted by Ms Atkin further to her original statement to police, upon which the particulars of Mr Johnstone's pleas of guilty and sentence were based. I am, however, satisfied for reasons contained in this finding that Mr Johnstone did inflict severe violence towards BJay that caused his death.

Simon Johnstone

Mr Johnstone gave evidence at inquest in October 2015 and again in January 2016. He also participated in four police interviews that were tendered in evidence. Three of these were prior to the inquest, with the last interview after the conclusion of the October 2015 sittings.

In his interviews with police he denied causing intentional injuries to BJay and alleged that Ms Atkin harmed BJay in some incidents. In his oral evidence at inquest in October 2015, he conceded that no one else besides him would have harmed BJay, although he could not remember what he did. He said that Ms Atkin was not responsible for any injuries upon BJay. In his video interview with police in October 2015 after his inquest evidence, Mr Johnstone repeated his inability to remember his actions and denied some of the more serious allegations.

In his evidence in January 2016 he maintained that he could not remember what he may have done to BJay to cause his death. However, he still did not nominate any other person as causing harm to BJay besides himself.

As a witness Mr Johnstone presented as withdrawn and having limited capacity to communicate. These characteristics were in keeping with the traits referred to in his early psychological reports which have previously been discussed.

There are reasons why Mr Johnstone might be correct in his assertion that he was unable to remember his acts of violence to BJay. He gave consistent evidence that when he had done something bad or violent, he would try to wipe out the memory in order to stop thinking about the event. He stated that it is easier for him to forget. He gave evidence that on several occasions after he had been told by others that he had done something violent he still could not remember his actions, or it would take some time to remember. Such evidence is consistent with the memory blackouts described in his psychological reports which appear to have commenced in his childhood, possibly to operate as a coping mechanism to deal with trauma. He became most emotional in his evidence when recounting events from his traumatic childhood.

Mr Johnstone told the inquest that he did not want to remember what happened to BJay. He described how he becomes angry to a point that he cannot remember his actions. It appeared that, at times, Mr Johnstone may have been trying to make a genuine attempt to try to remember what he may have done to BJay. Mr Johnstone was probed intensely at inquest about his recall of perpetrating serious acts of violence upon BJay. In evidence he gave answers such as *"I wish I could remember how his head injury had occurred, but I just, just can't remember"* and *"I would probably feel a lot better if I could remember"*. His position, on balance, was that he was not able to remember what he had done and that he had exhausted his memory.

In general terms, Mr Johnstone accepted that he could have committed the acts of violence against BJay that were the subject of his conviction and sentence. When questioned about individual acts of inflicting possibly fatal head trauma, he responded with denials or lack of memory. It appeared to me that these denials lacked any conviction or accompanying reasons. His position in evidence at inquest was, in fact, that he was responsible for hurting BJay and no one else was responsible. He agreed that he was the only violent person in the

house but could not recall how he was violent. He believed that he was the perpetrator of the injuries that caused BJay's death and did not resile from that proposition. As an example, the following exchanges occurred during Mr Johnstone's evidence:

"MS SUNDRAM: (Resuming): And in this household the only person who was being violent – and when I say violent I mean punching, hitting, was you?.....Yeah.

It wasn't Fleur?.....No.

It wasn't your mum?.....No.

And wasn't Ashley?.....No.

There was no one else going into that house?.....No.

So the person who was violent to BJay was who?.....Would've been me.

And do you recall how you were violent to him?.....No.

But any injuries BJay got who would have caused them?.....Myself."

And;

"MR VERNEY: Has anyone explained to you just all of the injuries that BJay actually sustained?.....Yeah.

Okay?.....Been told.

So you've been told?.....Yep.

So you now know how many and how serious they were?.....Yep.

You agree that those injuries were caused by you? I note you're nodding your head, the recording needs to hear it – an answer?.....Yeah.

You accept that?.....Yep."

The following passage is also illustrative of Mr Johnstone's evidence:

"MR TURNER: What injuries did he suffer?.....I think it was fractured skull, fractured ribs, femur, I think it was, yeah, that's all I can remember at the moment. Yeah, fractured skull fractured ribs and the femur.

How did those things happen?.....With stupidity and anger.

That's what caused them to happen but how did they happen?.....I dunno.

Right at this minute you're trying to block it out of your mind?.....No, I'm trying to remember.

Trying to -.....Yeah, I'm trying to remember.

You're trying to remember?.....Yeah.

Not trying to forget?.....No.

When you have those incidents of what you described as “blacking out” you don’t mean by that you lose consciousness?.....Eh?

You don’t lose consciousness?.....No.

You mean by that to describe that you completely lose your temper?.....Yeah

And -.....- to a point when I can’t remember.

To the point that you just lose complete control of yourself?.....Yeah.

And you go berserk? Is that right?.....Yep.

And then afterwards you feel ashamed? Yeah?.....Yeah.

And you try to forget, is that right?.....Yeah, to a degree, yeah.

Yeah. Because very early on you said, in answer to some questions from Ms Sundram, that you could remember bits and pieces? You can remember bits and pieces about what you did to BJay, can’t you?

HER HONOUR: You can remember the cricket bat?

WITNESS: Yeah, I can remember that.

HER HONOUR: So you can remember some things. Yes, Mr Turner?

MR TURNER: (Resuming): The last question from Ms Sundram was to the effect that any injuries BJay got he got from you and you said, “From myself.” That’s true?.....Suppose so, yeah.

Well, is it true or is it not true?.....I guess it’d have to be true if I said it.

And you said in answer to a question from Mr Verney when he was asking you about how you felt having punched BJay, you said you felt – or it makes you feel annoyed and sick. It makes you feel annoyed with yourself and sick with yourself, is that right?.....Yes.

Because you’re ashamed of what you did? Is that right?.....Yeah

Because it’s not something that you would have expected to do to a baby - is that right?.....Yeah.

Mr Johnstone told the inquest that he would lose his temper whenever anger overtook him, whether it was in the bedroom, kitchen or lounge room area. Mr Johnstone agreed that when he lost his temper no one was able to stop his subsequent rage, particularly if it was just him and Ms Atkin in the house. Counsel assisting questioned Mr Johnstone about his state of mind leading to his violent outbursts of anger. Mr Johnstone agreed that the anger arose as a result of an inability to prevent certain thoughts from entering his head. It was apparent from

his evidence that a particularly insidious thought causing extreme anger was that BJay was not his biological son.

I point out here that there was no DNA analysis conducted to link Mr Johnstone genetically to BJay. Nonetheless, at all material times throughout the relationship he accepted that he was the father of his unborn baby. Throughout the investigation, he did not raise any issue relating to BJay's paternity. Further, there was no evidence that Ms Atkin was in a relationship with any other person at the time. I am satisfied that he was BJay's biological father. I find that Mr Johnstone's accusations of infidelity towards Ms Atkin, expressed in the grip of rage, were a product of his dysfunctional thought process.

He was not able to deal with the anger and frustration created by such repetitive thoughts until an explosion of rage occurred. It was clear from Mr Johnstone's evidence, consistent with the evidence of Ms Dykstra and Ms Atkin, that he could not tolerate BJay crying and that his crying would precipitate high levels of anger and frustration, including a loss of control.

It is quite likely that Mr Johnstone does in fact recall some serious acts of violence but cannot bring himself to recount them. As discussed it is also plausible that he has memory blackouts in some circumstances. However, I cannot determine from his evidence whether he is telling the truth about his lack of memory in respect of some or all incidents put to him. In early interviews with police, he denied inflicting intentional violence upon BJay. He did not impress me as an honest and forthright witness but, instead, evasive and cautious in his answers. It is contrary to common sense, for example, that he has no memory of entering the bedroom with Ms Atkin and BJay on a regular basis and inflicting violence. His assertions of lack of memory regarding the more serious violence to BJay are convenient. His motivation to give evidence of lack of memory is strong.

Ultimately, Mr Johnstone, while not forthcoming with details, was accepting of responsibility for BJay's injuries. His evidence gave me no reason to doubt Ms Dykstra's account.

Mr Johnstone made some allegations in his statements to police that Ms Atkin had mistreated BJay. He outlined an incident where he saw Ms Atkin harming BJay. His evidence was that on one occasion he observed Ms Atkin feeding BJay and then hit BJay to the forehead twice with his feeding bottle. He indicated that she struck him with the bottom corner of the bottle. He did not know how hard she had hit him, but that it was not a soft hit. He did not confront her over it and stated that he walked out of the room, with Ms Atkin having no idea that he had seen the incident. He stated the reason he had not told anyone previously was because he was trying to protect her. Ms Atkin denied this allegation, both to Ms Shand and to police. As with other forms of her inappropriate parenting, I cannot rule out that Ms Atkin may have tapped BJay with a feeding bottle. If this did occur I am satisfied that she did not cause BJay harm nor was she intentionally violent.

Mr Johnstone in his second interview of 5 November 2012, alleged that Ms Atkin would "*throw him [BJay] around the room as well*". He provided no other details about this, either in that interview or in his two subsequent interviews. Ms Atkin denied the allegation at all stages. Mr Johnstone did not raise these incidents in giving evidence. I am positively satisfied that Ms Atkin did not throw BJay around the room or engage in any similar action with him.

Summary of findings on violence to BJay

Having set out the substance of the evidence provided by the main witnesses and having made comments regarding the quality of their evidence, I now summarise my conclusions regarding the nature of the violence administered to BJay and the physical consequences of it to him.

Episodes of violence the subject of Mr Johnstone's sentence

I summarise below those incidents comprising the charge of ill-treating BJay to which Mr Johnstone pleaded guilty and served a prison sentence.

- On 16 October he grabbed BJay around the throat and threw him onto the hospital bed.
- On 22 October, whilst seriously assaulting Ms Atkin by strangling her, he caused BJay to be released from her grip and fall on the floor.
- On 23 October, he punched BJay to the underside of his thighs.
- On 26 October he forcibly pushed the bottle into BJay's mouth causing damage to his upper lip and tearing the frenulum.
- On 30 October he applied pressure with his thumb near BJay's left eye, causing bruising.
- Between 23 and 29 October he placed his hand over BJay's mouth and his finger down BJay's throat, causing cessation of breathing for about 30 seconds.
- He regularly threw BJay into the air.
- He swung a cricket bat over BJay's head on several occasions when frustrated and angry at BJay's crying.
- On at least one occasion he placed his hand over BJay's nose and mouth to stop him crying.
- He was regularly rough with BJay whilst changing his nappy and wrapping him in blankets.

The facts for the charges against Mr Johnstone for the above incidents were all based upon Ms Atkin's first detailed statement to police. As discussed, she did not provide details of any other violence by Mr Johnstone towards BJay at that stage.

The charge of ill-treating a child is contained in section 178 of the *Criminal Code*. It is not one of the offences specified in section 25(2) of the *Coroners Act*, where I would be bound under section 25(4) to ensure that the finding is not inconsistent with the determination of the matter by the result of the criminal proceedings. However, at inquest, Ms Atkin adhered to her evidence regarding these particulars. The various modes of force used by Mr Johnstone were supported by the evidence of Ms Dykstra. Mr Johnstone variously admitted, denied or claimed

lack of memory in respect of these matters without giving any explanation. However, it is significant that he pleaded guilty to the charge comprising the above incidents with the benefit of legal advice.

The large volume of medical opinion heard at inquest suggests that none of these incidents of themselves had the capacity to cause the severe head trauma that caused BJay's death. This was explored in detail at inquest.

Mr Johnstone was ignorant as to how to raise a child and how to handle an infant. His limited intelligence and lack of any appropriate role models meant that on some occasions he did not wish harm to BJay and yet treated him inappropriately and roughly. The example of regularly throwing BJay up into the air was an example of this mindset as, perhaps, was the rough changing of his nappies and wrapping him. On these occasions it does not appear that BJay was crying or that Mr Johnstone's anger was uncontrollable. Other episodes, for example punching BJay and applying pressure to his face and throat to stop him crying, were examples of gratuitous violence to his infant son perpetrated in sheer anger.

Mr Johnstone holding BJay against the shower screen

I find in accordance with the evidence of Ms Dykstra that within the first week of BJay arriving home, Mr Johnstone pushed BJay's head against the shower screen forcefully and stated words to the effect of "*you are going to have a bath whether you like it or not*", after which BJay cried. Mr Johnstone denied this incident, but conceded that his mother would have no interest in lying to the court about her observations. I reject Mr Johnstone's denial of this incident, although for the above reasons, it is possible that he has little memory of it occurring. I cannot be satisfied to the requisite standard, despite the description of the pressure exerted upon BJay's head as "hard" that this incident caused damage to BJay's brain or was the incident responsible for the fracture across two plates of his skull. Although a crushing injury can cause serious injury, it is too difficult to make any finding as to the extent of the pressure exerted.

Mr Johnstone holding BJay against the bedroom wall

Ms Dykstra indicated this incident occurred a "couple of weeks" after the shower screen incident. Mr Johnstone was alone in the bedroom and had the side of BJay's head pressed against the wall with his hand. When she entered the room Mr Johnstone started to talk about the flowers outside as if to make it appear that he was trying to give BJay a peek at the flowers. Ms Dykstra's oral evidence conveyed a degree of serious alarm in relation to coming upon this incident, stating "*surely he can't be doing what he's doing. You just don't want to believe it*". Mr Johnstone denied this incident but conceded that Ms Dykstra would have no interest in lying to the court about her observations. I reject Mr Johnstone's denial although it is possible that he has no memory of the incident. I am satisfied that the pressure exerted by Mr Johnstone on BJay's head was very hard on this occasion. It is possible on the medical evidence that permanent brain damage and fractures to the skull may have resulted, but again I am not able to ascertain the extent of any injuries suffered to BJay's head from this incident.

Pressure on BJay's head

Ms Dykstra provided evidence that she would observe Mr Johnstone place inappropriate pressure on BJay's head in two ways. Firstly, by the manner in which Mr Johnstone held BJay around the home, and secondly by pressing on the soft spot on top of BJay's head.

She stated that she would see Mr Johnstone poke and squeeze BJay's head. She described Mr Johnstone pushing his thumbs into the 'soft spot' in BJay's head and doing this a couple of times a day if she did not pull him up on it.

She also gave evidence that she would observe Mr Johnstone carry BJay in his arm with his head pressed up under his arm and chest. She said that Mr Johnstone would carry BJay like this for half of the day. Her evidence was that BJay was held with a lot of force and that his legs would be dangling down. She provided an example of finding out how much force was actually being exerted on BJay's head in that on one occasion she tried to take BJay from Mr Johnstone and grabbed BJay by the waist, but found it hard to remove BJay because of the force Mr Johnstone was using to keep him in position.

Ms Dykstra appeared to retreat from her evidence in regards to the pressure used in carrying and holding BJay by the head. However, I accept the evidence that she first provided about this incident. It was given in an open manner and acknowledged her difficulty in accepting that her son was responsible for such behaviour.

I find that whilst carrying BJay, Mr Johnstone would exert unnecessarily forceful pressure upon BJay's head, and failed to support the rest of his body. For the same reasons as given above, this pressure exerted upon BJay may have caused head injury but I cannot make definite findings regarding the consequences to BJay of this treatment.

Mr Johnstone throwing BJay on the mattress

Ms Dykstra gave evidence of observing Mr Johnstone on one occasion, likely in the first week of BJay being home, forcefully throwing BJay onto the mattress from approximately head height. Her evidence of coming upon Mr Johnstone throwing BJay down in the bedroom was very clear and forthright. She vividly described BJay's crying, as it clearly made an impression upon her. It prompted Ms Dykstra to tell Ms Atkin and Mr Johnstone that she was intending to place BJay in a cradle in her room and threatening to have BJay removed. Her evidence about the force and height of the drop was subsequently modified to a degree but I accept her initial, credible evidence. The incident witnessed by Ms Dykstra may have caused injury to BJay's brain but I cannot determine that it actually did so.

Punching of BJay to the chest

Ms Atkin gave evidence that she observed Mr Johnstone punching BJay to the chest area whilst they were in the bedroom, stating that it was a hard punch that resulted in BJay crying. She outlined circumstances in which BJay was laying on the bed and that Mr Johnstone just grabbed his fist and punched him in the middle of the chest. She also stated that after this occurred, she observed Mr Johnstone grab BJay around the throat and drop him onto the mattress. As discussed previously, Ms Dykstra observed Mr Johnstone throwing BJay onto a

mattress in a separate incident, which provides credibility to Ms Atkin's account. Ms Atkin's account was plausible, and I have set out reasons why late disclosure of further incidents may have occurred. There is no suggestion of bruising to BJay's chest that might be expected. Absent corroboration, for the reasons previously discussed, I cannot find to the requisite standard that Mr Johnstone punched BJay to the chest.

Head contact with wall whilst Mr Johnstone was pushing a bottle into BJay's mouth

The event which caused the torn frenulum occurred when Mr Johnstone was sitting with BJay at the kitchen bench next to the wall. Ms Atkin stated that Mr Johnstone shoved the bottle into BJay's mouth with enough force to cause BJay's head to go back and hit the wall behind him. She told police about his head hitting the wall in her first description of the incident. She indicated that she tried to take BJay from Mr Johnstone and it was at this stage that Ms Dykstra and Mr Richelme entered the house, and blood was seen pouring out of BJay's mouth. Ms Atkin also subsequently told Nurse Copping that Mr Johnstone hit BJay's head against a brick wall. Consistent with Ms Atkin's account, Ms Dykstra observed on one occasion Mr Johnstone trying to shove a bottle into BJay's mouth whilst he was crying, and then moving BJay's head onto the wall. Whilst I find that this incident occurred as described, it is difficult to gauge from the evidence the severity of the force of contact. Mr Johnstone had obviously lost control of his anger and it is more likely that BJay suffered quite violent contact to his head. Again, it is possible BJay may have suffered a brain or skull injury from this incident but I cannot make a positive finding.

Mr Johnstone slamming BJay into the kitchen bench at night

Ms Atkin was the only one to give evidence regarding this incident. She was unable to provide a specific date as to when it occurred, except to say it occurred within two or three days of bringing BJay home. She said in evidence that it occurred in the early hours of the morning, between 4.00am and 5.00am, when Mr Johnstone got up to BJay and took him into the kitchen to prepare his bottle. She described walking out and seeing Mr Johnstone with BJay, and observed that BJay was crying. She then observed Mr Johnstone grab BJay by the throat and slam him onto the bench with a significant amount of force. She took BJay from Mr Johnstone and told him that she would prepare his bottle and that he should go back to sleep.

In her evidence Ms Atkin demonstrated the action with a doll. She used a forceful slamming action, despite her obvious reluctance to use such a degree of force. Ms Atkin also disclosed to Ms Shand that she had observed Mr Johnstone slam BJay down on the bench when he would get him his bottle, and that she saw this happen three or four times. However, she did not articulate to Ms Shand details of this particular incident. Moreover, in evidence at inquest Ms Atkin said that she could not recall any other occasion where Mr Johnstone slammed BJay onto a hard surface, apart from this single incident.

In evidence, Mr Johnstone agreed that he prepared BJay's bottle at night. He denied anger at the need to wake to feed BJay but agreed that he had in his mind at these times the repetitive thought that BJay was not his child. Mr Johnstone initially denied slamming BJay onto the kitchen bench, but ultimately agreed that the incident could have probably happened and he did not want to remember it.

The account of this incident by Ms Atkin has presented a most difficult fact-finding task. It has the features of a coherent narrative, describing violent action characteristic of Mr Johnstone. Nevertheless, for all of the above reasons concerning the quality of Ms Atkin's evidence, I am not able to make a positive finding that this event occurred.

Mr Johnstone shaking BJay

Ms Atkin gave evidence that Mr Johnstone would shake BJay after he had been mocking BJay's cries. She gave evidence that these incidents would happen either in the bedroom or lounge room of the residence. Ms Atkin recalls the shaking action as resulting in BJay's legs and arms being all over the place, with a backward and forward motion at a very fast speed. Ms Atkin gave evidence that there were four or five incidents of shaking that occurred. Ms Atkin stated that these incidents "*would be after he had been mocking his cry and he couldn't get him to stop so then he'd start shaking him and mocking his shaking cry*".

Apart from the above evidence, first stated to Ms Shand, the other evidence from Ms Atkin and Ms Dykstra described Mr Johnstone using a less forceful motion. For example, Ms Dykstra observed Mr Johnstone shaking BJay sideways in a manner that was excessively vigorous, with BJay's head being unsupported.

Mr Johnstone, when questioned, maintained that he did not shake BJay and would always support BJay's head. This was his position from his first video interview. However he did concede in evidence that it was possible that he shook BJay and does not remember. I do not accept Mr Johnstone's evidence that he always supported BJay's head. It is against the weight of all other cogent evidence regarding his treatment of BJay.

Ms Atkin's evidence of Mr Johnstone shaking BJay and mocking his cry is plausible, particularly considering his inability to handle BJay crying and his demonstrated propensity to imitate his cries. Ms Atkin may well be correct in her account. However I cannot be satisfied to the required standard upon her uncorroborated evidence that she witnessed Mr Johnstone shaking BJay in this manner.

Nevertheless, I am satisfied that Mr Johnstone did shake BJay with great force. The medical evidence very clearly corresponds with injuries associated with shaken baby syndrome. It is more likely that he did so whilst in the bedroom alone with BJay. BJay's multiple bilateral rib fractures correspond with Mr Johnstone placing hard pressure around BJay's torso, with both hands and shaking him. The number and varying ages of the fractures suggest that BJay was held and shaken on multiple occasions. His global, diffuse brain damage is also consistent with such a mechanism of injury. The lack of bruising seen on BJay's skull is consistent with shaking, as opposed to impact of the head upon a hard surface. I find that Mr Johnstone did shake BJay, and that the shaking contributed to his fatal head injury.

Ms Atkin throwing BJay into the air and catching him

I am satisfied that both Ms Atkin and Mr Johnstone, at times, threw BJay a short distance in the air and caught him. Ms Atkin told Nurse Reid that she had thrown BJay into the air but later told Ms Shand that she could not remember having done so. Again, this is an example of Ms Atkin's overriding desire to paint herself in the best light as a protective and proper mother

to BJay. Whilst I do not accept Ms Atkin's denials, I am satisfied that the evidence indicates that Ms Atkin was not malicious in her intent and that engaging in this behaviour reflects her lack of knowledge of age-appropriate care for BJay. I am satisfied on the medical evidence that BJay was not harmed during this action.

Manipulation of BJay's legs and hips by Ms Atkin and Mr Johnstone

I am not satisfied that this action caused BJay's pelvic and femur fractures. I find that this action was undertaken in a benign but clumsy manner to reduce BJay's constipation. The fractures required the application of greater force.

Ms Atkin throwing BJay around the room

For the reasons discussed previously, I find that Ms Atkin did not throw BJay around the room or any similar action.

Ms Atkin hitting BJay with feeding bottle

For the reasons discussed previously, I cannot find to the requisite standard that this occurred.

Mr Johnstone alone in the bedroom with BJay

I am satisfied that Mr Johnstone was alone in the bedroom with BJay with the door closed about once every two days. I accept the circumstances as outlined by both Ms Dykstra and Ms Atkin. I find that it was in this setting that Mr Johnstone inflicted physical violence upon Ms Atkin. When Ms Atkin left the room, I find that he then perpetrated severe acts of violence upon BJay, disguising the sound of his violence by either singing loudly over BJay's cries or loudly mimicking BJay's cries. These acts were unwitnessed.

Conclusions regarding how BJay's death occurred

BJay suffered at least two episodes of severe head injury that caused his death. It is quite likely on the evidence that there were a greater number of episodes of severe head trauma, however the medical and lay witness evidence does not extend to permit this finding. BJay's head injuries occurred in the setting of multiple, regular episodes of violence inflicted upon him. I find that all injuries were caused by Mr Johnstone. I am not able to determine the exact incidents in which Mr Johnstone inflicted the fatal head injuries. At least one was inflicted between 14 and 20 October. At least one was inflicted between 28 and 31 October. It is more likely that the fatal head injuries occurred in the bedroom setting when Mr Johnstone was alone with BJay. However, I cannot rule out that they may have occurred in other settings within the home environment when he was by himself with BJay. I also cannot rule out that Mr Johnstone inflicted head trauma to BJay whilst he was still in hospital after his birth between 14 and 17 October. I am satisfied that forceful shaking caused significant head trauma but I cannot determine whether death resulted from this mode of violence alone. Other causes may

have included Mr Johnstone throwing BJay forcefully onto a bed, putting hard pressure upon his head with his hand and banging his head into solid objects.

Ms Atkin knew that Mr Johnstone was perpetrating violence upon BJay from two days after his birth. However, she suspected whilst pregnant that Mr Johnstone would be violent towards their child. She did not leave the relationship to protect herself or her child. Ms Dykstra was aware of the abuse of BJay by Mr Johnstone from the third day of the family staying at her home. Mr Richelme reasonably suspected abuse of BJay by Mr Johnstone from 24 October.

Under section 13(1) of the Act an adult who knows, or believes or suspects on reasonable grounds, that a child is suffering, has suffered or is likely to suffer abuse or neglect has a responsibility to take steps to prevent the occurrence or further occurrence of the abuse or neglect. The section further provides that one such step may be to inform the Secretary (that is, to make a report to CPS). Another step that could have protected BJay was to simply telephone the police.

These measures required Ms Atkin to be supported and encouraged by Ms Dykstra. Ms Atkin had no other sources of support, did not wish to lose BJay and was effectively paralysed by the fear instilled by Mr Johnstone. Ms Dykstra, herself severely affected by a history of violence and fear of her son, was not able to protect Ms Atkin or BJay. Her actions of attempting contact with CPS on 1 November and taking BJay to hospital the following day were taken only when BJay was obviously and gravely damaged.

I have already commented above that Mr Richelme had the ability to assist in taking steps to protect BJay. He did not, however, wish to involve himself.

Thus, these three adult family members were in breach of their obligations under section 13 of the Act by failing to take steps to protect BJay. Putting aside the provisions of the Act, BJay was entitled to safety and protection from his mother and grandmother, who were specifically charged with that duty. His uncle, who lived in the same house had power to take effective steps, but did not do so. Their failure to remove BJay from Mr Johnstone in the days after he came home from hospital exposed BJay to continued abuse and deprived him of a significant chance of survival.

The role of organisations

In the chronology of evidence I have outlined the roles of various organisations in the life of BJay and I have touched upon the areas of inadequacy and the points at which BJay might have been provided with protection from the abuse he suffered and, ultimately, his fate. I now turn to further comments and discussion concerning the relevant actions of those organisations, with my recommendations at the conclusion of the finding.

Child Protection Services

CPS was involved with BJay from three days before his birth until his death. Evidence was heard from a variety of CPS workers involved with BJay.

Before the inquest commenced CPS commissioned Ms Suzanne Botak to conduct an internal review of CPS decisions and action regarding the notifications concerning BJay. Ms Botak

also provided expert evidence during the inquest. Ms Botak is a former CPS senior practice consultant. She is qualified in the field of social work, having 27 years of experience as a social worker, predominantly clinical, working with children and their families and in child protection related areas. She has previously been commissioned by CPS and other organisations to provide assessments and independent reviews relating to systems within the areas of her expertise. Ms Botak was an impressive witness at inquest. She provided a thoughtful and rational evaluation of CPS practice in respect of notifications regarding risk to BJay. I note that the terms of her review did not include interviewing individual CPS workers, as she was forbidden from doing so.

Ms Botak's review included a schedule of recommendations for improvements to CPS practice. I accept that those recommendations, so far as they apply to the issues in this inquest, are sound.

Mr Tony Kemp, then Deputy Secretary of Children and Youth Services, also provided evidence concerning the CPS response to the notifications in respect of BJay. He provided a detailed written statement and gave helpful, informed evidence at the inquest. He was not employed by DHHS until after BJay died but presided over the process of commissioning Ms Botak's review and commencing implementation of many of the recommendations from her review.

Mr Kemp, in many respects, agreed with the analysis and recommendations made by Ms Botak. Mr Kemp categorised deficits in CPS practices relating to BJay as primarily including:

- A lack of background checks and information gathering in investigating the notifications;
- Inadequate risk assessment in respect of the notifications;
- Inadequate consultation in decision making;
- Inadequate checks on BJay's home environment;
- A lack of coordination of involved professionals in case planning; and
- Issues relating to the recording and triaging of the secondary notification of 23 October.

Mr Kemp stated that, although many of the deficits identified were deficits in child protection practice, these issues must be seen in the context of overarching difficulties with leadership, staffing and communication. At the conclusion of his statement Mr Kemp set out a table of the main recommendations made by Ms Botak and the progress made by CPS in implementing those recommendations.

Ms Botak's recommendations are wide-ranging and undoubtedly require very significant resources and effort on the part of CPS to implement successfully. Whilst I do not intend to reproduce them fully, they include recommendations pertaining to Intake and Response practice and recording, staffing structure, CPIS usage, infant notifications and hospital liaison.

It is apparent that progress on some of these recommendations has not been made or has stalled. Several of the recommendations have been implemented. CPS is to be commended for its work towards implementation. The recommendations that I have made in this finding in respect of CPS practice overlap to some extent with those made by Ms Botak. However, in accordance with my functions under the *Coroners Act* I have sought to confine them to those that are connected with and are appropriate on the evidence at inquest. In particular, I consider that the recommendations I have made in respect of CPS practice, if implemented, will assist in preventing further deaths of children the subject of CPS notifications.

Mr Kemp described the role of statutory child protection as difficult and complex. He stated that *“internationally, there is now acceptance and growing understanding that the social ill of child abuse and neglect is truly a “wicked problem”*”. The reason for such description, he said, involves various factors including there being no definitive formulation of the problem, the lack of consensus regarding the root of the problem, treating children and families involved in multiple systems, and there being no mitigation strategy with a definitive scientific test. He also said that both the problem and understanding of it is not constant but evolving.

Mr Kemp further described the complexity of balancing CPS interventions to mitigate risk against the statutory requirement to maintain a child within his or her family of origin. He stated *“risk assessment is a difficult and an inexact science. Risk itself is contextual, dynamic and continuous. There is therefore no reliable way of weighting the scores for particular factors to develop an aggregated picture of risk”*. He emphasised, in particular, that without a history of previous harm or significant indicators of potential harm it is difficult to demonstrate likelihood of future harm. In the case of first-time parents there may be multiple risk factors, but the impact of those factors in terms of risk to the child is untested.

I fully accept Mr Kemp’s statement that child protection is a notoriously difficult field in which to work and can take an immense emotional toll upon the workers. In the case of the death of a child, Mr Kemp said that there may be a sense of failure by those involved, which is exacerbated by public criticism for not correctly predicting the probability of an adverse event occurring and then preventing it. Ms Botak, too, describes the phenomena of staff burnout due to the workers having to constantly attend to disadvantaged children and their families in a climate of stretched resources and competing work demands. I am mindful of Mr Kemp’s comments regarding public scrutiny negatively influencing retention of skilled staff and impacting on the ability to recruit new staff. I do not underestimate the effect of BJay’s death upon the workers involved, nor the impact of being obliged to provide evidence at inquest.

Mr Kemp also emphasised that non-accidental child deaths are rare, and yet there is a tendency of society to overestimate the occurrence of such deaths. He discussed the difficulty in prediction and detection of warning signs regarding this category of deaths. Mr Kemp cautioned against the use of hindsight. He stated *“the ill-treatment and violence which caused BJay’s death was not predicted by CPS. It is difficult to ever know for certain that a person is capable of, or will deliberately cause such harm to, an infant. It is even more difficult to predict that other adults who may have knowledge of the abuse occurring will be unwilling or unable to protect the infant. This is the rarest and most terrible combination.”*

Nevertheless, Mr Kemp gave evidence that had all required information been gathered and analysed to construct an assessment, further and more threatening risk factors would have emerged. He said that the completion of a more comprehensive risk assessment *may* have

indicated that additional safety was needed to offset the presence of risk. Mr Kemp was unduly conservative in expressing this latter view. There was overwhelming evidence that a properly conducted risk assessment would certainly have indicated the need for additional protection of BJay.

I agree with Mr Kemp's summary of the areas of deficiency in practice as well as the problematic organisational context at the time in the north-west of the state. I am mindful of and sympathetic to the points he raises regarding the difficulty of CPS work, the complexity of finding solutions to child protection issues, negative public scrutiny and judging critically through the prism of hindsight.

The unfortunate fact remains that, in BJay's case, there were extensive failings. Those failings reflect, in my view, entrenched systemic and cultural deficiencies in the context of inadequate resourcing. The evidence very strongly indicates that the pressure upon the individuals and the organisation, the inexperience and turnover of the workers, inadequate staff numbers and lack of training were constant issues preventing effective responses to the notifications. In such a context, the solution is not to criticise any individual, but to address those issues that impacted so strongly on the inability of proper decisions being made in accordance with correct practice.

My intention is to emphasise those points at which BJay should have been afforded greater protection from risk. I will deal below with the three notifications made to CPS and discuss the opportunities that each presented to protect BJay from harm. These should already be apparent from the chronology of evidence.

First notification: 10 August 2012

A notification was made by Nurse Salter to CPS. Under the Act CPS has a power and obligation to investigate notifications relating to risk to an unborn baby. However, the notification was overlooked completely and therefore not recorded with CPS. It was critical that CPS fully recorded the details of the notification, including transferring those details onto CPIS. Further, it was critical that CPS then commenced a risk assessment process in accordance with the TRF.

If action had been taken to assess risk from this first notification, there would have been ample time and information available to make a fully informed assessment of risk to the unborn baby. Such information would have included obtaining the parents' CPS records and histories, criminal histories, medical records, information concerning Ms Dykstra's ability to protect the baby, and the identity of those living in the home. It would also have enabled time for discussions with each parent separately and together regarding their ability to care for the baby, the dynamic of the relationship and to consider signs of family violence. It would further have enabled greater scrutiny of the behaviour and attendance of Mr Johnstone and Ms Atkin at antenatal appointments, and the extent to which they used and were affected by drugs. A full profile of risk to the baby could easily have been compiled between the notification and birth.

The evidence strongly indicated that a major cause of this serious oversight was the lack of adequate staffing levels. Ms Botak in her review states that, at the time, the practice had developed in CPS to place unborn baby notifications and the consequent alerts "on hold" to

enable the workers to attend to other pressing work. When the birth occurred CPS would then act on the notification by allocating it for assessment. It is clear that this practice was fraught with the danger of CPS treating unborn baby notifications with less importance and being unprepared for informed decisions as to risk once the child was born. It would therefore appear that there may have been little incentive to ensure proper recording of such notifications. Another issue associated with the practice was the loss of confidence of the Mersey staff in the ability of CPS to act promptly on reported risk to unborn babies and to provide ongoing communication to the notifying staff. They did not expect replies or feedback from their notifications, and therefore saw little point in actively following up the results of their notification.

Even in absence of the worker's error of not recording the notification at all, I conclude that CPS workers would not have allocated it nor commenced undertaking the significant task of properly completing the TRF assessment until BJay was born. Mr Kemp provided evidence that such a notification is now allocated and assessed upon its receipt using the TRF and relevant Specialist Practice Guides.

Since 2013 closure of an infant notification is only permitted upon approval by a Three and Under Review panel, comprising senior CPS staff, a senior CHAPS nurse and a senior counsellor in family violence. This is a very positive development and reflects the vulnerability of infants.

Mr Kemp cautioned against retrospective supposition about actions which might have been taken by CPS in response to a notification. Mr Kemp stated that CPS, in response to the notifications, may have opted for less intrusive measures as opposed to intervention due to the only issues being housing and cannabis use. With respect to Mr Kemp, it would have taken very little time for CPS, if it had gathered sufficient background material on the parents, to appreciate the significant nature of the risk to the unborn baby based upon the extremely traumatic and dysfunctional nature of the parents' backgrounds. In particular, if the information concerning Mr Johnstone's sociopathic and violent nature had been obtained and properly analysed, he should have been prevented from being alone with BJay.

Mr Kemp, in his evidence, tended to downplay the parents' cannabis use as a serious risk factor. The CPS workers also did not explore the possible impact of cannabis upon their lives. Perhaps the consumption of cannabis by parents is not thought to be an important risk factor as it is a common theme in notifications. Perhaps on occasions it does not have a significant impact upon risk to a child.

In the finding of *Ebony Simone Napier*, 16 January 2016, the South Australian Deputy State Coroner, Anthony Schapel, dealt with the death of an infant in circumstances bearing many similarities to those of BJay. He stated at page 82:

"If there is evidence that cannabis consumption is affecting a parent's behaviour to such an extent that it poses a risk to a child, then such a scenario has to be dealt with having regard to the magnitude of the risk and its potential adverse consequences. Indeed, the risk may have two independent elements, and they are the affect it has on the parenting behaviour of the individual concerned and the fact that the cannabis habit may be depriving a family of proper financial support. It is no answer to say that the risk posed by cannabis consumption is not as high as that posed by the consumption of other harder drugs and can therefore be ignored."

I agree with the comments of the Deputy State Coroner. In BJay's case, the dependence of Mr Johnstone and Ms Atkin upon cannabis was obvious before his birth. It would only have taken minimal investigation for CPS to determine the following; that the daily quantities being consumed were significant; that their desperation for the substance would distract them from parenting a newborn; that the large cost of its use would deprive their child from proper financial support and; that their moods and behaviour were obviously affected by its use as well as their inability to obtain it. However, there was no enquiry and no analysis by CPS as there should have been.

I find that these lost opportunities to ascertain crucial information pertaining to risk, to formulate a detailed risk assessment and plan for the protection of the unborn baby, were critical in the failure to protect BJay and caused a lack of preparedness of CPS to respond at the point of his birth.

Second notification: 12 October 2012

Nurse Taylor made a CPS notification on Friday 12 October. She was informed that it was too late in the day for further action and therefore the information would be acted upon on Monday 15 October. Ms Botak is critical of this approach and is of the view that immediate action was required notwithstanding the intervention of the weekend. The imminent birth of the child was the trigger for the notification, with the notifier expressing the view that the parents would abscond after the birth of the child. As such, there was urgency to the notification that required at least the immediate recording of it onto CPIS and consideration given to whether further information regarding risk was necessary before the coming Monday. It does not appear that the need to obtain further information immediately was considered at all. If this action had commenced, for example, by simply obtaining Ms Atkin's medical records, it could have placed the CPS workers in a better position to conduct their role immediately upon commencing work on Monday. If the notification was approached with particular diligence, having considered Mr Johnstone's CPS history, then workers may have requested notification immediately upon the birth to ensure appropriate protection of the baby was in place at the hospital. As it happened, the next relevant occurrence was another call from the Mersey staff to CPS on Monday to notify that BJay had been born the previous day, being Sunday 14 October.

It was not until 2.55pm on Monday 15 October that the CPS workers attended the Mersey. By that time, there was a real risk that BJay and Ms Atkin may have left, as there was nothing to prevent them doing so. Also by this time, there is a possibility that BJay had already suffered the fatal injury at the hands of his father. From the point of view of CPS, there was only now the smallest window of opportunity in the hospital environment in which to obtain sufficient information to assess risk.

CPS thus found itself in the most unsatisfactory position of having only the information conveyed in the notification of 12 October and the information gleaned on 15 October, at the time when the workers first attended the hospital and spoke to the parents. The workers were not in any position to formulate a proper view as to risk, given the volume of work required to be done, as noted below. Nevertheless, the report they compiled assessed the consequence of harm as "concerning", the harm probability as "likely" and future risk as "high risk".

In relation to the category of “high risk” pertaining to BJay, the report stated *“the immediate safety for (sic) BJay in his parent’s care is considered as high risk and his future safety is not guaranteed until there is acknowledgement and addressing of the issues raised (parental drug usage, homelessness, family conflict and low-level personal care and hygiene) and a capacity and willingness to do so.”* Given the contents of the report, Ms Botak was of the opinion that a “priority one” should have been allocated to the notification requiring action within half a day. This may be the case; however, the referral to the CPS response team was immediate, with two Response team workers attending the hospital on the same day.

In receiving the notification, the Response team should have commenced information gathering for the purpose of a more detailed risk assessment using the TRF. The situation, from the perspective of the Response team, was not irredeemable. The CPS workers could have requested that Ms Atkin remain in hospital with BJay whilst they ascertained sufficient information regarding risk. Again, the obvious available material would have been Ms Atkin’s medical records that noted her aggression, immaturity, problematic relationship with Ms Dykstra and, on one occasion, bruising to her face. Other sources of information would have been further discussions with the nurses making the notifications, accessing Mr Johnstone’s child protection records, Ms Dykstra’s history, conducting a full home visit and discussion with Ms Dykstra. In that way BJay could have been in a place of relative safety whilst crucial information was obtained to inform a proper risk assessment. If Ms Atkin had refused to stay in hospital, then that in itself would indicate concerning risk sufficient to consider application for orders to protect BJay.

Without the necessary depth of information, CPS was unable to determine whether any legislative powers under the Act should have been immediately invoked, or whether there should have been consultation with the Court Assessment Advisory Group to discuss an appropriate intervention. This may well have included entering into a voluntary care agreement under section 11, application for short-term custody under section 21, or a court application for an assessment order under section 22. The taking of all such protective action is predicated upon CPS forming, on reasonable grounds, a belief that BJay was at risk. It could not have been in a position to form such belief without having conducted further enquiries.

Instead, the approach taken by CPS was to effectively refer the family out of the CPS sphere and into Gateway to assist the family with their particular issues. This referral clearly informed the further inadequate course of practice by CPS that followed until BJay was hospitalised and died. This decision may have provided CPS with a sense of security and having taken prompt action. If it did, it was misplaced.

At this point, I observe the different focus and responsibilities of CPS as compared with a CBIS, being Gateway. The IFSS organisations referred through Gateway by CPS are intended to provide support and do not have the power to remove children from the home or take other protective action as provided by the Act. The workers in the Gateway organisations are mandatory notifiers to CPS.

Gateway, being a CBIS, is also required by the Act to assess risk on a preliminary basis. The essential role of the IFSS organisations the subject of Gateway referrals is to support and build rapport with the family but not to actively assess risk. In cases of significant risk, there is

inherent tension in the IFSS workers' role between the need to build trust with a family on the one hand and to be vigilant to risk on the other (and if necessary, make a notification to CPS).

Once a notification is referred by CPS, it is apparent that CPS, Gateway, IFSS and the family have a strong incentive for the family to remain in the Gateway sphere. The presence of serious risk factors is therefore vulnerable to minimisation. Further, once successful referral to Gateway occurs, the formal arrangements are such that CPS requires imminent closure of the notification.

Gateway intake is obliged to assess risk when CPS make a referral and may reject a referral if risk is too high. However, Gateway has never, or rarely, rejected a referral. I comment further upon this fact shortly.

The correct approach by CPS in this instance would have been to firstly ensure the complete assessment of risk in accordance with proper practice, and then to consider, in light of that risk, whether referral was appropriate. The failure to properly or fully complete the TRF was a critical defect in CPS procedures through the life of BJay. It was whilst BJay was still in hospital that CPS needed to make decisions based on all available sources of information.

A main focus of Ms Botak's review was around the failure by CPS to properly investigate and complete the TRF at this initial stage, before considering referral to Gateway. Ms Botak noted that there were many deficiencies in the completion of the TRF. With the assistance of her opinion I now comment upon these matters.

The fact that Mr Johnstone's CPS files were not reviewed meant a lack of essential information pertaining to risk to BJay. I can only emphasise that this glaring failure meant that all subsequent decision-making by CPS was flawed. Those files would have immediately provided the information set out in the chronology of evidence in this finding - Mr Johnstone's past trauma, abuse, neglect, attachment issues, drug use, cognitive functioning, social skills, frustration tolerance, challenging behaviours, sociopathic tendencies and criminal activities. I add that, specifically, the files would have revealed his ill-treatment of his younger sister and alleged sexual assault upon a very young female. This information was all the more important as it was a relatively short period of time since Mr Johnstone himself had been the subject of a care and protection order. If this had been conducted, CPS workers would have also been able to have made an assessment about Ms Dykstra's ability to protect BJay given the manner in which she herself was unable to care for her children.

The failure to obtain and review Mr Johnstone's criminal record meant a further lack of crucial information showing his disrespect for authority, extent of offending and his violent tendencies.

Although the response workers made a telephone call to Ms Dykstra to ensure that she would allow the family to stay with her, they did not visit the home or determine any information about her dysfunctional history, cannabis use, mental illness nor the fact that she was the victim of severe family violence. All of these matters impacted upon the ability of Ms Dykstra to protect a newborn infant. If that information had been obtained, it is unlikely that she would have been deemed suitable. It is well established in academic research concerning family violence that individuals subjected to prolonged family violence begin to view violent behaviour towards themselves and others as being normal and acceptable. This normalisation of family violence is clearly demonstrated in Ms Dykstra's case.

It was critical that experienced workers spent time with Ms Dykstra to assess her protective abilities. When the home visit was conducted by two workers, neither worker was the primary case worker. Both had little time to review the case before the visit and no previous contact with Ms Dykstra. This cannot be considered good practice.

Ms Atkin's VCPS records were ordered and apparently received by CPS on 15 October but there is no evidence that they were reviewed at any stage. Ms Atkin's behavioural issues, mental health, drug use, extensive child protection history and traumatic background would have greatly affected any risk assessment in respect of BJay. When viewed in combination, the histories of both Ms Atkin and Mr Johnstone could have only led to the conclusion that an infant child would not be safe in their care.

The information required to be obtained by CPS for the risk assessment was in accordance with the CPS Practice Manual, including the Infants Guide. Analysis of all such information was then required. The Infants Guide is a comprehensive guide as to risk assessments in respect of infants under two years. The document is well set out and comprehensive. For example, it requires the CPS worker to provide comprehensive details regarding both female and male caregivers' histories and antecedents, criminal behaviour, family violence indicators and drug abuse. Nevertheless, for a CPS worker who is either inexperienced and/or overworked, this required risk analysis process would have been daunting. Yet nothing short of such analysis was required in BJay's case, for very good reason. CPS did not take information in any proper detail from Mr Johnstone and Ms Atkin in regards to family history, childhood abuse, their past child protection involvement, intellectual disabilities, criminal behaviour, or past family violence histories. In fact, CPS workers did not address the majority of the questions outlined in that guide. The failure to follow this set process, and to consider ways to have BJay remain in the hospital environment whilst giving themselves time to do so, was a key issue in the failure to protect BJay.

The fact that CPS did not take the time to properly interview the adults with whom BJay was to reside is concerning, especially as the home environment had not been assessed and there was no knowledge that another adult male, Mr Richelme, was living there.

BJay's family had substantive risk factors, all of which were contained in the risk factor warning lists set out in the Child Protection Manual. If they had been properly considered, it would have been apparent that further investigation and then intervention was required by CPS. Under no circumstances should there have been a Gateway referral by CPS on the first day of its consideration of BJay's notification.

Ms Botak noted that the process of risk assessment required to be undertaken in accordance with the TRF involved four phases; gathering information, analysis of information, making professional judgment and writing a safety statement. It is clear that CPS did not gather the information required and did not complete the next three phases as should have occurred. In particular, a risk assessment was absent. CPS could not, in any event, have been in a position to proceed to the next three phases that would involve analysis of the manner in which BJay should have been protected. There was no attention or consideration given to the document apart from the entry of basic notes of communication. It is not apparent on the face of the document that there was any analysis or reasoning process regarding the possibility of intervention.

Ms Botak remained steadfast in her report and oral evidence that if the TRF document had been properly examined, completed and considered then BJay would have been prevented from leaving the hospital with his parents. This is because the TRF risk assessment result would have required CPS to initiate action under the Act to protect BJay by removing him from the care of his parents. I find that such action was required.

If CPS had made an application to the court for an assessment order in respect of BJay upon the notification of 12 October there was no absolute certainty that the order would have been granted. It is also possible on the medical evidence, but less likely in all of the circumstances, that Mr Johnstone inflicted a severe head injury upon BJay whilst in hospital after his birth. Therefore, even if taken from his parents before they took him home, it is possible that BJay might have suffered permanent damage by that early stage sufficient to ultimately cause his death.

However, those comments are predicated upon the notification of 12 October being the first notification when it was not. If risk had been properly assessed at the time of the first notification on 10 August, an application for an assessment order would have been ready to proceed immediately upon his birth. In exercising its powers to restrict access to BJay under any order that would have almost inevitably been granted, CPS should not have permitted Mr Johnstone and Ms Atkin to be alone with BJay, even in the hospital setting.

Third notification: 23 October 2012

Nurse Luke of CHAPS made a home visit to BJay on 23 October. On the same day she notified CPS about BJay's home environment and the bruising that she sighted on three locations upon BJay's body. CPS did not consult Nurse Luke personally for further discussion regarding her observations before visiting the home the following day. Further, the notes taken by the CPS worker of the conversation with Nurse Luke indicated a somewhat more benign situation than had actually confronted Nurse Luke. Putting aside the flavour of the notes, it was critical that the CPS workers visiting the house spoke to Nurse Luke regarding her observations. By this stage, CPS should also have gathered a significant amount of information for the ongoing investigation. The previous notification was still open in the response stage, notwithstanding the referral to Gateway. Therefore a risk assessment was required before closure.

The CPS manual sets out the required actions to be taken by a CPS worker in relation to notifications concerning physical abuse. Relevantly, it states: *"notifications relating to physical abuse and neglect require child protection workers to physically sight the child and, where appropriate, the alleged injuries, to decide whether medical examination is required."*

Thus the workers who visited were required to make a determination as to whether, firstly, the injuries were non-accidental and, secondly, whether medical examination was required. Despite attending primarily due to the report of bruising, they did not look at any of the bruises. They could not, therefore fulfil the requirements of the manual to make a decision as to whether medical examination was required.

It appears that the family did not allow the workers near BJay, nor did the workers insist on examining BJay for bruising. I agree with counsel assisting's submission that, in this context, the abuse received by the workers should have raised some suspicions about the home

environment. As such, proper and urgent consideration as how to further the investigation was warranted. Consultation could have occurred with the CAAG, who almost certainly would have detected the incomplete TRF document, including the absence of the risk assessment.

A notification from a CHAPS nurse of bruising on a newborn infant is a most uncommon occurrence. A more thorough assessment should have occurred immediately. It should have been obvious that BJay was in a harmful environment. By this stage he was 9 days old and already had 3 bruises on separate locations on his body, with one of the bruises covering an extensive area. Despite the existing open notification and the further notification by Nurse Luke, CPS was not focussed upon continued risk assessment.

After the home visit of 24 October CPS did not return to see the family or BJay again, or conduct a risk analysis regarding this notification. Instead, a recommendation was made to close the CPS file. Even without having considered the respective histories of Mr Johnstone and Ms Atkin, this decision should not ever have been made. Instead, an urgent application for an order to remove BJay from the home should have been made.

Closure of the notifications and investigation

The primary CPS case worker in the investigation did not speak to the IFSS workers prior to informing the CBTL of the intention to cease CPS involvement with BJay and his family. The CPS decision to endorse closure without consulting with the IFSS workers was not best practice, nor conducive to making a final assessment of risk to BJay. If the primary CPS case worker had spoken to the IFSS workers, the information that she would have received would have disclosed that:

- Mr Johnstone was not positively involved in parenting matters and that he had been seen by Mr Greeny to imitate BJay's cries;
- Ms Atkin lacked understanding of BJay's needs for his age;
- Ms Boyd observed on 30 October that BJay did not have a reflex response and appeared sluggish; and
- Ms Boyd had concerns that Ms Atkin was co-sleeping with BJay.

The above information from the IFSS workers could have assisted CPS with assessing the whole profile of risk before deciding to cease involvement. The presence of this information, particularly in light of the notification of bruising upon BJay, should have led to an immediate assessment of risk to BJay and the consideration of an application for a 28-day assessment order or other protective option under the Act. However, it was apparent that there was no consideration by CPS of other avenues of action apart from an apparent contentedness that the Gateway referral to the IFSS workers would mitigate any ongoing risk.

The written points of advice provided by CPS to Ms Atkin and Mr Johnstone, to be conveyed through Mr Greeny, was simplistic and comprised largely generic platitudes. As noted earlier, these included requests to "*ensure that BJay is not exposed to violence, yelling or screaming,*" "*continue to bond with BJay*" and to "*ensure that BJay's interests are considered first above the interests of anyone else.*" As well-meaning as this advice to the family may have been, it

was patently unachievable for Ms Atkin and Mr Johnstone given the multitude and depth of their issues.

Either directly or through the CBTL, CPS should have fostered close communication with Mr Greeny and Ms Boyd. The CPS notifications were still open in Response. It was incumbent upon CPS to communicate with IFSS to monitor the family's progress and to assess the true extent of engagement and risk to BJay. CPS Response workers did not adopt this approach. Further, the CBTL acted merely as a conduit between CPS Response and the IFSS workers, without becoming involved in an independent assessment of whether closure was appropriate.

The decision by CPS to close its file represented the culmination of a process that appeared almost inevitable from the time of referral to Gateway on 15 October. Once referral to Gateway was made and accepted CPS effectively divested itself of responsibility. The IFSS organisations were then, quite unfairly, left to take responsibility for BJay's protection. This was a role for which they were not trained and was outside the scope of the work of their respective organisations.

Community Based Team Leader- CPS

The role of the CBTL, a CPS worker, is to facilitate referrals from CPS to Gateway, support and consult with IFSS workers who are working with high risk families and completion of initial assessments of notifications received by Gateway.

Under the MOU between CPS and Gateway the CBTL is required to attend Gateway allocation meetings to provide advice and clarification on matters referred by CPS. Referrals may only be made directly from CPS to Gateway via the CBTL. However, it provides that where a direct referral is made, CPS must inform the CBTL to enable monitoring and tracking of referrals

In this case the CBTL, who had input into the referral to Gateway and attended the allocation meeting on 18 October, agreed with the initial assessment that Gateway referral was an appropriate way to mitigate risk. This was notwithstanding the moderate to high risk score on the CAF risk document. The CBTL did not appear to engage in any depth of analysis of risk, did not query the incomplete state of the CAF form and appeared to take the view that risk issues would be further mitigated if two IFSS workers were allocated instead of the usual single worker. Ms Botak commented in her review that it was concerning that the CBTL did not question the appropriateness of the referral. I agree with her opinion in this regard.

The CBTL relied, fully it seems, upon the CPS response team to make decisions regarding BJay. This is understandable as the notifications were still open and should have been in the process of active investigation. However, in this situation the CBTL was a critical liaison role who was mandated to support the IFSS workers and convey full information back to the CPS Response team.

Any information conveyed by the CBTL could inform the risk assessment in the investigation. In this case the CBTL role was critical in assessing risk but did not operate as an effective check and balance. For example, the CBTL was aware of the notification of bruising to BJay but did not read the notification nor question it. It appears that she was content that CPS

workers were satisfied of the parents' explanation for the bruise even though they did not sight it.

Further, the CBTL's email of 2 November positively recommended closure to CPS without having analysed the information obtained by CPS, met the family or conducted a home visit.

In *Jasmine Rose Pearce 2015 TASCD 75*, an inquest involving a high risk family the subject of CPS notifications, I commented at page 33:

"I consider that in cases at a nominated risk threshold it may be appropriate to keep notifications open for a specified period whilst Gateway progress is strictly monitored. Mr Minehan considers that this should occur. I consider that it would be appropriate for CPS to review their policy of file closure in the Gateway cases involving higher assessment of risk.

Mr Minehan states that, given the importance of the CBTL role, it should be strengthened. Having heard the evidence, I agree that the CBTL's role is a crucial one, with a great deal of decision-making power and control of information reposed in one individual. I agree with Mr Minehan, who suggests that CPS re-examine the role of the CBTL with a view to clarifying its decision-making power and increasing its level of support."

The evidence in this matter also highlighted the crucial nature of the role of the CBTL, particularly in monitoring ongoing risk levels for those particularly higher risk families referred to Gateway.

In *Pearce, supra*, I made recommendations regarding specific training for the role of the CBTL. The evidence in this inquest did not touch upon whether those recommendations had been considered or implemented. However, the CBTL gave evidence that she did not have formal training for her role. From her evidence it appears that she was reliant upon IFSS workers approaching her with issues pertaining to risk to children and families. It would be desirable for the CBTL to have in place a formal, regular system of monitoring and reviewing ongoing risk, particularly in respect of those higher risk families referred from CPS into the Gateway system.

Summary of CPS action

CPS omitted to record and investigate the first notification, losing a critical opportunity to assess risk to BJay during Ms Atkin's pregnancy and to properly protect him from the time of his birth.

Having received a second notification just prior to BJay's birth, CPS did not carry out the risk assessment correctly or completely. CPS therefore failed to appreciate the extent of the risk to BJay and did not use protective powers available to it under the Act to prevent him living with his parents, at until least a full assessment could be made.

Having received a third notification concerning multiple bruises upon BJay, CPS did not recognise the obvious risk to him in his home environment. CPS did not carry out a risk assessment or take steps to remove BJay from his home, as should have occurred. Shortly thereafter, CPS decided to close the notification and cease involvement.

Gateway

The Gateway involvement in this matter was between 17 and 19 October, during which it accepted the CPS referral and determined that the family would be referred to the two IFSS organisations. However, because of the number of risk factors involved, CPS advised Gateway that it would keep the notification open for investigation and assessment.

Under section 17A of the Act the Secretary may refer a risk notification received by CPS to a CBIS if satisfied that the CBIS is an appropriate organisation to take action in respect of the notification.

Gateway, as a CBIS, is an organisation referred to in section 53E of the Act. This provision is as follows:

53E. Functions of a Community-Based Intake Service

(1) A Community-Based Intake Service has the following functions:

(a) providing a referral service for children and their families that –

(i) is readily accessible; and

(ii) enables early intervention in support of families;

(b) receiving referrals from the Secretary under section 17A;

(c) undertaking preliminary inquiries, in accordance with the CBIS guidelines, to determine –

(i) whether a child is at risk or in need; and

(ii) whether a child, once born, is likely to be at risk or in need; and

(iii) the most appropriate person or organisation to receive a referral from the Community-Based Intake Service;

(d) making referrals to other persons and organisations who provide services relevant to children and their families;

(e) providing the Secretary, in accordance with the CBIS guidelines, with a record of each determination of risk or need made under paragraph (c)(i) or (ii) and each referral made under paragraph (d);

(f) cooperating with other persons and organisations providing services to a child;

(g) any other prescribed function.

(2) A Community-Based Intake Service may have any other additional function specified in the agreement referred to in section 53D.

A CBIS such as Gateway has no coercive powers under the Act. A family's utilisation of the IFSS services selected by Gateway is voluntary.

The MOU governs the process of referrals from CPS to Gateway. This MOU would appear to be an agreement between CPS and a CBIS under section 53D of the Act. The MOU provides, *inter alia*, that:

- (a) Transfer of case responsibility should be made within two days of the handover meeting. If a later date beyond two days is mutually agreed, the point at which case responsibility will transition to Gateway/IFSS should be agreed and clearly specified in writing at the handover meeting.
- (b) On a case-by-case basis, and not as a rule, "open" cases may be accepted by Gateway when consultation has occurred between Gateway and CPS. Where Gateway accepts this referral, case responsibility will remain with CPS until it becomes a closed case and this will be communicated and agreed in collaboration with Gateway through an email from CPS.

Under section 53E of the Act, it was specifically the function of Gateway to undertake preliminary enquiries to assess risk and needs of BJay for the purpose of making a referral to any suitable IFSS organisations, or alternatively to determine that it would not accept the referral from CPS due to the level of risk. Under the MOU, Gateway is not required to accept a referral. Where a referral has not been accepted by Gateway, CPS must consider an appropriate response to the risk. This may involve intervention in cases of significant risk to the child.

On 17 October, when Gateway became formally involved by receiving the CPS referral, it also received the CAF that was designed to set out details of the family and risk issues. The CAF is a comprehensive 39 page document requiring detailed completion of relevant areas. As the standard practice, the first 19 pages of the document are required to be completed by CPS and updated by Gateway intake workers. It appears that many further parts of the document are required to be completed subsequently by IFSS workers. The CAF had already been completed in part by CPS before forwarding to Gateway. However, the answers were largely provided by tick boxes and did contain all of the information held by CPS.

As submitted by Ms Sundram in her detailed submissions, there are fundamental difficulties with the use of the CAF as a suitable tool to assess risk. She submitted that a reader of the document is unable to ascertain which organisation or worker has completed any particular section and upon which date. The ambiguity and loss of accountability in this practice is most undesirable, particularly if it is to function as a useful, working document to guide response to risk.

Ms Sundram also pointed to the location of vital questions concerning risk and safety to a child at the rear of the document and designated for completion by IFSS workers. Such questions relate to exposure of the child to family violence, cumulative harm and illicit drugs. For example, question 85c reads "*Is basic care and protection from harm provided consistently?*" Similarly, question 85d reads "*Is there evidence of a cumulative history of*

exposure to harm, abuse or neglect for the children or young people?” Question 95b reads *“Do the strengths and protective factors sufficiently ameliorate the impact of the risk factors that have been identified?”* With respect to the IFSS workers, these types of questions require professional and rigorous assessment. They represent ultimate issues for CPS risk assessment even before the case can be contemplated as suitable for Gateway referral. In BJay’s case, these and many other questions were not completed at all. I accept Ms Sundram’s careful analysis and criticisms of the CAF tool. In my view, the format of the document, as well as the procedures surrounding the completion and use of it, require major revision.

Upon receiving the referral, the Gateway intake worker then telephoned Mr Johnstone and Ms Atkin to confirm their willingness to receive Gateway assistance. In that conversation both provided the Gateway intake worker with requested information as to risk issues consistent with the information already held by CPS. The Gateway intake worker then completed the remainder of the CAF form and risk assessment based upon the information received. This risk assessment function demonstrates the importance of Gateway’s role as provided by the Act. In this case, the risk assessment score upon the purportedly completed CAF was 22/27, being high. However, Gateway did not consider requesting the CPS notification documentation, placing conditions upon Gateway’s involvement or declining the referral. Gateway did not consider a home visit or face-to-face meeting with the family. Although such matters would not have been in accordance with usual practice, they were clearly required in this case.

At the time of accepting the referral, the time period for CPS closure was not agreed or discussed. There was no indication given by CPS regarding the steps it would take to investigate the open notification.

Nevertheless, Gateway would have been aware of the likelihood of imminent closure by CPS. The evidence indicates, as per the standard practice and MOU provisions, that CPS would close the notification within a short time. This would effectively leave the management of BJay’s safety to the IFSS organisations with assistance from the CBTL. In such circumstances rigorous assessment was required by Gateway.

The Gateway area manager gave evidence that Gateway asked CPS to keep BJay’s notification open because of the number of risk factors involved. She said in evidence that there were *also “probably unknown risks until you get into the home with the IFSS service to really get a good picture of what was going on in that family”*.

The closing of Gateway’s file on 19 October ended Gateway’s involvement as a referral service. There was no established procedure under the MOU or otherwise for Gateway to review its acceptance of the referral from CPS despite having received significant information regarding areas of risk to BJay and having completed a risk assessment with a high score.

The evidence of the Gateway area manager and intake worker indicate a lack of sufficient knowledge and training in assessing risk. Under the Act, Gateway is required to make “preliminary enquiries” to determine risk. Although such risk assessment function is considerably more limited than that of CPS, it must be exercised at the critical point of deciding whether the risk to a child or children is sufficiently low that voluntary participation in IFSS alone will mitigate that risk. In the case of high risk families that require ongoing CPS

intervention, Gateway must be in a position to assess that fact and decline the referral if appropriate.

A lack of training in risk assessment prevents Gateway workers being able to effectively and robustly discuss with CPS the extent of risk in the case of any particular family. It also hampers proper completion and analysis of the CAF, being the crucial risk assessment document that guides the further decision-making of Gateway. In BJay's case the risk assessment based upon the CAF was high notwithstanding the significantly incomplete state of that document.

The evidence at inquest also demonstrated that Gateway did not, and does not as a matter of course, have access to the CPS file or CPIS that could provide important information to Gateway in determining whether to accept a referral. There was no reason apparent upon the evidence as to why access to such information should not be provided in all cases.

During evidence at inquest and in written file documentation, workers in the Gateway system and CPS consistently concluded that there was "engagement", by using that particular term, when Ms Atkin and/or Mr Johnstone expressed willingness to accept support or acknowledged issues of risk. Such terminology is prone to be misleading when used as a mitigating factor in a risk assessment. As a matter of common sense, genuine and positive engagement is not likely to be demonstrated until the persons concerned have shown commitment to addressing the issues over a period of time. In the case of many families who risk CPS intervention, there is a strong incentive to readily agree to participate in Gateway support, whether or not they have the desire or dedication to do so in the longer term. It is important that the file records the content of the discussion and actions of the persons involved and avoids the blanket use of a conclusion that there has been "engagement" without strong evidence that this has occurred.

A notable example was the conclusion of the Gateway intake worker that Ms Atkin and Mr Johnstone demonstrated "positive engagement" on the basis of the single telephone call with them to which I have referred. As it transpired, the Gateway intake worker was not able to subsequently contact Ms Atkin and Mr Johnstone to advise of the referral to IFSS. Instead of then questioning their willingness or ability to participate, the family were exited from Gateway intake and the referral to IFSS proceeded.

Ms Botak, in her review, noted that BJay's notification, being of high risk, was not suitable for Gateway referral. She was of the opinion that Gateway referral is a viable option where CPS assess low risk to the child such that voluntary family support and engagement may be a sufficient response. She stated that the referral of this case for family support placed significant and unrealistic responsibility on the non-government sector. She stated that *"the referral was made without adequate risk assessment and the referral to Gateway then led to a dilution of responsibility from CPS for this case"*.

I agree with Ms Botak's statement. Gateway quite understandably gained considerable comfort in accepting the referral by the fact that CPS was still involved and investigating. Conversely, CPS operated under a misplaced sense of security and inertia once Gateway agreed to provide support through IFSS. CPS then became more focussed upon closure of the notification rather than apprehending an urgent need to investigate the multiplicity of continuing risk factors and complete the risk assessment analysis.

The Gateway area manager gave evidence that Gateway receives pressure from CPS to take referrals. I took her evidence in this regard to mean referrals that presented an unacceptable level of risk and, as such, unsuitable for Gateway. In the case of CPS, high workloads may mean that cases otherwise not suitable for Gateway involvement are the subject of referrals.

The evidence did not explore whether there exists institutional incentives for Gateway to maximise its case numbers by accepting referrals. On the evidence, the main reason for Gateway declining to accept a referral is the unavailability of a suitable program to assist with the issues required by the family. This is a different matter from declining due to an unacceptable level of risk to a child. The evidence is that declining on the basis of excessive risk is rare.

In summary, I have identified a number of matters that impacted upon Gateway's ability to make an accurate and independent assessment of risk to BJay as it was required to do under the Act. These matters are systemic and have implications for other referrals where thorough consideration of risk is required. These matters require attention so as to ensure that Gateway can properly perform risk assessments in respect of a child to the extent required by the Act, and to decline referrals in appropriate circumstances.

In this case CPS had the obligation of continuing to manage the considerable risk to BJay in accordance with the Act and the MOU, having kept open the notification in Response for ongoing investigation and assessment. In light of this fact, Gateway was entitled to assume that CPS would take any action to protect BJay that was necessary. In such circumstances, I do not consider that deficits in Gateway's actions or decision-making between 17 and 19 October 2012 played a role in BJay's death.

IFSS

The organisations of Glenhaven and YAFF were involved with the family by virtue of Gateway's acceptance of the referral. I do not criticise their actions or those of their workers. In terms of risk to BJay, they were reliant upon both CPS and Gateway intake having assessed the risk as appropriate for receipt of their support. Further, both organisations were aware that CPS had an open notification and continued to be actively involved in risk assessment. They also knew that in respect of the further notification of 23 October relating to bruising on BJay, CPS had considered and accepted the explanation of Ms Atkin and Mr Johnstone. Finally, it was not their statutory mandate as IFSS organisations to assess risk to BJay. Such obligation under the Act fell upon CPS and, to a lesser degree, Gateway intake. The evidence of the interactions between the IFSS workers and Mr Johnstone and Ms Atkin demonstrates that the workers avoided approaching difficult topics that would have informed risk. Given the involvement of CPS, they understandably felt justified in taking such approach. However, it was also clear that the workers avoided the topics due to the volatility of Ms Atkin and Mr Johnstone.

The IFSS workers were mandatory reporters under section 14(1)(k)(ii) of the Act, assuming that their respective organisations receive funding from the Crown. They are also under a duty by section 13 in circumstances where they suspect on reasonable grounds, that a child is suffering, has suffered or is likely to suffer abuse or neglect, to take steps to prevent the occurrence or further occurrence of the abuse or neglect. The discharge of their duty under

both sections would involve reporting any such knowledge or suspicion to the CBTL for further assessment by CPS.

In this case, the IFSS workers were aware that CPS were in possession of the relevant facts, were actively investigating and had responsibility for monitoring ongoing risk. Further they were receiving instructions directly from the CBTL. In these circumstances the IFSS workers were not required to make any further report to the CBTL.

The IFSS workers, being regularly in the home of families, are in a position to obtain facts and matters that may pertain to the issue of risk to the child. It is therefore important that this information is recorded in a manner that is accessible to all assisting the family, including CPS, Gateway and other involved IFSS organisations. The CAF document does not appear to be used by IFSS workers to add new information of relevance. In BJay's case the Glenhaven worker had access to the CAF document, but the YAFF worker did not. The Glenhaven worker did not add to the CAF document but created his own separate document containing notes of visits and goals of the family. The creation of different documents is not conducive to a holistic assessment of progress and ongoing monitoring of risk, which can be reviewed by the CPS or the CBTL when appropriate.

Mersey Nursing Staff and Social Workers

The nurses and social workers at the Mersey did all that that they reasonably could within their sphere of duties to alert CPS of the risk factors pertaining to the unborn child and to assist Ms Atkin and Mr Johnstone. Ideally, procedures might have been in place in the Mersey to follow up the notification of 10 August within a discrete, short period of time when no contact was made by CPS. Unfortunately, there was little expectation of communication or action from CPS and this acted as a disincentive to regular and effective communication. I make no criticism of the nursing staff or procedures of the Mersey. They were diligent in their antenatal care, alert to areas of risk and need in respect of the family and communicated effectively between themselves and the involved social workers.

Tasmania Police

Shortly before 2.00am on 29 October 2012 the Tasmania Police radio room received the call from Katherine Bond, the content of which I have set out in the chronology of evidence. The purpose of Ms Bond's call to police was to notify of intentional harm allegedly being inflicted upon BJay.

The call by Ms Bond and the information contained in it proceeded through four distinct stages within Tasmania Police, these being as follows:

1. The radio room, where a Sergeant took the call from Ms Bond and created an IDM report;
2. The Crime Management Unit ("CMU"), where a Constable undertook a vetting process and then allocated the investigation to Devonport CIB;
3. The Devonport CIB, where the Senior Sergeant further allocated the report to a detective within that station for investigations; and

4. The intended investigating officer at the Devonport CIB, who was responsible for investigating the report.

The four police officers involved in the above processes all gave evidence. As discussed earlier, the issue arising from these processes was that timely steps were not taken to investigate a potentially serious threat to a newborn baby.

At the outset, I am not able to find that BJay would have survived if police action had been taken without delay to investigate the report and/or refer the allegation of abuse to CPS. To make such a finding would involve speculating upon many variables. However, I have determined that BJay suffered a severe head injury between 28 and 31 October which either contributed to, or was the major cause of, his death. As further discussed, police action in relation to BJay did not occur until police became involved again upon his hospitalisation on 2 November. An opportunity arose for police to take steps towards the protection of BJay from 29 October to 2 November. As the report was not investigated, the opportunity was lost.

Sergeant Robert Schiwy, a very experienced police officer, took Ms Bond's call in the radio room. He gave evidence at inquest that, whilst the call was "*third hand information*", the caller appeared concerned. Sergeant Schiwy presented as diligent in attending to his task in respect of Ms Bond's call. He had never previously taken a call about a bruise on a newborn baby. He gave evidence that he had not had training regarding calls concerning suspected child abuse or injuries to a child, nor in police procedures applicable to reporting to CPS.

Sergeant Schiwy gave evidence that, because Ms Bond stated that the last Facebook post referring to injuries to BJay was several hours before the call, he formed the view that it was not a report of an ongoing situation and therefore did not request a police car to attend. He said that it was not his role to investigate the matter but to verify information by looking at the police systems. In this regard, his interrogation of the system did not locate any additional information, including previous CPS referrals to police. However, he telephoned the Devonport Sergeant to ascertain whether there was any additional information not recorded on the police systems for the purpose of the report. The Devonport Sergeant indicated that he had no knowledge of any relevant matter.

Sergeant Schiwy ultimately submitted a report on the IDM system ("the information report") containing most of the details of Ms Bond's call. He had access to an after-hours CPS number, but stated that he did not place a referral to CPS as the information received by him was not direct. He stated that he would have made a referral if there was a previous CPS referral on the IDM system or if some other information flagged his concern. He said in evidence that he adopted the correct procedures for dealing with the report from Ms Bond. He was questioned in evidence as to his reasons for not electronically converting the information report into a CPS referral that would be forwarded automatically to CPS. He indicated that if an electronic CPS referral was appropriate, then this would have taken place in the vetting process conducted by the CMU occurring at the next stage. He maintained that, due to the lack of verifying information for an electronic CPS referral, the completion of the information report was sufficient action as he believed it would be acted upon by the allocated investigating officer the next day. He also stated that this was not a case where he would have tasked a police vehicle to proceed to the address to investigate immediately. In hindsight this may have been a prudent action in light of the nature of the report.

Sergeant Schiwy gave evidence that during his time in the radio room (since 2010) he never had occasion to make a CPS referral. The process of electronic referral by police to CPS is available to officers of Tasmania Police. An electronic referral can be made and sent to CPS successfully even if not all of the fields available can be completed at the time. In the case of Ms Bond's call, the surname of the newborn baby was not provided. This fact would not have prevented a CPS referral being made immediately.

At this point, I observe that Sergeant Schiwy and the other three police officers handling Ms Bond's report were required by the provisions of the Tasmania Police Manual and the MOU between Tasmania Police and CPS to "immediately" notify CPS, as the report alleged physical injury to a child. I will discuss this requirement further in this section.

At 7.10am on 29 October 2012 Constable David Eastley of the CMU received Sergeant Schiwy's information report and, after a vetting process, forwarded it on to Devonport CIB. At the time of the incident, Constable Eastley had been working in CMU for a period of 10 years. He gave evidence that, upon receiving the report, he considered whether a CPS referral was necessary, but concluded that the report lacked details which enabled or warranted its conversion to such a referral.

In his evidence, Constable Eastley explained that the vetting process for information reports involved reviewing for grammatical errors; ensuring entry of complete names, addresses and dates of birth, value-adding and correcting content from police systems, and ensuring that the correct template is used.

Constable Eastley gave evidence that the conversion of an information report to a CPS referral was a simple task and, once completed, an email would have been automatically sent to CPS. He was not able to say how often he had received reports of bruising to infant children and he did not recall any previous occasion when he had converted an information report to a CPS referral. He stated that he is able to "value-add" to an information report from information contained on Tasmania Police systems but it is not the role of CMU to contact outside agencies for additional information. He did say, however, that in some circumstances it is appropriate to contact other organisations to obtain information, giving the example of contacting rental car companies for information about vehicles.

Constable Eastley stated that it was not his role to investigate information reports. He stated that the investigating officer to whom the report was allocated would be expected to investigate. He said that it was the investigating officer's task to make a CPS referral, if appropriate. Constable Eastley ascertained that Mr Johnstone was linked to the female named in the report, being Ms Dykstra, but he was unable to find a child. This information concerning Mr Johnstone was consistent with the information provided by Ms Bond in respect of the existence of an adult son. However, Constable Eastley believed that without the name of the baby there was not enough information in order to successfully transmit an electronic CPS referral. He also gave evidence that it was not his role to make telephone contact with CPS.

Inspector Stuart Wilkinson received the report from Constable Eastley. Inspector Wilkinson was, at the time, the Detective Senior Sergeant in charge of the Devonport CIB. He gave evidence that his role at that time included reviewing outstanding reports allocated to the Devonport CIB area, making assessments of the reports, and prioritising them. If investigation

was required, his role was then to allocate a report to a detective for that purpose. He stated that he would allocate the reports electronically to a detective. It was also his practice to print the report and place it into the allocated detective's work tray or hand it to him/her personally in the event that there was a delay in checking the system.

Before 10.30am on 29 October Inspector Wilkinson allocated the investigation of the report to Detective Constable Bobby Gray who was already investigating some minor criminal matters relating to Mr Johnstone. Inspector Wilkinson was unable to say how he prioritised the report or whether he checked Detective Gray's workload prior to allocating him the matter. He stated that he expected Detective Gray, as the investigating officer, to speak to CPS in relation to the information with a view to validating it or otherwise. He stated that he did not see anything in the report that signalled the need for immediate action. He gave evidence that it was not his practice to set time frames for investigating officers unless immediate action was required.

Inspector Wilkinson said in evidence that he had no indication as to when Detective Gray was intending to speak with Mr Johnstone. He does not recall turning his mind to mandatory reporting obligations to CPS when allocating the report. Further, he did not recall any conversation about the matter with Detective Gray prior to BJay being admitted to hospital. He was not able to recall previously receiving any other report of a child with unexplained bruising.

Detective Bobby Gray was the final officer in the chain of allocation of Ms Bond's report. As the allocated investigating officer, he was tasked to investigate and validate the information that had come to the attention of police in the early hours of the morning. He did not have a recollection of receiving the report and much of his evidence was based upon his assumptions, having subsequently reviewed the report. Detective Gray gave evidence that the report contained no specific information that would have caused him to prioritise it. He stated that he did not recall accessing the report on 29, 30 and 31 October 2012, as indicated by a subsequent police audit of the report. He did not undertake any investigation prior to being notified of BJay's hospitalisation on 5 November 2012.

Detective Gray gave evidence that the report did not attract priority because there were no allegations of assaults or any specific details as to how the injuries may have occurred or the persons involved. With respect to Constable Gray, it was very clear from the report that it was a report of physical abuse to a newborn infant, almost certainly by his father. He could not recall the volume of his workload at the time of allocation of the report. He did remember being involved in two particular investigations that week, being an abduction and sexual assault, and assumed that he chose to prioritise them over this report.

Two senior police officers, with knowledge of relevant procedures and not involved in the processing and investigation of Ms Bond's report, provided affidavits and evidence to assist me at the inquest.

One of those officers was Acting Inspector Michael Smith who conducted a review of Tasmania Police involvement with Ms Bond's call concerning BJay. He provided his findings to Assistant Commissioner Donna Adams on 5 January 2016. His review and his evidence centred on the specific roles of the radio room, the CMU and the investigators. He described the radio room as a "*call taker dispatch area*" which receives calls, records information,

dispatches police units or passes on information. He said that it is rare that information reports are generated by the radio room.

Inspector Smith also described the role of the CMU in processing information reports. He indicated that a CPS referral is the responsibility of the allocated investigating officer. However, he said that the CMU has the capacity to change the format of information reports into CPS referrals. He indicated that the allocation officer, in this case being Inspector Wilkinson, decides who the information report will be allocated to. That person should also provide directives about the priority or urgency to be given to the report.

Inspector Smith gave evidence that Inspector Wilkinson, in allocating the investigation to Detective Gray, should have directed the report as a priority for action as the report involved unexplained bruising to an infant. It was then for Detective Gray to assess the credibility of the information and to communicate with CPS. Acting Inspector Smith was of the view that the "allocation officer" had a pivotal role in ensuring the report was actioned by the officer to whom he referred it, including ascertaining that officer's current workload capacity.

The second senior police officer who reviewed police action following Ms Bond's call was Inspector John Arnold, Inspector-in-charge of Investigative and Intelligence Support Services, the organisation administering the police IDM system. Inspector Arnold gave evidence that, in his view, it was appropriate for the information relating to BJay to have been contained within an information report at the initial radio room stage, particularly given that the existence of the child central to that report could not be verified in the early hours of the morning when the information was received. Like Inspector Smith, Inspector Arnold was of the view that Sergeant Schiwy exceeded the usual response of a radio room operator by documenting the information in a report and also contacting the Devonport supervisor. Inspector Arnold was guarded about whether CMU should have submitted a CPS referral or contacted CPS by any other means. He did indicate that it was nevertheless within the scope of the CMU officer's work to submit a CPS referral when appropriate and that an information report can be converted to a CPS referral simply through a "drop-down" function. In this way the content of the information report would remain in its exact form, but the heading would change to a CPS referral. However, he gave evidence that CMU officers tend not to convert information reports into CPS referrals and noted the issue of regional differences as to how CMU officers approached their work.

Unexplained bruising on a small baby is an uncommon occurrence. This fact was reinforced by the experience of the police officers who gave evidence of the lack of such reports, as well as other evidence in the inquest. Ms Bond's telephone call should have been treated with urgency. The reviewing police officers were of the view that either of the officers at Devonport CIB should have contacted CPS during working hours in the morning of 29 October. This did not occur within this time period, nor even before BJay was hospitalised on 2 November 2012.

It is likely that BJay was subject to further violence by his father subsequent to Ms Bond's call, although it is possible that his second severe head injury may have already occurred. Further, I cannot make a finding that if CPS had received a referral from police on 29 October it would have removed BJay from his home environment. CPS was already involved, having received a prior notification regarding suspected injuries, and had not taken such steps. However, a further notification based on information from a potentially credible outside source (such as Ms Bond) may have caused CPS to reconsider risk and initiate immediate

protective action. The failure of police to appreciate the potential urgency of the matter and take action meant that an opportunity to intervene was lost.

The MOU between Tasmania Police and CPS requires a police officer receiving a report of physical injury to a child to immediately inform CPS. This is to be by telephone in urgent cases or by completion of a referral in non-urgent cases. The CMU has the role under the MOU of determining whether CPS referral is necessary and, if so, to assist in value adding to the referral and creating the report. This process occurs before the matter is allocated to the investigating officer.

As noted, the Police Manual also requires that police officers must verbally report to CPS all cases where physical injury is alleged. The reporting requirements for police officers under the Manual and MOU are both stricter than the test of “reasonable suspicion” for mandatory reporting under the Act.

Sergeant Schiwy performed his role diligently and completed a detailed information report. Ms Bond’s information was presented to him coherently, although based upon hearsay information. With the benefit of hindsight and in light of the extremely serious nature of the content, Sergeant Schiwy might have made the CPS notification as required by the Manual or arranged to have a vehicle visit the address to ascertain the existence of an infant and the other persons mentioned by Ms Bond. However, in the circumstances, it was not unreasonable for him to assume that the CMU would immediately value-add to the report and convert it to a CPS referral if required. He was also entitled to assume that the report would be allocated to an investigating officer later that day who would take immediate action to contact CPS.

The CMU officer had the ability to convert the information report to a CPS referral. A CMU officer can and should make a CPS referral where appropriate, particularly in urgent cases as prescribed by the Manual. Constable Eastley had linked Mr Johnstone’s name to that of Ms Dykstra. It could not have been considered unusual that a newborn infant’s name might not appear on the police system. This fact in itself should not be seen to render the report unreliable. Constable Eastley should have converted the information report to a CPS referral. This would have ensured timely notification to CPS and would have operated as an important safeguard in the event of delay in investigation of the report.

I accept that effective investigation of the report would only occur upon allocation to Devonport CIB officers who were properly equipped to deal fully with the matter. Their investigative work, however, should have been immediate in light of the subject matter. Inspector Wilkinson should have given Detective Gray instructions regarding the time frame for conducting his enquiries to validate the information. If Detective Gray was unable to initiate enquiries on the same day that it was allocated to him, then he should have discussed it with Inspector Wilkinson, who could have re-allocated the matter.

At the very latest, contact should have been made with CPS during the morning of 29 October by Inspector Wilkinson or Detective Gray to advise of the report and to ascertain what information, if any, it possessed concerning the family. This did not occur. Further, Constable Gray, who was working on other matters, did not himself prioritise the report as should have occurred.

It appears to me that the four officers handling Ms Bond's report did not have a solid working knowledge as to how to respond to it. They did not demonstrate familiarity with the necessary electronic processes, Police Manual provisions or the MOU. This may have been caused, or exacerbated, by the fact that their roles have not regularly involved such referrals. However, such lack of training and knowledge appears to have limited their competency in the event of the need to make a prompt report. In this case the delay in responding to Ms Bond's report was, in relative terms, lengthy and of critical significance. Most of the delay occurred at the stage of the investigating officer but each officer in the chain could have made an immediate CPS referral. There may have been understandable confusion about their duties as mandatory reporters under the Act as compared with their duties under the Manual, given the different requirements. I doubt that any of the officers involved could have formed a belief or suspicion of abuse upon reasonable grounds, to attract a duty as mandatory reporters, until they had at least obtained information from CPS and had viewed Ms Dykstra's Facebook messages about the bruising.

Several factors in addition to familiarity with CPS reporting procedures, combined to cause the lack of action. Firstly, the fact that the report was based upon Facebook information with incomplete details of names was a factor in the report not being given priority. The report was also given the lowest rating of "F6" on the police admiralty scale, meaning "*reliability unknown and truth cannot be judged*". Whilst this rating was correct, it may also have contributed to the report not being treated as seriously or urgently as if the rating had been higher. The manual and MOU provisions do not provide less urgent CPS reporting requirements where the original report contains hearsay information, presumably because such reports may ultimately be found to be correct. Further, in the multiple transmissions of the report, the coherence and credibility of Ms Bond's account became lost. The police officers may also have gained comfort because, according to the report, CPS was already involved in the case generally. However, Ms Bond had specifically advised that CPS was not aware of the fresh bruising to BJay.

The CMUs across the state are under review as part of the Tasmania Police Strategic Intelligence Plan. Such review should consider how a CMU's role might be maximised and standardised in relation to reports of risk to children.

I agree with Mr Miller that there is no evidence that within Tasmania Police there is a systemic issue of delay in responding to reports of child abuse. It appears to me that the facility for electronic CPS referrals, the clear pathways for processing an information report and the Manual and MOU provisions, are all factors that found a reliable system of response and information exchange between police and CPS. However, it is often single and difficult instances that demonstrate areas where improvement might be made. In this case, it is appropriate to make recommendations concerning the enhancement and standardisation of the role of the CMU, and ongoing training of police officers in their CPS reporting duties.

Summary of formal findings under section 28(1) of the *Coroners Act*

- a) The identity of the deceased is BJay Adam Johnstone;
- b) BJay died as the result of at least two episodes of severe trauma to his head inflicted by his father, Simon Adam Johnstone. Those injuries were inflicted in

a setting of extensive physical abuse of BJay by the said Simon Adam Johnstone occurring between his birth on 14 October 2012 and his hospitalisation on 2 November 2012. BJay suffered injuries at the Mersey Community Hospital until 16 October 2012 and subsequently at his home in Railton in Tasmania.

- c) The cause of BJay's death was traumatic head injury; and
- d) BJay died on 28 November 2012 at the Royal Hobart Hospital, Hobart in Tasmania.

Persons and organisations responsible for BJay's protection

BJay's mother, Fleur Atkin, did not protect BJay as she had a duty to do. She could have prevented his death. However, her incapacity to do so by reason of the violence and control to which she was subject by Simon Adam Johnstone contributed to her failure to act.

BJay's paternal grandmother, Hellen Dykstra, and BJay's paternal uncle, Ashley Richelme, did not protect BJay as they had a duty to do. If either had taken steps to remove BJay from Simon Johnstone, BJay's death may not have occurred.

Child Protection Services did not protect BJay as it had a duty to do. If it had undertaken its duty under the Act in accordance with correct practice and procedure, BJay's death would not have occurred.

Tasmania Police did not, contrary to appropriate practice and procedure, take steps towards attempting to ensure BJay's safety at a time before he may have suffered a fatal injury.

Recommendations

CPS, Gateway and IFSS

The following recommendations are intended to apply to CPS practice on a state-wide basis, unless otherwise indicated. Where I refer to IFSS, I intend to refer to any family support services that are part of the Gateway referral system throughout the state.

I **recommend** that CPS implement a comprehensive training regime for all its workers in the application of the TRF, CPS Practice Manual and Specialist Guides, and that the training be regularly updated to maintain the integrity of the risk assessment process and current learning in the field.

I **recommend** that CPS implement a comprehensive independent review of the functionality and usage of CPIS including but not limited to: the capacity of CPIS to aid CPS in meeting its statutory and organisational responsibilities; barriers to CPIS usage - including workplace culture and worker confidence in using the system, the adequacy of staff knowledge and training in CPIS, and; the quality of CPIS cases notes, recording of decision-making processes, and use of CPIS for related searches.

I **recommend** that CPS implement an audit and quality assurance system to determine whether the TRF is being routinely and correctly used, that CPIS searches are being routinely and correctly conducted and that risk assessments based upon the TRF accord with the statutory responsibilities of CPS and the CPS Practice Manual.

I **recommend** that CPS implement an audit system in respect of unborn baby notifications for the state to determine whether such notifications are being investigated and actioned properly and in a timely manner and consistent with the Act and CPS Practice Manual.

I **recommend** that CPS, with the support of DHHS, develop child protection liaison officer positions in the North and North West of the state, the key duties of the roles to include but not limited to:

- (a) Provision of consultation and assistance to hospital staff in relation to the full range of child protection matters across antenatal, neonatal and paediatric services.
- (b) Facilitation of positive and effective working relationships between the relevant hospitals, CPS, Gateway, IFSS and government agencies in respect of child protection issues.
- (c) Management of the unborn baby alert process across the hospitals and CPS, including the coordination of multidisciplinary case conferencing involving social work staff across the maternity and neonatal and paediatric intensive care units.

I **recommend** that in respect of infants under six months of age where the subject of a notification involves bruising, CPS arranges an examination of the infant and review of the circumstances by a paediatrician or other suitably qualified medical practitioner as soon as practicable for the purpose of assisting in the determination of whether the bruising is non-accidental in origin.

I **recommend** that CPS provide all notifiers with an electronic receipt for all notifications, including email and telephone notifications.

I **recommend** that CPS continuously reviews the working and constitution of the Three and Under Panel to ensure that it remains effective in its role.

I **recommend** that where a notification has been referred by CPS to Gateway, CPS ensures that Gateway is provided with a copy of the completed TRF relating to the notification, and that Gateway, in turn, provides that document to any IFSS organisations tasked to work with the families.

I **recommend** that, as a matter of priority, DHHS implement a formal review of the functions and working of the CBIS system, with focus upon;

- (a) The capacity of a CBIS to effectively manage referrals from CPS in accordance with the Act;
- (b) The statutory, procedural, organisational and cultural environment in which referrals from CPS take place; and
- (c) The timeframe for appropriate risk assessments; the adequacy, enhancement and access to the CAF tool as a risk assessment tool; the standard of completion of the CAF tool required from CPS; implementation of home visits and personal meetings

with the family in nominated higher risk cases; the optimal procedures for comprehensive provision, sharing and disclosure of documents between organisations; intake, case management and case closure procedures; and ongoing quality assurance.

I **recommend** that CPS, Gateway and IFSS implement regular training for their workers as appropriate to the functions of their organisation in the following:

- (a) The rarity and significance of bruising on an infant not yet mobile, and associated reporting requirements;
- (b) The risk factors for family violence, the detection of family violence and the impact of a family violence history upon the ability to be protective towards a child;
- (c) The possible risk factors posed to a child by the use of cannabis, and the need for a thorough investigation into the extent and effect of that use; and
- (d) Effective, robust questioning of parents or those with whom a child is living in order to properly assess critical factual matters regarding risk to a child.

I **recommend** that CPS, Gateway and IFSS implement joint training for its workers in risk assessment in respect of children, including but not limited to the operation of the Child Protection Manual and TRF as appropriate, the CAF (or any replacement) and the matters referred to in the previous recommendation so as to ensure consistency in knowledge and approach to risk assessment between organisations.

I **recommend** that the government considers amendments to the *Children, Young Persons and Their Families Act 1997* to provide for increased powers of the Secretary where the Secretary knows or suspects on reasonable grounds that a child is at risk as a result of drug abuse by a parent, guardian or other person, and the cause of the child being at risk is not being adequately addressed; such powers including orders to ensure that the parent, guardian or other person undergoes appropriate treatment for drug abuse; and to ensure that the parent, guardian or other person submits to periodic testing for drug abuse.

I **recommend** that the CPS Redesign Reference Group and those responsible for developing the Vulnerable Infant Strategy incorporate these recommendations, where appropriate, into the respective strategies with a view to their implementation in a staged and monitored setting.

I **recommend** that the government consider strengthening protocols between agencies, utilising the Safe Families Coordination Unit if appropriate, to identify at an early stage high risk perpetrators of family violence who may also perpetrate child abuse.

Tasmania Police

I **recommend** that Tasmania Police identify whether there is a need across all police officers, or any group of police officers, to provide training and education regarding reports of child abuse or neglect, including:

- (a) The making of electronic referrals to CPS from the IDM system or other system used by police officers;
- (b) The requirements for reporting to CPS under the Police Manual and/or MOU;
- (c) The requirements for mandatory reporting under the *Children, Young Persons and Their Families Act 1997*; and
- (d) The prioritising of the investigation of such reports by an allocated investigating officer.

I **recommend** that, if such need is identified, Tasmania Police implement training and education programs as required in those areas identified, and maintain training and education programs upon a sufficiently regular basis to ensure that police officers are able to respond efficiently and effectively to reports of child abuse or neglect.

I **recommend** that Tasmania Police review the role of the CMU in vetting information reports regarding child abuse and neglect and the creation of electronic CFS referrals, with a view to enhancing and standardising their role across the state; and, if necessary, create guidelines for CMUs in respect of their role and the processes to be followed.

Conclusion

The inquest into BJay's death was lengthy, complex and a most difficult process for so many involved. I extend my great appreciation to counsel assisting, Ms Sundram, for her dedicated work over a lengthy period. I am also appreciative of the support provided by Coroner's Associates Senior Sergeant Paul Reynolds Constable Hamish Woodgate.

I am grateful to all other counsel involved, particularly Mr Turner and Ms Morgan who were present through the entirety of the inquest and represented their respective clients competently and in a manner that assisted me in performing my functions.

Dated: 26 June 2017 at Hobart in the State of Tasmania

Olivia McTaggart
Coroner