



## ATTORNEY-GENERAL

Parliament House  
State Square  
Darwin NT 0800

GPO Box 3146  
Darwin NT 0801

### REPORT TO THE LEGISLATIVE ASSEMBLY

Pursuant to section 46B of the *Coroners Act 1993*

In the matter of the Coroner's Findings and Recommendations regarding the death of Baby G.

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Pursuant to section 46B of the *Coroners Act 1993* (the Act), I provide this Report on the findings and recommendations of Local Court Judge Elisabeth Armitage, Territory Coroner, regarding the death of Baby G (the Deceased) (Attachment A refers).

This Report includes the response to the recommendations of the Territory Coroner by Mr Chris Hosking, Chief Executive Officer (CEO) of the Department of Health (DoH), and Ms Karen Broadfoot, Acting CEO of the Department of Children and Families (DCF).

The Deceased, a six month old male, died at 11.25 am on 18 March 2023 at the Royal Darwin Hospital in the Northern Territory. The cause of death was Trisomy 21 with complex cardiac anomalies complicated by pulmonary hypertension, chronic lung disease and recurrent respiratory infections. When the Deceased passed away, he was a child in care and therefore an inquest into his death was mandatory.

#### Recommendations of the Coroner

The Coroner made the following four recommendations in regard to the Deceased:

- 133 I **recommend** that NT Health promote the Australian Pregnancy Care Guidelines with all health practitioners.
- 134 I **recommend** that NT Health, in consultation with Miwatj and other appropriate Aboriginal health care providers, consider how, and in what circumstances, NIPT testing can be made freely available to pregnant women, particularly those in remote locations, and make all reasonable endeavours to secure funding for and facilitation of the provisions of free NIPT's where identified as appropriate.
- 135 I **recommend** that NT Health and Territory Families work together with the Down Syndrome Association (NT) to ensure that staff working with children are aware of the available services and referral pathways to that Association.

136. I **recommend** that the Attorney-General consider a reform of the *Care and Protection of Children Act 2007* (NT), to include the principle of “active efforts” similarly to the New South Wales provisions.’

### **Response to Coroner’s recommendations**

A copy of the Coronial Findings were provided to Ms Emma White, CEO, DCF, on 10 April 2025, in accordance with section 46A(1) of the Act. This included a request to consider Recommendation 136 as the responsibility for the *Care and Protection of Children Act 2007* (CAPCA) sits under the DCF portfolio.

A written response was received from Ms Broadfoot dated 7 July 2025, as required by section 46B(1) of the Act. The response was as follows:

#### Recommendation 135

‘The Department and NT Health has been working with the Down Syndrome Association (NT) (the Association) to understand its services and referral pathways. The Association has provided the Department with records of its hospital and clinic liaison and education work, as well as providing the Department with relevant information for parents about its services.

The Department will disseminate information provided by the Association through relevant email broadcasts to staff as well as uploading information to the Department's intranet which is accessible to child protection practitioners and practice leaders in all regions across the Northern Territory.

Similarly, NT Health has advised the Department it will also disseminate the information to its paediatrics, neonatology, midwifery and Child and Family Health divisions.

The Department is of the view that the dissemination of this information will result in support services for parents of children with Trisomy 21 being engaged at an earlier stage.’

#### Recommendation 136

‘On 10 February 2025, [Government] gave authority to the Department to conduct a comprehensive review of the *Care and Protection of Children Act 2007* (NT) (CAPCA). The review has commenced and the Department has received a range of stakeholder submissions in relation to the review.

The review contemplates the introduction of an “active efforts” (active efforts) framework similar to that used in other jurisdictions (for example New South Wales, Queensland and South Australia) for all children in contact with the statutory child protection system.

The Department will continue to explore the merits of this important proposed legislative reform as it continues its review of CAPCA.’

A copy of the Coronial Findings was provided to Mr Chris Hosking on 10 April 2025, in accordance with section 46A(1) of the Act.

A written response was received from Mr Hosking dated 30 July 2025, as required by section 46B(1) of the Act. The response was as follows:

Recommendation 133

'NT Health partnered with South Australia Perinatal Practice Guidelines (SA PPG) in 2023. Staged adoption of SA PPG is underway in the NT maternal and newborn networks.'

Recommendation 134

'This work is being led by our Clinical Excellence and Patient Safety Unit.

NT Health has funding identified to NIPT test women in Top End and Katherine regions. At this stage, over 20 women have been tested. The work has involved training for all staff, development of documents to perform the testing; and implementation.

NT Health is concluding discussions with the Senior Project Coordinator, Reproductive Epidemiology at Murdoch Children's Research Institute to evaluate the program which is in the final stages of ethics approval.'

Recommendation 135

'The Department of Children and Families and NT Health are working with the Down Syndrome Association (DSANT) for the provision of information about their services and referral pathways. NT Health has disseminated the DSANT Hospital Program and its Service Delivery Report through relevant media and intranet and to teams within the respective Departments:

Department of Health:

- a) Paediatrics
- b) Neonatology
- c) Midwifery and NT Health Maternal and Newborn Network
- d) Child and Family Health
- e) Chair NT Health Multicultural Working Group to invite DSANT to present at Grand Rounds which is an educational meeting that focuses on consumer experience and diversity in healthcare
- f) NT Health intranet document collection
- g) NT Regional Health Service e-bulletin.'

I am satisfied that the Acting CEO of DCF and the CEO of the DoH have considered the recommendations of the Territory Coroner and that they have responded to the recommendations.

DATE: 18 SEP 2025



MARIE-CLARE BOOTHBY

The Hon Marie-Clare Boothby MLA  
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File reference  
EDOC2025/193045

Dear Attorney-General

## INQUEST INTO THE DEATH OF BABY G [2024] NTLC 16

Section 46B (3) of the *Coroner's Act* requires Northern Territory Health to provide a written response to the coroner's recommendations to enable the Attorney-General to table a report to the Legislative Assembly.

I provide you the following statement of action taken by Northern Territory Health in relation to the three recommendations.

**Recommendation 133:** that NT Health promote the Australian Pregnancy Care Guidelines with all health practitioners.

**Response:** NT Health partnered with South Australia Perinatal Practice Guidelines (SA PPG) in 2023. Staged adoption of SA PPG is underway in the NT maternal and newborn networks.

**Recommendation 134:** that NT Health, in consultation with Miwatj and other appropriate Aboriginal health care providers, consider how, and in what circumstances, NIPT testing can be made freely available to pregnant women, particularly those in remote locations, and make all reasonable endeavours to secure funding for and facilitation of the provision of free NIPTs where identified as appropriate.

**Response:** This work is being led by our Clinical Excellence and Patient Safety Unit.

NT Health has funding identified to NIPT test women in Top End and Katherine regions. At this stage, over 20 women have been tested. The work has involved training for all staff, development of documents to perform the testing; and implementation.

NT Health is concluding discussions with the Senior Project Coordinator, Reproductive Epidemiology at Murdoch Children's Research Institute to evaluate the program which is in the final stages of ethics approval.

**Recommendation 135:** that NT Health and Territory Families work together with the Down Syndrome Association (NT) to ensure that staff working with children are aware of the available services and referral pathways to that Association.

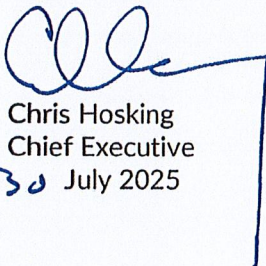
**Response:** The Department of Children and Families and NT Health are working with the Down Syndrome Association (DSANT) for the provision of information about their services and referral pathways. NT Health has disseminated the DSANT Hospital Program and its Service Delivery Report through relevant media and intranet and to teams within the respective Departments:

Department of Health:

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- f) NT Health intranet document collection
- g) NT Regional Health Service e-bulletin

Should you require any further information, Ms Fiona Wake, Executive Director Clinical Excellence and Patient Safety, NT Health can be contacted at [Fiona.Wake@nt.gov.au](mailto:Fiona.Wake@nt.gov.au).

Yours sincerely



Chris Hosking  
Chief Executive  
30 July 2025