Baby H, Gemma

Ask your question (type q to quit): Who was the deceased?

2025-10-10 15:02:18,089 - INFO - HTTP Request: POST http://127.0.0.1:11434/api/embed "HTTP/1.1 200 OK"

2025-10-10 15:02:30,329 - INFO - HTTP Request: POST http://127.0.0.1:11434/api/generate "HTTP/1.1 200 OK"

Question:

Who was the deceased?

Answer:

The deceased was referred to as ‘Baby H’.

Source 1:

\* text: "SUPPRESSION ORDER:\nSuppression of the deceaseds name from publication and any evidence likely to lead to her identification. The deceased is to be referred to as 'Baby H."

\* page: 3

\* document: data/Baby-H-finding.pdf

Source 2:

\* text: "Creation of a Department policy for grieving family members\nquestion during the inquest: 177\n[A]fter Baby Hs death and obviously there was a lengthy criminal process, feel that and particularly the father of Baby H, were left with really no information or contact from the department following that. So no discussion about the changes that have bee..."

\* page: 47

\* document: data/Baby-H-finding.pdf

Source 3:

\* text: "INTRODUCTION\n- 1 H died on 28 2017 from head and neck injuries. She was 4 months and 9 old. Two days before her death, Baby H had been placed into the care of the Chief Executive Officer (CEO) of the Department of Child Protection and Family Support (the Department) ! May Baby days\n- 2 Accordingly, immediately before her death, Baby H was a 'pers..."

\* page: 3

\* document: data/Baby-H-finding.pdf

Ask your question (type q to quit): When did the death occur?

2025-10-10 15:05:16,340 - INFO - HTTP Request: POST http://127.0.0.1:11434/api/embed "HTTP/1.1 200 OK"

2025-10-10 15:05:28,263 - INFO - HTTP Request: POST http://127.0.0.1:11434/api/generate "HTTP/1.1 200 OK"

Question:

When did the death occur?

Answer:

Baby H’s death occurred on 29 May 2017.

Source 1:

\* text: "Cause of death\n124. Dr Judith McCreath, a forensic pathologist, conducted a post mortem examination on Baby Hs body on 29 May 2017.\n125. That examination noted the presence of bleeding over the surface of the brain (right subdural haemorrhage over the cerebral hemisphere and diffuse subarachnoid haemorrhage) , swelling of the brain; bruising to ..."

\* page: 35

\* document: data/Baby-H-finding.pdf

Source 2:

\* text: "[2021] WACOR 2\n- e Bucket-handle fracture of the distal aspect of the left fibula (the smaller of the two bones that make up the lower leg) showing early signs of healing and probably the distal aspect of the right fibula, with possible proximal fibula metaphyseal fractures bilaterally;\n- f. Possible subtle fractures at the posteromedial ..."

\* page: 37

\* document: data/Baby-H-finding.pdf

Source 3:

\* text: "CONCLUSION\n173. Baby H brought much happiness to her father and grandparents during her short life. She was a much loved infant.\n174. Baby H was placed into the care and protection of the Department on 26 2017, shortly after she suffered horrific inflicted injuries. Regrettably, the potential care and protection that the Department could offer unde..."

\* page: 49

\* document: data/Baby-H-finding.pdf

Ask your question (type q to quit): Where did the death occur?

2025-10-10 15:09:56,192 - INFO - HTTP Request: POST http://127.0.0.1:11434/api/embed "HTTP/1.1 200 OK"

2025-10-10 15:10:11,337 - INFO - HTTP Request: POST http://127.0.0.1:11434/api/generate "HTTP/1.1 200 OK"

Question:

Where did the death occur?

Answer:

Princess Margaret Hospital

Source 1:

\* text: "Cause of death\n124. Dr Judith McCreath, a forensic pathologist, conducted a post mortem examination on Baby Hs body on 29 May 2017.\n125. That examination noted the presence of bleeding over the surface of the brain (right subdural haemorrhage over the cerebral hemisphere and diffuse subarachnoid haemorrhage) , swelling of the brain; bruising to ..."

\* page: 35

\* document: data/Baby-H-finding.pdf

Source 2:

\* text: "RECORD OF INVESTIGATION INTO DEATH\nI with an inquest held at Perth Coroners Court; Central Law Courts; Court 85, 501 Hay Street;, Perth, on 19 21 October 2020, find that the death of Baby H occurred on 28 May 2017 at Princess Margaret Hospital, from head and neck injuries in the following circumstances:"

\* page: 2

\* document: data/Baby-H-finding.pdf

Source 3:

\* text: "INTRODUCTION\n- 1 H died on 28 2017 from head and neck injuries. She was 4 months and 9 old. Two days before her death, Baby H had been placed into the care of the Chief Executive Officer (CEO) of the Department of Child Protection and Family Support (the Department) ! May Baby days\n- 2 Accordingly, immediately before her death, Baby H was a 'pers..."

\* page: 3

\* document: data/Baby-H-finding.pdf

Ask your question (type q to quit): What was the cause of death?

2025-10-10 15:15:31,190 - INFO - HTTP Request: POST http://127.0.0.1:11434/api/embed "HTTP/1.1 200 OK"

2025-10-10 15:15:46,639 - INFO - HTTP Request: POST http://127.0.0.1:11434/api/generate "HTTP/1.1 200 OK"

Question:

What was the cause of death?

Answer:

According to the provided information, the cause of death was head and neck injuries. Dr. McCreath, the forensic pathologist, concluded this based on the findings of bleeding over the surface of the brain, swelling of the brain, bruising to the left jawline, left arm, and front of the neck.

Source 1:

\* text: "Cause of death\n124. Dr Judith McCreath, a forensic pathologist, conducted a post mortem examination on Baby Hs body on 29 May 2017.\n125. That examination noted the presence of bleeding over the surface of the brain (right subdural haemorrhage over the cerebral hemisphere and diffuse subarachnoid haemorrhage) , swelling of the brain; bruising to ..."

\* page: 35

\* document: data/Baby-H-finding.pdf

Source 2:

\* text: "Cause of death\n2017, 18 October 2017 and 26 March 2019\n156 Exhibit 1, Vol. 1, Tab 7, Report of Dr Andrew Baker dated 24 March 2019\n155 Exhibit 1, Vol. 1, Tab 8A-B; Reports of Dr Vicki Fabian dated 14 June 2017 and 22 June 2017\n157 Exhibit 1, Vol. 1, Tab IOB, Report of Dr Louise Houliston dated 7 June 2017"

\* page: 35

\* document: data/Baby-H-finding.pdf

Source 3:

\* text: "[2021] WACOR 2\n- e Bucket-handle fracture of the distal aspect of the left fibula (the smaller of the two bones that make up the lower leg) showing early signs of healing and probably the distal aspect of the right fibula, with possible proximal fibula metaphyseal fractures bilaterally;\n- f. Possible subtle fractures at the posteromedial ..."

\* page: 37

\* document: data/Baby-H-finding.pdf

Ask your question (type q to quit): Who was the presiding coroner?

2025-10-10 15:17:37,457 - INFO - HTTP Request: POST http://127.0.0.1:11434/api/embed "HTTP/1.1 200 OK"

2025-10-10 15:17:49,533 - INFO - HTTP Request: POST http://127.0.0.1:11434/api/generate "HTTP/1.1 200 OK"

Question:

Who was the presiding coroner?

Answer:

Philip John Urquhart

Source 1:

\* text: "Counsel Appearing:\nMs S Tyler appeared to assist the Coroner Mr B Nelson and Ms A Miller appeared on behalf of the Department of Communities and WA Country Health Services Ms R Young appeared on behalf of Dr Isaac Adewumi"

\* page: 1

\* document: data/Baby-H-finding.pdf

Source 2:

\* text: "Case(s) referred to in decision(s):\nInquest into the death of PT [2020] WACOR 26\nCoroners Act 1996 (Section 26(1))"

\* page: 1

\* document: data/Baby-H-finding.pdf

Source 3:

\* text: "JURISDICTION CORONER'S COURT OF WESTERN AUSTRALIA\nACT\nCORONERS ACT 1996\nCORONER\nPhilip John Urquhart\nHEARD\n19 21 October 2020\nDELIVERED\n9 FEBRUARY 2021\nFILE NO/S\nCORC 726 of 2017\nDECEASED\nBABY H\nCatchwords:\nNil\nLegislation:\nCoroners Act 1996 (WA)\nChildren and Community Services Act 2004 (WA)"

\* page: 1

\* document: data/Baby-H-finding.pdf

Ask your question (type q to quit): What were the circumstances leading to the death?

2025-10-10 15:18:42,713 - INFO - HTTP Request: POST http://127.0.0.1:11434/api/embed "HTTP/1.1 200 OK"

2025-10-10 15:18:56,691 - INFO - HTTP Request: POST http://127.0.0.1:11434/api/generate "HTTP/1.1 200 OK"

Question:

What were the circumstances leading to the death?

Answer:

Based on the provided context, Baby H died from head and neck injuries. The post-mortem examination revealed subdural and subarachnoid hemorrhages, swelling of the brain, bruising to the jawline, arm, and neck. Microscopic examination confirmed the bruising and also identified bronchopneumonia in the lungs and stress-related changes in the thymus. The circumstances leading to the injuries and subsequent death were inflicted by the mother. The Department of Child Protection and Family Support was involved in Baby H’s care but missed opportunities to intervene earlier, and the inquest found that simply missing an opportunity does not imply responsibility for the death.

Source 1:

\* text: "Cause of death\n124. Dr Judith McCreath, a forensic pathologist, conducted a post mortem examination on Baby Hs body on 29 May 2017.\n125. That examination noted the presence of bleeding over the surface of the brain (right subdural haemorrhage over the cerebral hemisphere and diffuse subarachnoid haemorrhage) , swelling of the brain; bruising to ..."

\* page: 35

\* document: data/Baby-H-finding.pdf

Source 2:

\* text: "CONCLUSION\n173. Baby H brought much happiness to her father and grandparents during her short life. She was a much loved infant.\n174. Baby H was placed into the care and protection of the Department on 26 2017, shortly after she suffered horrific inflicted injuries. Regrettably, the potential care and protection that the Department could offer unde..."

\* page: 49

\* document: data/Baby-H-finding.pdf

Source 3:

\* text: "INTRODUCTION\n- 1 H died on 28 2017 from head and neck injuries. She was 4 months and 9 old. Two days before her death, Baby H had been placed into the care of the Chief Executive Officer (CEO) of the Department of Child Protection and Family Support (the Department) ! May Baby days\n- 2 Accordingly, immediately before her death, Baby H was a 'pers..."

\* page: 3

\* document: data/Baby-H-finding.pdf

Ask your question (type q to quit): What relevant medical or mental health history did the deceased have?

2025-10-10 15:24:18,745 - INFO - HTTP Request: POST http://127.0.0.1:11434/api/embed "HTTP/1.1 200 OK"

2025-10-10 15:24:33,467 - INFO - HTTP Request: POST http://127.0.0.1:11434/api/generate "HTTP/1.1 200 OK"

Question:

What relevant medical or mental health history did the deceased have?

Answer:

Based on the provided context, the deceased (Baby H) had the following medical findings:

\* \*\*Bronchopneumonia\*\* in the lungs.

\* \*\*Stress-related changes in the thymus\*\* (a gland in the chest).

\* \*\*Fresh bruising\*\* to the left jawline, left arm, and front of the neck (confirmed by microscopic examination).

There is no mention of any pre-existing mental health history.

Source 1:

\* text: "Creation of a Department policy for grieving family members\nquestion during the inquest: 177\n[A]fter Baby Hs death and obviously there was a lengthy criminal process, feel that and particularly the father of Baby H, were left with really no information or contact from the department following that. So no discussion about the changes that have bee..."

\* page: 47

\* document: data/Baby-H-finding.pdf

Source 2:

\* text: "Cause of death\n124. Dr Judith McCreath, a forensic pathologist, conducted a post mortem examination on Baby Hs body on 29 May 2017.\n125. That examination noted the presence of bleeding over the surface of the brain (right subdural haemorrhage over the cerebral hemisphere and diffuse subarachnoid haemorrhage) , swelling of the brain; bruising to ..."

\* page: 35

\* document: data/Baby-H-finding.pdf

Source 3:

\* text: "[2021] WACOR 2\n- 171.I am of the view that a policy which addresses contact with the family following the death of a child in the Department?s care would be appropriate. In much the same way that the Central Intake Model improved consistency in the decision-making process in relation to the assessment of notifications of concerns, a policy t..."

\* page: 48

\* document: data/Baby-H-finding.pdf

Ask your question (type q to quit): Who testified or assisted in the inquest? (eg, doctors, police, witnesses)

2025-10-10 16:21:01,377 - INFO - HTTP Request: POST http://127.0.0.1:11434/api/embed "HTTP/1.1 200 OK"

2025-10-10 16:21:18,131 - INFO - HTTP Request: POST http://127.0.0.1:11434/api/generate "HTTP/1.1 200 OK"

Question:

Who testified or assisted in the inquest? (eg, doctors, police, witnesses)

Answer:

Here’s a breakdown of who testified or assisted in the inquest, based on the provided context:

\*\*Witnesses who gave oral evidence:\*\*

\* Baby Hs maternal grandmother

\* Maria Barry (team leader with the Department)

\* Sergeant Simon Bowen (detective with the Homicide squad)

\* Nicole Mitchell (team leader with the Department)

\* Suzanne Smith (registered nurse at the Bunbury Regional Hospital (BRH))

\* Tara Tomsett (nee Clement) (child protection worker with the Department)

\* Dr Helen Truong (resident medical officer in the emergency department of BRH)

\* Dr Isaac Adewumi (consultant medical officer in the emergency department of BRH)

\* Dr Louise Houliston (forensic paediatrician, Child Protection Unit at Princess Margaret Hospital (PMH))

\* Sharlene Abbott (acting director of Population Health at the WA Country Health Service (WACHS) South West)

\*\*People assisting:\*\*

\* Ms S Tyler (appeared to assist the Coroner)

\* Ms A Miller (appeared on behalf of the Department of Communities and WA Country Health Services)

\* Ms R Young (appeared on behalf of Dr Isaac Adewumi)

Source 1:

\* text: "[2021] WACOR 2\n- 4 I held an inquest into Baby Hs death at Perth on 19 The following witnesses gave oral evidence:s\n- 21 October 2020.\n- 1 Baby Hs maternal grandmother;\n- iii. Maria Barry, team leader with the Department;\n- ii. Sergeant Simon Bowen; detective with the Homicide squad;\n- Nicole Mitchell, team leader with the Department;\n- vi. Suzanne..."

\* page: 4

\* document: data/Baby-H-finding.pdf

Source 2:

\* text: "[2021] WACOR 2\n- 5 . The documentary evidence at the inquest comprised of two volumes that were tendered as exhibit 1 at the commencement of the inquest and a further four exhibits (exhibits 2-5) that were tendered during the inquest. Four exhibits were provided after the inquest (exhibits 6 9)\n6. My primary function has been to investigate Baby Hs..."

\* page: 4

\* document: data/Baby-H-finding.pdf

Source 3:

\* text: "Counsel Appearing:\nMs S Tyler appeared to assist the Coroner Mr B Nelson and Ms A Miller appeared on behalf of the Department of Communities and WA Country Health Services Ms R Young appeared on behalf of Dr Isaac Adewumi"

\* page: 1

\* document: data/Baby-H-finding.pdf

Ask your question (type q to quit): Was there evidence of any substance or drug in the body? Summarise the toxicology findings.

2025-10-10 16:29:27,879 - INFO - HTTP Request: POST http://127.0.0.1:11434/api/embed "HTTP/1.1 200 OK"

2025-10-10 16:29:42,124 - INFO - HTTP Request: POST http://127.0.0.1:11434/api/generate "HTTP/1.1 200 OK"

Question:

Was there evidence of any substance or drug in the body? Summarise the toxicology findings.

Answer:

Based on the provided context information, there is evidence of toxicology findings.

\*\*Summary of Toxicology Findings:\*\*

\* \*\*Subsequent microscopic examination of Baby Hs tissues showed bronchopneumonia in the lungs and stress related changes in the thymus.\*\* While not explicitly stated as a drug finding, the presence of bronchopneumonia suggests a potential infection, which could be related to substance exposure.

\* \*\*Dr McCreath, the forensic pathologist, did not express an opinion as to the cause of death as further investigations were pending.\*\* This indicates that toxicology testing was being conducted at the time of the post-mortem examination.

\*\*Therefore, the context suggests that toxicology testing was being undertaken, but the specific findings related to substances or drugs are not detailed in the provided text.\*\*

Source 1:

\* text: "Findings of accidental injury by Dr Truong and Dr Adewumi\n90. From all the evidence before me, I find that the bruise to the right cheek of Baby Hthat was visible on 10 2017 was not an accidental injury. In light of the mother's conviction of Baby Hs murder, it is open for me May\n99 ts. 19.10.20 (Tomsett), p 123\n101 ts. 19.10.20 (Mitchell), p 93\n10..."

\* page: 24

\* document: data/Baby-H-finding.pdf

Source 2:

\* text: "[2021] WACOR 2\n- to find the mother had inflicted this bruise. Applying the necessary standard of proof I am satisfied;, on the balance of probabilities; that the mother did inflict this injury. However; it does not automatically follow that 9 finding adverse in nature should be made against either of the doctors for their conclusions that the brui..."

\* page: 25

\* document: data/Baby-H-finding.pdf

Source 3:

\* text: "Cause of death\n124. Dr Judith McCreath, a forensic pathologist, conducted a post mortem examination on Baby Hs body on 29 May 2017.\n125. That examination noted the presence of bleeding over the surface of the brain (right subdural haemorrhage over the cerebral hemisphere and diffuse subarachnoid haemorrhage) , swelling of the brain; bruising to ..."

\* page: 35

\* document: data/Baby-H-finding.pdf

Ask your question (type q to quit): Summarize the coroner’s findings in 2-3 sentences.

2025-10-10 16:30:35,245 - INFO - HTTP Request: POST http://127.0.0.1:11434/api/embed "HTTP/1.1 200 OK"

2025-10-10 16:30:49,465 - INFO - HTTP Request: POST http://127.0.0.1:11434/api/generate "HTTP/1.1 200 OK"

Question:

Summarize the coroner’s findings in 2-3 sentences.

Answer:

The coroner investigated Baby Hs death, aiming to determine how and why she died, and also commenting on related matters like health and safety. He made three recommendations to address further issues identified during the inquest and expressed hope that these, alongside existing departmental changes, would offer some comfort to the family. The investigation concluded with a focus on providing closure for the family following Baby Hs tragic loss.

Source 1:

\* text: "[2021] WACOR 2\n- 5 . The documentary evidence at the inquest comprised of two volumes that were tendered as exhibit 1 at the commencement of the inquest and a further four exhibits (exhibits 2-5) that were tendered during the inquest. Four exhibits were provided after the inquest (exhibits 6 9)\n6. My primary function has been to investigate Baby Hs..."

\* page: 4

\* document: data/Baby-H-finding.pdf

Source 2:

\* text: "Counsel Appearing:\nMs S Tyler appeared to assist the Coroner Mr B Nelson and Ms A Miller appeared on behalf of the Department of Communities and WA Country Health Services Ms R Young appeared on behalf of Dr Isaac Adewumi"

\* page: 1

\* document: data/Baby-H-finding.pdf

Source 3:

\* text: "[2021] WACOR 2\n179. I have made three recommendations aimed at addressing the further issues I have identified during the inquest. It is my hope that these recommendations;, and the changes already made by the governmental departments following Baby Hs death, may provide some consolation to her family for their heart-rending loss.\nP J Urquhart Co..."

\* page: 50

\* document: data/Baby-H-finding.pdf

Ask your question (type q to quit): Did the coroner make recommendations for future prevention? If yes, what were they?

2025-10-10 16:33:20,705 - INFO - HTTP Request: POST http://127.0.0.1:11434/api/embed "HTTP/1.1 200 OK"

2025-10-10 16:33:34,454 - INFO - HTTP Request: POST http://127.0.0.1:11434/api/generate "HTTP/1.1 200 OK"

Question:

Did the coroner make recommendations for future prevention? If yes, what were they?

Answer:

Yes, the coroner made recommendations for future prevention. He made three recommendations aimed at addressing further issues identified during the inquest and reiterated a previous recommendation.

Source 1:

\* text: "[2021] WACOR 2\n179. I have made three recommendations aimed at addressing the further issues I have identified during the inquest. It is my hope that these recommendations;, and the changes already made by the governmental departments following Baby Hs death, may provide some consolation to her family for their heart-rending loss.\nP J Urquhart Co..."

\* page: 50

\* document: data/Baby-H-finding.pdf

Source 2:

\* text: "2021] WACOR 2\n165. I am firmly of the view that the death of H highlights the need for this recommendation to be carefully considered by the Western Australian Government. It is for that reason make the same recommendation in this finding There is no need to make any the opportunities to report the bruising fall within the parameters of the State C..."

\* page: 45

\* document: data/Baby-H-finding.pdf

Source 3:

\* text: "Case(s) referred to in decision(s):\nInquest into the death of PT [2020] WACOR 26\nCoroners Act 1996 (Section 26(1))"

\* page: 1

\* document: data/Baby-H-finding.pdf

Ask your question (type q to quit): Differentiate between the immediate cause of death and contributing factors (eg, drugs, mental health, environment).

2025-10-10 16:34:48,079 - INFO - HTTP Request: POST http://127.0.0.1:11434/api/embed "HTTP/1.1 200 OK"

2025-10-10 16:35:02,231 - INFO - HTTP Request: POST http://127.0.0.1:11434/api/generate "HTTP/1.1 200 OK"

Question:

Differentiate between the immediate cause of death and contributing factors (eg, drugs, mental health, environment).

Answer:

Based on the provided context, the immediate cause of death was a right subdural haemorrhage and diffuse subarachnoid haemorrhage, alongside swelling of the brain. This is determined by Dr. McCreath’s post-mortem examination.

Contributing factors, as identified through microscopic examination, include:

\* \*\*Bronchopneumonia in the lungs\*\*

\* \*\*Stress-related changes in the thymus\*\*

The report does \*not\* mention any involvement of drugs, mental health, or environmental factors. It focuses solely on the physical findings of the post-mortem examination.

Source 1:

\* text: "Cause of death\n124. Dr Judith McCreath, a forensic pathologist, conducted a post mortem examination on Baby Hs body on 29 May 2017.\n125. That examination noted the presence of bleeding over the surface of the brain (right subdural haemorrhage over the cerebral hemisphere and diffuse subarachnoid haemorrhage) , swelling of the brain; bruising to ..."

\* page: 35

\* document: data/Baby-H-finding.pdf

Source 2:

\* text: "Table of Contents\nINTRODUCTION, 1 = . THE MOTHER'S PREGNANCY AND BABY HS EARLY MONTHS, 1 = . Relevant events during the mother's pregnancy, 1 = . Baby Hs birth, 1 = . Baby Hs contact with the Child Health Centre, 1 = . Observations of Baby H by the grandmother, 1 = . THE DEPARTMENTS INVOLVEMENT ON 10 MAY 2017, 1 = 1l. BABY HS ATTENDANCE AT BRH ON 1..."

\* page: 2

\* document: data/Baby-H-finding.pdf

Source 3:

\* text: "Cause of death\n2017, 18 October 2017 and 26 March 2019\n156 Exhibit 1, Vol. 1, Tab 7, Report of Dr Andrew Baker dated 24 March 2019\n155 Exhibit 1, Vol. 1, Tab 8A-B; Reports of Dr Vicki Fabian dated 14 June 2017 and 22 June 2017\n157 Exhibit 1, Vol. 1, Tab IOB, Report of Dr Louise Houliston dated 7 June 2017"

\* page: 35

\* document: data/Baby-H-finding.pdf

Ask your question (type q to quit): Did the coroner evaluate the adequacy of supervision, treatment, or care provided? Explain the conclusion.

2025-10-10 16:35:49,770 - INFO - HTTP Request: POST http://127.0.0.1:11434/api/embed "HTTP/1.1 200 OK"

2025-10-10 16:36:03,940 - INFO - HTTP Request: POST http://127.0.0.1:11434/api/generate "HTTP/1.1 200 OK"

Question:

Did the coroner evaluate the adequacy of supervision, treatment, or care provided? Explain the conclusion.

Answer:

Yes, the coroner evaluated the adequacy of supervision, treatment, and care provided.

\*\*Explanation:\*\*

Paragraph 3 of the Coroner’s report states: “Where, as here, the death is of a person held in care, I am required to comment on the quality of the supervision; treatment and care the person received from the Department while in that care.” This explicitly outlines the coroner’s mandate to assess these elements. Furthermore, the report concludes with three recommendations aimed at addressing identified issues related to supervision, treatment, and care.

Source 1:

\* text: "INTRODUCTION\n- 1 H died on 28 2017 from head and neck injuries. She was 4 months and 9 old. Two days before her death, Baby H had been placed into the care of the Chief Executive Officer (CEO) of the Department of Child Protection and Family Support (the Department) ! May Baby days\n- 2 Accordingly, immediately before her death, Baby H was a 'pers..."

\* page: 3

\* document: data/Baby-H-finding.pdf

Source 2:

\* text: "Counsel Appearing:\nMs S Tyler appeared to assist the Coroner Mr B Nelson and Ms A Miller appeared on behalf of the Department of Communities and WA Country Health Services Ms R Young appeared on behalf of Dr Isaac Adewumi"

\* page: 1

\* document: data/Baby-H-finding.pdf

Source 3:

\* text: "[2021] WACOR 2\n179. I have made three recommendations aimed at addressing the further issues I have identified during the inquest. It is my hope that these recommendations;, and the changes already made by the governmental departments following Baby Hs death, may provide some consolation to her family for their heart-rending loss.\nP J Urquhart Co..."

\* page: 50

\* document: data/Baby-H-finding.pdf

Ask your question (type q to quit): Does this case highlight any broader patterns or lessons relevant to public safety or institutional care?

2025-10-10 16:36:50,336 - INFO - HTTP Request: POST http://127.0.0.1:11434/api/embed "HTTP/1.1 200 OK"

2025-10-10 16:37:04,047 - INFO - HTTP Request: POST http://127.0.0.1:11434/api/generate "HTTP/1.1 200 OK"

Question:

Does this case highlight any broader patterns or lessons relevant to public safety or institutional care?

Answer:

Yes, this case highlights several broader patterns and lessons relevant to public safety and institutional care. Here’s a breakdown of the key takeaways:

\* \*\*Importance of Early Intervention:\*\* The core lesson is the critical need for proactive intervention in cases of suspected child abuse and neglect. The missed opportunities in Baby H’s case underscore how delays in recognizing and responding to concerning signs can tragically impact a child’s life.

\* \*\*Systemic Issues with Referral Processes:\*\* The case reveals potential weaknesses in the referral process. The delay in Ms. McKeogh contacting the Department after speaking with the nurse highlights a breakdown in communication and a lack of urgency in escalating concerns. This suggests a need for streamlined and prioritized referral pathways within child protection services.

\* \*\*Communication Breakdown:\*\* The document highlights a significant communication failure between the nurse, the Department worker, and ultimately, the Department itself. This emphasizes the importance of clear, consistent, and timely communication across all agencies involved in child protection.

\* \*\*Need for Rigorous Implementation of Policies:\*\* While the Department was commended for introducing new policies (High Risk Infant Policy), the case demonstrates that simply having policies in place isn't enough. Consistent and rigorous implementation of these policies is crucial.

\* \*\*Focus on Risk Assessment:\*\* The case points to the need for more robust risk assessments, particularly in situations where concerns about a child’s welfare are raised.

In essence, Baby H’s case serves as a cautionary tale about the potential consequences of complacency and the vital role of vigilance, proactive assessment, and effective communication within systems designed to protect vulnerable children.

Source 1:

\* text: "CONCLUSION\n176. The identification of missed opportunities does; however; allow for an analysis to be done and for improvements to be made. The Department quickly acknowledged the shortcomings that arose in Baby Hs case and implemented changes to address them.\n177. The Department is to be commended for its introduction of the new intake procedures,..."

\* page: 49

\* document: data/Baby-H-finding.pdf

Source 2:

\* text: "CONCLUSION\n173. Baby H brought much happiness to her father and grandparents during her short life. She was a much loved infant.\n174. Baby H was placed into the care and protection of the Department on 26 2017, shortly after she suffered horrific inflicted injuries. Regrettably, the potential care and protection that the Department could offer unde..."

\* page: 49

\* document: data/Baby-H-finding.pdf

Source 3:

\* text: "THE DEPARTMENTS INVOLVEMENT ON 10 MAY 2017\n34. When the grandmother contacted the Department she to Tara Clement,20 a child protection worker responsible for taking child referrals at the Department's Bunbury office. The grandmother reported that she was worried about bruising she had noted on Baby Hs face, including the initial bruises she had obs..."

\* page: 11

\* document: data/Baby-H-finding.pdf