MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

RECORD OF INVESTIGATION INTO DEATH (WITH INQUEST)

Coroners Act 1995

Coroners Rules 2006

Rule 11

(These findings have been de-identified in relation to the names of the deceased, family, friends and others by direction of the Coroner pursuant to S.57(1)(c) of the Coroners Act 1995)

Hearing Dates:

21, 22, 23, 27, 28, 29 January 2015 and 4 March 2015; submissions received by 1 April 2015

Counsel:

Counsel Assisting the Coroner: Garth Stevens

Counsel for the mother of Child 4: Kate Mooney

Counsel for the carers of Child 5: Greg Barns and Caroline Graves

Counsel for the mother of Child 6: Craig Mackie

Counsel for the State of Tasmania: Paul Turner

Counsel for Davies Brothers: Damien Geason and Daniel Zeeman

Counsel for the accommodation facility: David Barclay

Counsel for Christine Boyce: Audrey Mills

Introduction

Joint order for inquest

As delegate of the Chief Magistrate under the *Coroners Act* 1995, I made a direction that the deaths of six young persons be investigated at the one inquest. I made the direction because there appeared to be various common issues for consideration surrounding their deaths. The young persons were all under the age of 18 years. Four of them had significant contact with Child Protection Services, including one young person being the subject of a Child Protection Order. Questions arose in each case as to whether the response to notifications and/or care and protection, was adequate. Three deaths occurred during periods of media publication relating to the earlier death of another young person. Questions arose as to whether "contagion" had occurred as a result of the publicity, and as to media reporting of suicides generally. Further, issues arose as to whether the care, treatment and support of the young persons were adequate, and whether appropriate services were available to them for the treatment of their mental health and to minimise their risk of suicide.

Requirements for Findings under the Coroners Act 1995

The scope of my findings is governed by section 28 of the *Coroners Act* 1995, which states:

28. Findings, &c., of coroner investigating a death

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*; and
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.

4. A coroner must not include in a finding or comment any statement that a person is or may be guilty of an offence.
5. If a coroner holds an inquest into the death of a person who died whilst that person was a person held in custody or a person held in care or whilst that person was escaping or attempting to escape from prison, a secure mental health unit, a detention centre or police custody, the coroner must report on the care, supervision or treatment of that person while that person was a person held in custody or a person held in care.

I have dealt with the findings under section 28(1) (a) – (e) in respect of each young person separately. Their experiences, mental health issues and their need for treatment and support provides me with the proper basis upon which to make comment about prevention of suicide in young persons generally, including mental health services available to young people in Tasmania. Similarly, the evidence of the witnesses, including professional witnesses, has allowed me to make recommendations pursuant to section 28(2) of the *Coroners Act* 1995.

I express my appreciation to the families for their courage and patience leading to, during and after this inquest. They have allowed the lives and deaths of their children to be the subject of the inquest in the hope that improvements might be made to assist young people at risk of suicide, and therefore to prevent youth suicide. I also thank the other professional witnesses, both those who had contact with the young persons, and those who gave valuable evidence to assist me in my findings. I am most grateful to Mr Stevens, counsel assisting. I also appreciate the assistance given by all counsel to their clients and to the Court.

I express my sincere sympathy to the families, carers and loved ones of Child 1, Child 2, Child 3, Child 4, Child 5 and Child 6.

Terminology

In these findings;

CPS refers to Child Protection Services; the term is used in a general sense to refer to the child protection system and its staff.

CAMHS refers to Child and Adolescent Mental Health Services;

GP refers to **"**general practitioner";

IAST refers to Inter-Agency Support Team;

ACF refers to Australian Childhood Foundation; and

DEM refers to the Royal Hobart Hospital Department of Emergency Medicine.

Publication of Findings

These findings will be published on the Magistrates Court of Tasmania website in a de-identified form to accord with the suppression order and to protect the privacy of the young persons and their families. Therefore, names have been changed, verbatim quotations and submissions altered and significant redactions have occurred.

CHILD 1

I find, in accordance with section 28(1) of the Coroners Act, that:

(a) The identity of the deceased is to be known as Child 1;

(b) Child 1 died in the circumstances described in this finding;

(c) Child 1 died in December 2010 in southern Tasmania;

(d) Child 1 was a high school student.

Background

Child 1 was the third child of parents. An older sister was particularly close to Child 1 and gave evidence at the inquest. She described her sibling as a sensitive child who would not harm others and who could be spontaneously funny. The evidence indicates that Child 1 was intelligent and engaging.

When Child 1 was between 12 and 18 months old, the child's father, who had a history of suicide attempts, tried to take his life in the garage of the family home. The father was located by a daughter and was taken to the Royal Hobart Hospital for treatment. Between 1996 and 1997 Child 1's mother and father divorced and the children lived with their mother. There was a history of violence in the relationship between Child 1's mother and father.

When Child 1 was about six years of age, Child 1's niece, who was residing with the family died. Child 1 witnessed the response to the death and became very distressed. Child 1 started to see the school psychologist at this time.

In 2001 Child 1's father took his life by hanging himself at his residence. The suicide of the father had a profound effect on Child 1, who was well behaved and obtaining good marks at school. Child 1 then began to behave differently, becoming a manipulative child who was difficult to control at school.

In 2001 Child Protection Services (CPS) was first notified in respect of Child 1. The notification related to the mother's excessive use of alcohol and the significant grief being experienced within the family following the death of the father. CPS received many additional notifications throughout Child 1's life. From a very young age Child 1 spoke of ending his/her life. The mother states that when Child 1 was between seven and nine years of age Child 1 would often threaten to kill himself/herself.

In November 2003 Child 1 was diagnosed by workers of Child and Adolescent Mental Health Services (CAMHS) with adjustment disorder. This resulted in various supportive treatments and mediation sessions with the mother. These sessions were aimed at dealing with Child 1's complex feelings about and interaction with the mother and to provide support.

Following an argument with the mother in November 2007, Child 1 left home and began living in group youth shelters. In 2007 and 2008 CPS received nine notifications about Child 1's behaviour and welfare. Child 1 was frequently involved with police due to criminal behaviour and drug use. CPS enquiries with the mother of Child 1 determined that she was regularly unable to provide emotional, financial or practical support for Child 1.

For the three years prior to death, Child 1 resided at various locations including on the streets, group homes, and his/her mother's home. During this time Child 1 could spend up to six months without contact with the mother. At other times Child 1 would come and go from the mother's house as they pleased and she would see him/ her each morning and night.

Police records show that Child 1 was the subject of 64 police reports between 2007 and 2010 for anti-social and offending behaviour.

Child 1 had further contact with CAMHS in September 2009 when they presented with anger difficulties and mood deregulation. No psychiatric disorder was identified at that assessment. Child 1's mental state was again assessed in February 2010 by a psychologist at CAMHS, following an incident of self-harm with suicidal ideation. Child 1 told the psychologist that he/she experienced chronic suicidal ideation and wanted a painless way to die. However, Child 1 did not articulate a plan. No features consistent with a mood or anxiety disorder were deemed present at that time.

In January 2010 Child 1 commenced contact with a female friend via Facebook. By March 2010, they had entered an intimate relationship, with Child 1 moving in with the friend's family shortly thereafter. The relationship started to have problems in May 2010.

The friend became aware that Child 1 was speaking with other females on Facebook and she did not appreciate it. In August 2010, Child 1 deliberately cut the back of his/her arm after a fight with the female friend. The friend stated in her affidavit that Child 1 would speak of ending his/her life but the friend did not think Child 1 would actually do it.

In December 2010 the female friend discovered that Child 1 had a second Facebook account which they was using to 'chat up' males. The friend approached Child 1 about the matter and Child 1 admitted to being bi-sexual. The relationship ended and Child 1 went to stay with the mother and older sister. The sister stated in her affidavit that Child 1 was very upset about the breakup and made threats to self-harm. She spoke to Child 1 about counselling, but they indicated that they were not interested.

Also in December 2010 an ambulance was called to Child 1 as she/he had consumed a large number of Nurofen tablets in an attempt to self-harm. Child 1 was taken to the Royal Hobart Hospital but refused treatment and left. They were located by police

shortly after leaving the hospital and again refused treatment. Child 1 did not appear to police to be under the influence of any drugs or other substances. On that occasion, Child 1 was taken back into the care of the older sister. CPS was notified of this event and responded by referring Child 1 to Gateway Services for ongoing support.

Circumstances Surrounding Death

Before and at the time of death Child 1 was living with the mother, older sister and the sister's three young sons. Child 1 stayed in a shed at the rear of the property.

Later in December 2010 the female friend's father received a text message from Child 1 which read *"If I do die in my last wishes it has that [the female friend] gets my laptop and something else without question to remember me by".* The female friend's father was concerned and met up with Child 1 at a public library. They spoke about Child 1's relationship with the female friend. Child 1 said that he/she could not love anyone as he/she loved that friend.

Subsequently, Child 1 sent the friend a text message: *"I hope you are happy now, I'm going to kill myself. You won't have to put up with me now. It's all your fault"*.

Child 1 visited another friend on that day. Child 1 told this other friend that they were bi-sexual as well as mentioning suicide. The friend stated in his affidavit that Child 1 had been speaking of suicide to him intermittently for the previous five months.

Following a Facebook conversation between Child 1's female friend and AE on the same day, AE contacted police concerned for Child 1's welfare. Neither friend had been able to contact Child 1 by telephone.

On the following day, child 1's older sister looked out into her backyard and noticed the door to the main shed was shut (which was unusual) and that the shed door to Child 1's shed was open with the light still on. She went straight to the main shed door and opened it. Child 1 was found apparently dead. The sister called emergency services.

Upon the arrival of police and ambulance officers Child 1 was lying on the floor. It was determined that Child 1 was deceased. A note was located at the scene that indicated that they were intending to take their own life and included intentions regarding disposition of their property.

Dr Donald Ritchey, forensic pathologist, performed an autopsy upon Child 1. I accept his conclusion as to cause of death.

Toxicological results showed that there was no alcohol or drugs detected in Child 1's blood.

Conclusions Regarding Death

The circumstances of Child 1's death have been thoroughly investigated. I am grateful to investigating officer Constable Bryan Powell. I am satisfied that there were no suspicious circumstances surrounding Child 1's death and that there was no other person involved.

I find that Child 1 had clearly formed the intention to die and understood the finality of death. Tragically, Child 1 had chronic suicidal ideation that was particularly pronounced in the months before his/her death. They had attempted previously to take their life and engaged in self-harm. At an early age they foreshadowed taking their life in the same manner as the father. Child 1 was a severely troubled young person. His/her school psychologist, Rebecca Strong, gave impressive evidence to the inquest. She saw Child 1 in 2008, 2009 and 2010 on about 30-40 occasions. She stated that, for Child 1, the main issue was unresolved grief over the father's suicide. She also noted that Child 1 was unable to recover a bond with the mother and had ongoing anger towards her. She noted that the other risk factors for Child 1 included the death of his/her niece, disengagement from school, criminal activity and substance use. She stated that there were few protective factors. I accept Ms Strong's evidence. Her work with Child 1, including the development of individualised programs for him/her at school and connecting him/her with other supports, was dedicated and comprehensive. Unfortunately, Child 1 was not engaged in therapeutic intervention at the time of death or in the preceding months, due to non-attendance at school. The evidence indicates that the break up with the female friend was the final event that caused Child 1 to take the action of ending their life.

Child 1 was also supported from 2009 until his death by the Tasmania Police Inter-Agency Support Team (IAST) as a result of his/her offending behaviour. This process brought together a number of organisations in a coordinated response to assist Child 1 with their problems and with the aim of reducing their contact with police. I note that CPS was involved with the IAST. However, the evidence indicates that no CPS

representative attended the IAST meetings after 19 February 2010. The evidence does not allow me to determine why this was the case. It would have been a very valuable forum in which to gain knowledge of Child 1's current situation. A range of other services assisted Child 1 intensively over the course of his/her life. The inquest did not focus in detail upon the significant efforts by all of these services. It appears that they attempted as best as they were able to treat and support Child 1.

Child Protection Services

Child 1 was known to CPS since 2001 and on an ongoing basis since that time. CPS was aware of Child 1's multiple risk factors, homelessness and troubled behaviour. In particular CPS received 21 notifications in respect of Child 1 between 2007 and 2010. CPS was required to assess the extent of risk to Child 1, respond to the notifications and protect Child 1 in accordance with its mandate under the Children, Young Persons and their Families Act 1997. I deal with the actions and response of CPS under the heading "Recommendations and Comments". I have concluded that, in several respects, the investigation and assessment of risk and response was inadequate. I am not able to find that Child 1 would not have died if CPS decision making had been different.

CHILD 2

I find, in accordance with section 28(1) of the Coroners Act, that:

(a) The identity of the deceased is is to be known as Child 2; Child 2 died in the circumstances described in this finding;

(b) Child 2 died in June 2013 in southern Tasmania;

(c) Child 2 was a high school student.

Background

Child 2's separated in 2001. Child 2 lived with the mother and the father moved interstate and had little to do with Child 2 until 2009. Both parents served time in prison contributing to a fractured childhood for Child 2. Child 2's maternal grandparents provided primary care for Child 2 for periods of time given the unstable home environment. Child 2 often witnessed family violence and drug related violence at the home. Child 2 was described as vibrant, articulate and fiercely loyal by the mother.

From 2000 Child 2 was the subject of CPS notifications. These related initially to her/his exposure to family violence and possible drug use by the parents. Subsequently, the notifications related to his/her own troubled behaviour, non-attendance at school, and relationship difficulties with the mother and inappropriate relationships with older males. From February 2005 until her death Child 2 was the subject of 35 police reports, 9 of which included referrals to CPS.

In December 2008, Child 2 was first seen at the Royal Hobart Hospital (RHH) as a result of having suicidal thoughts.

In October 2009 Child 2 presented at the RHH having cut her/ his arms. Child 2 also told medical staff that she/he had tried to drown themselves and wanted to die. There is no evidence from family members that Child 2 did in fact attempt to drown himself/herself, and I cannot make such a finding. However, this admission provides insight into his/her mental state at the time.

Also in 2009, Child 2 was very seriously sexually assaulted by an 18 year old male. The male was later convicted of having sexual intercourse with a person under 17 years

old. The assault affected Child 2 deeply and she/he did not attend school for the next six months. It was during this time that the mother recalls Child 2 first saying that they wanted to kill themselves.

In 2009 Child 2 attended the RHH for psychiatric assessment and was diagnosed with Post Traumatic Stress Disorder. Child 2 was then referred to CAMHS.

Between 2009 and 2012 Child 2 underwent 63 sessions of psychotherapy with Clare House (CAMHS) mental health social worker, Jai Friend. During the counselling period there were regular reviews of individual treatment, supervised by a consultant psychiatrist. Anti-depressant medication was trialled for Child 2 but not found to be effective. The therapy sessions with Ms Friend concluded about six months before Child 2 died. Child 2 had, by that stage, made good progress and decided that they no longer needed therapy. Child 2 was informed that he/she should contact Ms Friend if he/she felt that he/she needed further counselling.

From 2009 onwards, Child 2 continued engaging in risk-taking behaviours including drinking alcohol, some minor criminal activity, non-attendance at school and having unprotected sexual intercourse and relationships with much older people. The medical reports indicate that Child 2 had ongoing health concerns including recurring tonsillitis and medical complaints related to promiscuity.

In 2010 Child 2 lived in a refuge. During the stay Child 2 once consumed mirtazapine and was found drowsy by staff and taken to the RHH. Child 2 expressed a desire on this occasion “not to wake up”. Later that year Child 2 was sexually assaulted in a park by a male who attended Child 2’s school.

In 2012 Child 2 began a relationship with a 20 year old man who was later charged with having sexual intercourse with a person under 17 years old.

Child 2 attempted to complete high school at a number of schools but failed to complete Year 10. The evidence is that Child 2 found it hard to form relationships with teachers and peers due to oppositional behaviour.

In her comprehensive report, Ms Friend described her approach to the therapy provided to Child 2 and the very significant improvement in Child 2 by mid-2012. Ms Friend stated that Child 2 no longer experienced thoughts of suicide, had made positive gains in functioning, had a good relationship with the mother, was engaging in a range of

activities and was able to regulate emotions. The mother confirmed the improvements in Child 2.

Child 2 commenced a traineeship at a Hobart-based salon which was looking promising for Child 2's future employment.

In 2013 Child 2 began a stable relationship with a 21 year old person whom she/he loved.

Child 2 received contact from the father approximately six months before her/his death. The mother understands the subject of this contact to be regarding his offer to pay for Child 2 to visit him. On the day of her/his death, the father told Child 2 that this was not able to happen and that Child 2 should find their own way there. Child 2 would often ask the grandmother for money, as is common for teenagers. Child 2 asked the grandmother to pay for Child 2 to visit the father. The grandmother and mother did not think that it would be a good idea for Child 2 to reconnect with the father in this manner given the violent history and Child 2's already fragile state. Therefore the request for funding the travel was declined. The mother wanted to travel with Child 2 and stay somewhere close while Child 2 visited the father so that she could be there for Child 2 if things did not go smoothly.

In early 2013 when Child 2 was living once again with the mother, the mother allowed another young person to live with her and Child 2.

Child 2's relationship with the mother was, at times, strained but they were close and trying to work on their relationship towards the last years of Child 2's life. The mother felt that the dark times were behind them and they were gaining successful results with Relationships Australia's Reconnect Program before Child 2 died.

Circumstances Surrounding the Death

Several days before the death Child 2 attended the mother's place of work in the late afternoon, and then returned home and cooked dinner.

After returning home Child 2 began texting her/his boyfriend. Child 2 appeared to be angry at the grandmother for not providing money for Child 2 to visit the father. Child 2 soon commenced in the texts to express suicidal intentions, making such statements as "I just want to die, I don't see the point any more".

Later that evening the young person who lived with Child 2 and the mother arrived home and saw Child 2 in her bedroom. Child 2 was also observed by the mother watching a DVD on a laptop in the bedroom.

Late that evening the young person who lived with Child 2 and the mother heard the laundry door shut believing Child 2 was going to do laundry. The mother found Child 2 apparently dead just before midnight.

A neighbour came to help after hearing the mother's screams. CPR was performed on Child 2 until ambulance officers arrived and took Child 2 to the Department of Emergency Medicine at the RHH. Child 2 was unconscious and in a stable but critical condition. Child 2 survived only in a comatose state and dependent upon a ventilator.

Several days later Child 2's life support was ceased. Dr Donald Ritchey, forensic pathologist, performed an autopsy upon Child 2. I accept his conclusion as to cause of death.

Dr Ritchey observed no defensive or restraint type injuries, but did observe numerous horizontal superficial incised injuries and scars on Child 2's left forearm consistent with self-harm. I note that toxicological testing of Child 2's blood prior to death revealed that no drugs or alcohol were present.

Conclusions Regarding Death

The mother stated that on previous occasions of cutting and ingesting pills, Child 2 would notify her immediately so that she could save Child 2. The mother believes that Child 2 intended the mother to save her/him. Understandably, the mother questions whether Child 2 intended to end their life or whether in fact child 2 was engaging in risk taking behaviour. The mother also expressed concerns that Child 2 may have been

encouraged to take the actions they did by the young person living with them. This aspect has been further investigated with no evidence to suggest this to be the case.

Police officers attending the scene found no evidence that would indicate suspicious activity or the involvement of any other person in Child 2's death. I accept this evidence.

I am satisfied that Child 2 had the intention to end their life and that they understood the finality of death. Child 2's mood had declined over several hours. It may have been that Child 2's intention to actually end their life was formed impulsively.

In the months prior to Child 2's death a strong friendship that Child 2 had with a female friend broke down such that the two no longer spoke. The mother stated she thinks this would have affected Child 2 deeply because they were very close.

It appears that Child 2 was upset at the inability to travel to see the father; however, Child 2's life generally had become positive and promising. The counselling with Ms Friend assisted Child 2 greatly. However, Child 2 had grown up as a traumatised child witnessing family violence and in a family with intergenerational dysfunction. Child 2 also suffered harm by being sexually assaulted. The damage was severe, and even though her improvement was manifest, Child 2 took their own life in most tragic circumstances. The family were shocked and did not expect Child 2 to take their own life at the time or in the manner that they did.

Child Protection Services

Child 2 was the subject of CPS notifications since he/she was four years of age and on an ongoing basis since that time until death. CPS was aware of Child 2's multiple risk factors and CPS was required to assess the extent of risk, respond to the notifications and protect Child 2 in accordance with its mandate under the *Children, Young Persons and their Families Act* 1997. I deal with the actions and response of CPS under the heading "Recommendations and Comments". I have concluded that, in several respects, the investigation and assessment of risk and response was inadequate. I am not able to find that Child 2 would not have died if CPS decision making had been different.

CHILD 3

I find, in accordance with section 28(1) of the Coroners Act, that:

(a) The identity of the deceased is to be known as Child 3;

(b) Child 3 died in the circumstances described in this finding;

(c) Child 3 died in September 2013 in southern Tasmania; and

(d) Child 3 was a high school student.

Background

Child 3 was the youngest of eight siblings, all being half-siblings. The mother, died in 2006, as a result of cancer. Child 3's parents had separated in 2003 and the father had left the family home.

In 2005 a family friend involved in the care of Child 3 and the siblings notified the father that it was no longer safe for Child 3 to live at the family home with older siblings due to their alcohol and drug use. Child 3 then moved in with the father. The evidence indicates that Child 3's life with the father for the following six years was relatively stable.

In about 2011 Child 3's behaviour began to change and she/he started to stay at the houses of friends rather than at home with the father. School attendance also dropped significantly.

In late 2011, Child 3 stayed the night at the home of a boyfriend. The father was concerned about this fact and approached the father of the boyfriend. Child 3 then refused to return to live with the father. At this time Child 3 told the boyfriend's father, that her/his father was physically abusive to her/him, in that the father would regularly hit her/him. Child 3 subsequently made similar statements about the father to various adults and organisations assisting with her/his care.

I am unable to find to the requisite standard that the father was, in fact, physically abusive to Child 3. There is no independent corroboration of such physical abuse. I accept that Child 3 made such allegations. The father strongly denies them. Child 3's aunt gave evidence to the inquest. She stated that, on the basis of her knowledge of the

father and Child 3, she did not accept such allegations. She stated that the father cared for and indulged Child 3. It is apparent, however, that the relationship between Child 3 and the father may have been strained and difficult for the father to maintain during Child 3's early teenage years. I am simply unable to determine on the evidence whether there is truth in the assertions or, if not, the reasons why Child 3 made the statements.

The evidence indicates that Child 3 disclosed to a high school counsellor that she/he had suffered suicidal thoughts and engaged in self-harm from the age of 10 years. Child 3 gave her/his psychologist the same information in 2012. It is difficult to determine what other crucial early childhood factors may have contributed to Child 3's unhappiness, even while the mother was still alive. However, there is ample evidence that the death of the mother and Child 3's unresolved grief caused great ongoing distress.

From 2011 Child 3 began a path of risk taking behaviour, including sexual relationships with older males, cannabis and alcohol abuse and school non-attendance. From this time onwards, Child 3's living arrangements greatly contributed to her/his anxiety, depression, anger and poor self-concept. In particular, whilst Child 3 was living with her adult siblings Child 3 suffered neglect of her/his physical and emotional needs, this fact being well-documented. In particular, one of the sisters who took on a guardian role in respect of Child 3 had significant mental health issues as well as two young children of her own. Child 3 did not want to live with the father and grieved for the mother. Child 3 craved a loving family and a sense of order. Yet, Child 3 lived in an environment of chaos, substance abuse and was often without sufficient food. Child 3 regularly spoke to support persons of the unhygienic state of the home. Child 3 had no appropriate, supportive role model within the house.

Child 3 attended four separate high schools before her/his death. Attendance at school deteriorated despite the school counsellors actively attempting to assist her/him with her/his difficulties. In particular the counsellors from her/his last school made concerted efforts to assist Child 3 and to try and engage them.

In 2012 Child 3 was involved in a same-sex relationship for a short period. Child 3 also formed a relationship with a 20 year old person, who had moved into Child 3's siblings' home and who was a friend of Child 3's brother. The relationship was reported by police to CPS. During this same year Child 3 was allegedly exposed to an older sister's self-harm and suicide attempt.

Child 3 was the subject of 20 police IDM reports during her/his life mostly concerning homelessness, substance abuse, inappropriate relationships and troubled behaviour. Police made 7 referrals to CPS from these reports.

From 2007 Child 3 was the subject of CPS notifications. In total there were 12 notifications in respect of Child 3. The first notification was by police and related to the lack of guidance for the family and the grief reactions of the children subsequent to the death of their mother. The later notifications from 2011, specifically relating to Child 3, involved her/his risk taking behaviour, lack of an effective guardian, lack of engagement at school, and the mental health issues involving self-harm and suicidal ideation.

In December 2012, Child 3 overdosed on 'No Doz' tablets and Red Bull energy drinks. Child 3 told those assisting her/him that this was not an act of self-harm but an attempt to "get high". Child 3 was admitted to hospital but discharged as the risk of self-harm was assessed as low by the treating doctor. In this context, police records indicated various incidences where Child 3 was found heavily intoxicated in the streets and public places.

In 2012 Child 3 also began living at an accommodation facility for homeless young women. This was the first of four separate periods of residence at this accommodation facility through 2012-2013. After the first stay at the accommodation facility it appears that Child 3 became unwilling to comply with the facility's restrictions relating to Child 3's boyfriend sleeping there, and Child 3 moved into the home of an adult female in early 2013. This female was not registered as a foster carer and this living arrangement was, on its face, a largely unsupervised environment for Child 3. Child 3 also, at times, moved back to the house of the siblings between the stays at the accommodation facility.

In 2013 Child 3's relationship with the boyfriend ended as a result of his alleged infidelity. Child 3 was heartbroken. The boyfriend was later charged with maintaining a sexual relationship with a young person (Child 3) and I find that the charges also significantly impacted on Child 3's emotions. Child 3 did not want to see the boyfriend charged.

Child 3 continued to live between her/his siblings' home, the home of the adult female friend and the accommodation facility. The returns to the accommodation facility were

brought about by the lack of food in the family home or the feeling of not being safe or nurtured by siblings.

During 2013, Child 3 was allegedly sexually assaulted twice and allegedly raped once. I accept, regarding the allegation of rape, that at the very least Child 3 and a male associate had sexual intercourse. The male associate stated to police that the intercourse was consensual and that Child 3 had seduced him. Police investigation occurred in respect to these reported incidents but Child 3 did not wish charges to be laid. Therefore no charges were laid for any of these incidents.

Circumstances Surrounding the Death

In 2013 Child 3 reported to police that a male friend, B, forced himself upon her/him in public toilets despite protests. Child 3 stated that he forced her/him to have intercourse. This is the allegation of rape that I have referred to above. Child 3 did not wish to make a formal report to charge B, particularly as Child 3 was also friends with B's girlfriend, RF. Further witness statements obtained by police indicated that the sexual activity may have been consensual. I cannot determine exactly what occurred in respect of this incident. However, it led to reprisals against Child 3 by RF.

Also in 2013 2013 Child 3 was advised that the ex-boyfriend had been charged with maintaining a sexual relationship with a person under the age of 17 years. He had been bailed with conditions not to approach Child 3. Child 3 was very upset upon being advised that the ex-boyfriend had been charged.

Child 3 expressed to staff of the accommodation facility that she/he wanted to enquire into living with a foster carer. Consequently, the accommodation facility contacted CPS that day. The staff member at the accommodation facility explained to the CPS worker that Child 3 was interested in a foster care placement. The accommodation facility staff member expressed the importance of Child 3 being allocated a CPS worker as Child 3 wanted to get their life back on track, but needed support to do this. The staff member further stated that the accommodation facility was not the best place for Child 3 to be. The child protection worker told the staff member that she would review Child 3's case and speak with her team leader and then return contact with the accommodation facility.

In the days leading to her death Child 3 also received abusive messages from a sister denigrating the sexual behaviour and drug use and stating that Child 3 was ruining their

own life. Although the investigation did not recover these messages from any device, I fully accept the evidence of Child 3's friends and the accommodation facility staff regarding the content of them and the upset experienced by Child 3 upon reading them.

In September 2013 Child 3 was assaulted by RF (associate previously referred to) who alleged that Child 3 had had sexual intercourse with her boyfriend, B. There were later statements by RF that she would post the film on social media. Child 3 was embarrassed and distressed at the prospect that the film would be posted.

Also in September, the accommodation facility staff member called CPS to follow up on the proposal for Child 3's foster care that had been initiated by the facility eight days previously. No response had been received from CPS during that time. At this time the staff member left a message again for CPS to make contact to progress Child 3's need for a stable home.

On that same day, Child 3 left school early claiming that they felt unwell. That same afternoon Child 3's friendship group from the accommodation facility walked to a nearby school oval to chat and drink alcohol. Two of the friends stated in their affidavits that they felt that Child 3 was sad that evening but that Child 3 did not often voice their emotions. One of the friends left the oval early to return to the accommodation facility by the curfew time. The remaining three friends returned intoxicated at approximately 7.00pm and were refused entry. One friend was particularly intoxicated and was taken by police to the Royal Hobart Hospital. The remaining friends, including Child 3, were let inside. They were spoken to by staff about their behaviour and were sent to their rooms. Before going to the room, Child 3 asked staff for a cigarette but was refused and went straight to the room in an unhappy mood.

Later that evening Child 3 was found by a staff member apparently dead. The staff member immediately commenced CPR and asked another member of staff to call an ambulance. When paramedics arrived they made a lengthy attempt at reviving Child 3 but were unable to do so. They then determined that Child 3 was deceased.

Dr Donald Ritchey, forensic pathologist, performed an autopsy upon Child 3. I accept Dr Ritchey's opinion as to cause of death.

Dr Ritchey noted that Child 3 had superficial cuts to her/his wrist consistent with self-harm. Toxicology testing showed that Child 3 had a blood alcohol content of 0.08

g/100ml. This result is consistent with Child 3's observed state of intoxication before death.

Police officers attended the accommodation facility and commenced an investigation into the circumstances of Child 3's death.

Child 3 left notes on the bed addressed to those close to her/him that categorically indicated a desire to die. To a sister, for example, Child 3 stated; *"I'll be looking down on you with mummy soon. I'm just sorry I'm not strong enough to keep going. We all have to go some time and now is my time".* To a friend, Child 3 stated; *"I'm sorry that it's too late for me. The devil took me a long time ago. Now it's time for me to leave."*

After a full examination of Child 3 and the scene, attending officers concluded that no other person was involved in the death. Having reviewed and heard the evidence, I accept that this is the case.

Conclusions Regarding Death

Child 3 led a life of risk taking, self-harm and habitual association with people who were not a good influence upon them. Some of her/his friends also had serious mental health issues and suicidal ideation. Child 3 saw counsellors, psychologists and social workers intermittently but did not engage sufficiently to make good progress in overcoming grief, a state of anxiety and unhappiness, or substance abuse. The efforts of the accommodation facility, Headspace and her schools, to help Child 3 should be recognised. Whilst Child 3 did not fully engage with the assistance offered to her/him, these organisations did their best to maintain engagement with Child 3 and address her/his difficulties. The police also acted professionally and responsibly in dealing with Child 3 and referring matters to CPS. Child 3's aunt, in her evidence and submissions, makes some pertinent points regarding how services could have better assisted Child 3. She submits principally that there was a lack of coordination between the services, a failure by CPS to care and protect Child 3, and a lack of communication with and sidelining of Child 3's father and legal guardian. I will deal with her submissions further in this finding.

I am satisfied that Child 3 was fully aware that death would be or was likely to be a consequence of their actions. Those who knew Child 3 stated that she/he had good insight into what she/he wanted and needed; and felt sad and distressed when she/he

could not obtain the love and nurturing that she/he required. Child 3 was an intelligent and caring young person who expressed desires for a future involving an education, the love of family and a settled home. Child 3 was motivated to cease cannabis use and was making good efforts in that regard. Child 3 may or may not have realised the extent to which other risk taking behaviours were impacting on her/his health and wellbeing but felt somewhat powerless to change them. There were a number of serious risk factors present in Child 3's life - the unresolved grief and loss of the mother; drug and alcohol abuse; sexually risky behaviours and possible sexual abuse; homelessness and instability of care; dysfunctional family relationships; and a history of self-harm and suicidal thoughts.

The evidence does not permit me to ascertain Child 3's thoughts that lead to the ultimate decision to take their own life. Child 3 was desperately unhappy and longing for a loving family environment. Child 3 does refer in her last writings to being heartbroken with the only person she/he had let into her/his "little cocoon" having left them without hope. This reference must be to the ex-boyfriend.

Child 3 had not presented to the staff at the accommodation facility as suicidal and the death came as a great shock to them. I accept that it could not have been predicted that Child 3 would take their life at that time. This also accords with Child 3's last consultation in August with Dr Alison Edwards, a medical practitioner at Headspace. At that consultation Dr Edwards noted that Child 3 was lacking motivation and was finding it hard to get to school but did have a desire to continue education and attend university. Child 3 told Dr Edwards that they were so disappointed and sad that the family had basically left them abandoned and that they had had to fend for themself so long. Dr Edwards noted that there was no issue of bullying that appeared to be troubling Child 3. She stated that Child 3 appeared to be coping well and appeared to not be at risk of suicide. Child 3 told her that the accommodation facility was "okay" but they wanted their own place to feel settled and stable. Dr Edwards stated that she assessed Child 3 as a mature young person, living in secure accommodation, and gaining confidence in being independent and actively developing positive plans for the future. There was no indication at presentation that Child 3 was suicidal. I note that Child 3 did not attend a further scheduled medical health check with Dr Edwards in August 2013 nor a psychologist's appointment arranged for Child 3 by Headspace in September (incidentally, on the day of the death). However, the Headspace report indicates that Child 3 missed half of their scheduled appointments and was reluctant to engage with

psychological assistance. Thus, the missed appointments were not regarded as an unusual occurrence.

I extend my appreciation to investigating officer, Constable Marisa Milazzo, for her thorough and comprehensive report to me. I also acknowledge the substantial assistance provided by Constable Stephen Evans. The time that they have spent obtaining the evidence, and verifying its accuracy on every aspect of the investigation has been invaluable.

Role of Bullying in Child 3's Death

Shortly after Child 3's death, Child 3's sister, was instrumental in founding an anti-bullying campaign. The campaign has an anti-bullying message and seeks to agitate for implementation of anti-bullying laws. The campaign is based on the premise that Child 3 had been bullied for much of her/his life, and ultimately ended her/his life because of bullying. The campaign was given significant media prominence. The campaign also has a website promulgating the same message.

The investigating officers, as part of the investigation, specifically investigated the issue of whether Child 3 was the subject of bullying by peers, and if so, whether such bullying was a reason for Child 3 taking their life. In such investigation Child 3's school records have been obtained and analysed, and reports and affidavits obtained from those who might assist with this aspect of the investigation. I am also satisfied that all attempts have been made to forensically analyse electronic devices for any evidence that Child 3 took their own life because of being bullied.

Ultimately, I cannot be satisfied on the basis of the evidence, that Child 3 was subject to a sustained course of bullying during her/his life, or that acts of bullying were the cause of them taking their own life.

The bullying of vulnerable people, and the ease with which it is able to occur through social media, is a matter that should rightly concern our community and provoke discussion. I cannot discount that there was some concern by Child 3 as to whether the video of the assault by RF would be posted. The people Child 3 spoke to about it stated that it did not greatly concern Child 3. Neither this incident nor any allegations of a sustained course of bullying featured in Child 3's final expressions in writing. Indeed, Child 3's notes conveyed entrenched sadness from the loss of the mother, the feeling of

having lost family love and stability and, finally, the heartbreak at the end of the relationship between Child 3 and the ex-boyfriend.

Media Publication of Child 3's Death

A significant issue in the inquest related to the prominence given to Child 3's death in the media, mostly as a result of the anti-bullying campaign, and whether there was any association between the media publications and the deaths of Child 4, Child 5 and Child 6, which occurred whilst the publicity was still prominent. For the reasons set out further in this finding, I accept the expert evidence that there is an association between media reporting and an increase in suicidal behaviour and an increased risk of copycat behaviour or contagion where the coverage is prominent, gives details of the method or location of the suicide, and where the suicide is glamorised in some way. The deaths of Child 4, Child 5 and Child 6, tragically, bear out such association. As discussed further, I have found that the reporting of Child 3's death did not comply in several respects with the "Mindframe" guidelines designed to minimise the contagion effect.

The Accommodation Facility and Housing Issues

The evidence is that the accommodation facility provides 24-hour supported accommodation for young people between 13 and 18 years who are homeless or at risk of homelessness. It accommodates an average of 50 young people per year. It provides a safe place for a young person to live while they are supported to reconnect with family, education and community, and either return home when safe to do so or move into long term suitable accommodation. As a transitional service, the accommodation facility is not intended to provide long-term accommodation. The staff of the accommodation facility therefore recognised that Child 3 required other suitable and stable accommodation.

Issues have arisen in the inquest in respect of (a) the suitability of this accommodation facility for Child 3; (b) communication by the accommodation facility with Child 3's father as next of kin; (c) the response of CPS to the contact and notifications by the accommodation facility; and (d) the options for stable housing for homeless youth generally, which I will discuss further in this finding.

The specific issue raised by the father of Child 3 and the aunt is whether the accommodation facility could have done more to notify Child 3's father of Child 3's stays

at the accommodation facility, to keep him informed generally and to reconcile Child 3 and himself.

Child 3's father states:

> "During the time that she/he was away from me, no one ever informed me what the story was that she/he was telling people. No one ever asked me to confirm or deny the physical abuse. No one ever checked the home she/he had left or my character and history. When I was contacted by Child Protection (eventually) there was no attempt made to support a family reconciliation. The only motive seemed to be to arrange for family support payments to be transferred elsewhere. This had previously been done via Relationships Australia as well. When I asked professionals in these organisations what I should do to reconnect with my child (sic) they always advised me to "give her/him space" so that I didn't risk pushing her/him further away."

Child 3's father also stated that he lost track of exactly where Child 3 was staying but when he did know he would ring once a week to check on Child 3 and in the hope of speaking to them. He stated that in the last few months of Child 3's life he had begun to see Child 3 again, met Child 3 in the city a few times for coffee and took Child 3 shopping. He stated that he felt helpless and unsure of how to respond when Child 3 told him worrying things about the life they was leading.

I accept the submissions of Mr Barclay, counsel for the accommodation facility, to the effect that the facility should not be subject to criticism on this point. I accept his submission that it is the role of CPS to investigate allegations of abuse, and not the role of the accommodation facility. The facility must take such allegations at face value. In accordance with its guidelines, it must respect the confidentiality of the young person. Evidence was given by Ms Shari Scott, former manager of the accommodation facility and experienced social worker. The evidence was that the practice of the accommodation facility is to notify the legal guardian when a young person requests accommodation and this contact forms part of the eligibility assessment. The exceptions to this practice are either when a young person is in receipt of independent income and also where a young person discloses violence or risk issues. In this latter situation the accommodation facility worker completing the assessment notifies the young person that the facility is a mandated reporter and this information will be passed on to CPS to undertake an assessment of the risk in returning home.

Mr Barclay submits as follows:

> "When a young person (sic) has disclosed risk and is adamant that she/he does not want her/his parent/guardian contacted the accommodation facility will respect her/his confidentiality. The young person is informed that the facility will notify Child Protection, who will let the parent know that she/he is in a place of safety. When working with vulnerable young people, it is critical for staff to build rapport and gain trust. This practice ensures that a young person feels safe to stay at the facility and allows staff to provide ongoing support. Once a trusting relationship is built, workers are then able to broach the subject of contact with a parent/other significant family member to rebuild family ties.
>
> During Child 3's first support period at the accommodation facility where Child Protection had said that the father wanted Child 3 to return home, the facility discussed a supported transition plan to return to the father. Child 3 was adamant that they would not return and live with the father and that it was not safe. Child 3 maintained that the father hit her/him, and said that the father was violent to the mother when Child 3 was alive. Child 3 stated that she/he would not return to her/his fathers to live and she/he did not even like being near the house."

I accept that the above submissions accord with the evidence of Ms Scott, the contemporaneous case notes made by the accommodation facility staff, and the accommodation facility policy documentation. In particular, I am satisfied that the facility staff discussed with Child 3 the relationship with the father generally and the possibility of a reconciliation but Child 3 was adamant at all times the matter was raised that she/he did not want contact with him. The accommodation facility provided accommodation and support for Child 3 in a caring and professional manner and could have done no more in the circumstances.

I do note that, for a reason that was not clear, the accommodation facility had listed a sister and not the father as Child 3's next of kin for Child 3's final support period. It would seem that Child 3 may have provided a different next of kin to the accommodation facility. It may nevertheless have been preferable for Child 3's father to remain listed on the records of the facility as the next of kin. However, the evidence indicates in this period that the father knew that Child 3 was at the facility and that he and Child 3 had both personal and telephone contact.

As a general comment, the inquest did not seek to, and did not, identify any areas of deficiency in the accommodation facility that may have prevented Child 3's death. As stated, Child 3's actions could not have been predicted at that time. It is apparent from the evidence that, most unfortunately, Child 3's death had a significant impact upon both the staff and operation of the accommodation facility. The staff had maintained good communication with CPS throughout Child 3's stays. The documents tendered in evidence demonstrate that the accommodation facility has given detailed consideration to the response to and sequelae of her death for the purpose of preparedness and planning for critical incidents. The accommodation facility is also to be commended for its thoughtful role at the inquest.

Child Protection Services

Child 3 was the subject of CPS notifications since she was nine years of age and on an ongoing basis since that time until her/his death. CPS was aware of the multiple risk factors in Child 3's life, including professional notifiers advising CPS of the unsatisfactory home environment, Child 3's troubled behaviour, as well as self-harming and suicidal ideation. In particular CPS received multiple notifications from police. The report of Ms Shari Scott also shows the diligence with which the accommodation facility staff made contact with CPS regarding Child 3's request for a foster family before the time of death. CPS was required to assess the extent of risk, respond to the notifications and protect Child 3 in accordance with its mandate under the *Children, Young Persons and their Families Act* 1997. Ultimately CPS closed every notification but one in respect of Child 3 at the intake stage without proceeding to further investigation by the response team. I deal more particularly with the actions and response of CPS under the heading "Recommendations and Comments". I have concluded that, in several respects, the investigation and assessment of risk and response was inadequate. I am not able to find that Child 3 would not have died if CPS decision making had been different.

CHILD 4

I find, in accordance with section 28(1) of the Coroners Act, that:

(a) The identity of the deceased is to be known as Child 4;

(b) Child 4 died in the circumstances described in this finding;

(c) Child 4 died in September 2013 in southern Tasmania;

(d) Child 4 was a high school student.

Background

Child 4's parents separated just before Child 4's fourth birthday. The parents' relationship was hostile, and there was an incident of family violence that Child 4 witnessed but was unlikely to have remembered.

The mother describes Child 4 as intelligent, caring and insightful with many friends.

Child 4 was born with dislocated hips and particularly weak knees that frequently dislocated with minimal physical exertion. Child 4's conditions made it difficult for them to be included in any physical education classes or team sports.

During 2002 Child 4's father married after his separation from Child 4's mother. His wife had a son to a previous marriage. I find, based upon Child 4's consistent disclosures, symptoms and evidence of her treating practitioners, that Child 4 was sexually assaulted between approximately the ages of seven and eleven by this boy. Child 4 did not disclose the assaults at the time they occurred. However, the evidence demonstrates that these assaults had a profoundly damaging effect on Child 4.

Child 4 commenced expressing suicidal ideation from a very young age. In 2010 Child 4 made three self-harm attempts over a period of six weeks; all of which resulted in hospital admissions. On the third admission Child 4 disclosed the sexual assaults. Child 4 stated that they wanted to end the pain as well as their own life. At this time Child 4 was aged 14 years and had participated in her/his first consensual sexual encounter with her/his boyfriend. The evidence suggests that this experience may have triggered the memories and effects of the abuse. At this time, Child 4 was diagnosed

with depression, suicidal behaviours, disordered eating, and adjustment disorder after a series of self-harm attempts.

Between 2010 and 2013 Child 4 was admitted to the Department of Emergency Medicine (DEM - RHH) on seven occasions for self-harm attempts.

Notably, in March 2013, Child 4 was admitted to DEM - RHH after having been removed from a bridge by police and stating that they had consumed a large quantity of paracetamol. The admission diagnosis was listed as 'paracetamol poisoning'. Child 4 was treated with an infusion until their paracetamol levels were acceptable. Child 4 was discharged the following day and recommendations were made for a follow up appointment to be conducted by their general practitioner.

Child 4 attended four schools during her life. Child 4 was supported well by the schools, but missed much of high school due to constant and persistent illness. The mother believes Child 4 would continually become ill due to low immunity. Child 4 had largely stopped eating solid foods by 2011 and had dropped weight rapidly. Child 4's eating disorder continued until death.

In 2011 Child 4 commenced to see Dr Christine Boyce, who became their regular general practitioner. The mother describes Dr Boyce as the one continuous support that Child 4 had, and an enormous support to their whole family. Having heard Dr Boyce give impressive evidence at the inquest, I fully accept that this was the case.

Child 4 also saw several psychiatrists, psychologists and counsellors. Child 4 was accepted to Clare House (CAMHS) in September 2010. In general terms, Child 4 found it difficult to consistently engage with CAMHS and with other services. Some of the non-engagement clearly related to her/his physical health. Child 4 did, however, engage very well with Dr Boyce and attended her/his appointments when scheduled.

The evidence suggests that Child 4 regarded the agencies, psychologists and counsellors to whom she/he had been referred as not focussing on what she/he saw as the important issues to address, and believed that some treated her/him like a child. Child 4 wanted to deal with the issues regarding the sexual assaults, but was not ready to speak openly about the subject. It seems that support personnel often focussed on the eating disorder, and that fact caused Child 4 to disengage from the services.

Dr Boyce, who saw Child 4 for a period of three years, indicated that Child 4 suffered from severe anxiety, depression and probable post-traumatic stress disorder as a result of alleged sexual abuse as a child. She also noted Child 4's disordered body image and disordered eating condition. She stated that Child 4 self-harmed by superficial cutting and had "permanent and pervasive suicidal ideation".

Dr Boyce spent significant time setting up a referral for Child 4 to see the Sexual Assault Support Service (SASS), but was very disappointed when that service would not continue to see Child 4 as she/he did not want to discuss the sexual assault. Dr Boyce stated that Child 4 was unwilling to try medication again as part of her/his treatment, but agreed to attend a private clinical psychologist. Child 4 was cheerful and compliant with suggested therapy. It is clear from the evidence that Dr Boyce was able to fully engage with Child 4 and provide considerable assistance to them. Nevertheless, Dr Boyce summarised Child 4;'s risk of committing suicide as "extremely high".

Child 4 regularly consumed quantities of alcohol. However, Child 4 did not offend, nor did Child 4 attract police attention, apart from self-harm attempts. It appears that Child 4 used alcohol as protection from feeling the pain of past trauma. Child 4's most recent psychologist, Dr Georgina O'Donnell, was working with child 4 to decrease the consumption of alcohol.

Between August 2012 and until the time of death, Child 4 was in a complicated intimate relationship with a young person. That young person also maintained a relationship of her own with another young person, a situation that was not ideal for Child 4. Child 4's intimate friend moved out of Child 4's house and in with her other intimate friend, which caused Child 4 to be upset.

Just prior to Child 4's death, psychologist Dr Georgina O'Donnell accepted Dr Boyce's referral to see Child 4. On her first meeting with Child 4, they had spoken of the treatment Child 4 had received previously, and the problems Child 4 had encountered with those services. Child 4 further spoke about the history of self-harm, eating issues, poly-pharmacy overdoses, and the incident on the bridge. Child 4 stated that the brother was highly protective and that she/he had not seen the father since the age of 13 as he was "not good". Child 4 also disclosed that she/he was allegedly sexually abused by a step-brother as a child on a regular basis, and had disclosed this to a doctor once she/he had had her/his first sexual experience at age 13 years. Child 4

stated to Dr O'Donnell that they wanted the pain to end and felt it was better not to be here.

Dr O'Donnell stated that, based on their first meeting, she formed the working diagnosis of Post-Traumatic Stress Disorder resulting from childhood sexual abuse, with maladaptive coping strategies. She stated that it was clear Child 4 was a chronic suicide risk.

Circumstances Surrounding Death

In the week leading to the actions that ultimately ended her/his life, Child 4 and the intimate friend had an argument about their relationship and did not see each other as much as usual.

Dr O'Donnell saw Child 4 for the second and final time. They spoke of Child 4's sexual abuse; which she described as opportunistic and predatory, indicating that the offender lost interest in Child 4 once Child 4 reached puberty. Dr O'Donnell did not question Child 4 on any details, only recording that which Child 4 chose to share. They planned to discuss the issue further on their next meeting. The evidence indicates that Dr O'Donnell was able to engage Child 4 readily and effectively.

During her session with Dr O'Donnell, Child 4 stated that she was intent on attending the funeral of a close friend, Child 3, the following day. Child 4 disclosed that they had had feelings for Child 3, but would not have pursued a relationship, as they felt Child 3 was too young. They discussed coping strategies and agreed that Child 4 would remain in the company of another person for the following week.

Child 4 attended the funeral of Child 3. Child 4 had been friends with Child 3 on Facebook. After Child 3's death, Child 4 told a close friend that they had a "thing" for Child 3, but thought Child 3 was too young for him/her. Child 4 also told a friend that it was strange that Child 3 had taken their own life in the same way as she/he was thinking about doing. Child 4 further said that they had even picked out a spot to do it.

On the day after the funeral Child 4 was at home and exchanged text messages with the intimate friend until late evening. Child 4 was consuming alcohol at this time. Child 4's brother was at home but stayed in his bedroom watching football. The mother had gone out. Late that night Child 4 sent a text to the intimate friend saying *"I love you".*

When the mother returned home she met Child 4's friend, AC, at the house, who had also just arrived as she and Child 4 had plans. Child 4 was not answering her/his mobile so the mother checked his/her room and found a note on the pillow indicating an intention to end her/his life. She called police and advised them that she thought Child 4 may have gone to the bridge in accordance with previous behaviour. Police were dispatched to the bridge.

The mother and the brother continued to search the residence. The brother found Child 4 outside. Child 4 was unresponsive and not breathing. The mother commenced CPR while waiting for an ambulance. Ambulance resuscitation was successful and Child 4 was admitted to the hospital's Intensive Care Unit on life support. CT and MRI scans of Child 4's brain showed extensive areas of damage and oedema incompatible with survival.

A week later Child 4's life support was ceased with the mother's consent, and Child 4 passed away.

Dr Donald Ritchey, forensic pathologist, conducted an autopsy. I accept Dr Ritchey's opinion as to cause of death. Dr Ritchey also noted multiple healing scars on Child 4's thigh consistent with previous self-harm.

Toxicological testing of Child 4's blood alcohol content at the time of admission to hospital was 0.101g/100mL. On the basis of this result, and the evidence in the investigation, I conclude that Child 4 had consumed a significant amount of alcohol before they took the action that took their life.

Conclusions Regarding Death

The circumstances of Child 4's death have been thoroughly investigated. I am satisfied that there are no suspicious circumstances, and that no other person was involved. I am grateful to investigating officer Constable Shelby Thomas for her detailed report to me.

I find that Child 4 understood the finality of death and that, tragically, Child 4 had formed the intention to die by their own actions. Child 4 was at a very high risk of suicide and, sadly, the death eventuated.

Child 4's notes are articulate and poignant, and very carefully set out the feelings of the pain being torturous and never ending, with no guarantee that it would disappear. Child 4 states that her/his decision was hers/his alone and made rationally. Child 4 states in a note found on her/his computer: *"The years have been a constant raging battle in my mind, and I've tried so hard, I really have. For five years or more, it has been a mental struggle deciding whether or not the emotional pain was at all bearable. And I have had to make it bearable, for the people I love".* In Child 4's notes he/she apologises profusely to those he/she loves for his/her actions, and states that there was nothing anyone could have done to stop him/her.

Child 4 had the love and support of a mother and brother. However, Child 4 suffered PTSD and related mental and physical health issues associated with prolonged sexual assaults as a child.

Child 4's behaviours reflected her/his trauma: excessive use of alcohol, self-harm by cutting, disordered eating, non-attendance at school, non-engagement with supports.

Most tragically, Child 4 suffered constant mental anguish and chronic suicidal ideation.

It appears that the final triggers for Child 4's decision to end their own life were the arguments with the intimate friend, the consumption of alcohol, and the death of Child 3, who took her/his life in the same manner as Child 4 and whose funeral Child 4 had attended the day before her own actions. Dr Boyce agrees with this assessment.

Contagion by Media Coverage

I discuss further in this finding the possible impact of the media coverage surrounding Child 3's death, including the anti-bullying campaign, upon the subsequent deaths of Child 4, Child 5 and Child 6.

When Child 3 died, Child 4 stated that she/he was sad that such a beautiful young person had to die the way they did. Child 4 was Facebook friends with Child 3 and had spoken to them online in the past.

I accept that extensive social media and newspaper coverage occurring in the two days before Child 4's death may have impacted on Child 4's sadness, but it cannot be said that media surrounding Child 3's death caused Child 4 to take their own life.

Issues Surrounding Child 4's Treatment and Support

The mother of Child 4 was critical of the practices and funding levels of CAMHS Clare House, of discharge practices at the Royal Hobart Hospital, and of the lack of a dedicated adolescent mental health inpatient facility. She was also critical of SASS. She also submitted that there was a lack of liaison by those organisations with Child 4's general practitioner to ensure consistent treatment, and better engagement so that Child 4 did not "fall through the cracks" in between numerous hospital admissions. The mother sought individualised treatment. She also commended those who assisted Child 4. Through her counsel, Ms Mooney, she submitted that it is important that criticism be met not with defensiveness, but with a willingness to listen to those who have experienced "the system" so that effective change can be contemplated.

The mother's counsel, Ms Mooney, presented thorough and helpful submissions on the ways that services could be improved based upon the evidence given by the mother, and the expert evidence at the inquest. These submissions are dealt with under the heading "Recommendations and Responses".

CHILD 5

I find, in accordance with section 28(1) of the Coroners Act, that:

(a) The identity of the deceased is to be known as Child 5;

(b) Child 5 died in the circumstances described in this finding;

(c) Child 5 died in September 2013 in southern Tasmania; and

(d) Child 5 was a high school student.

Background

Child 5's parent separated while Child 5 was still an infant. Child 5's mother then began a relationship with a man who was violent and abusive.

Child 5 had four siblings – one of the siblings died as an infant from untreated serious medical conditions exacerbated by parental neglect. Soon after the infant's death, Child 5 and his remaining siblings went to live with their father.

Several years later Child 5 returned to live with the mother but was removed from her care in 2006 when he/her was injured when the mother threw a lump of wood at Child 5 as punishment for fighting with a sibling. The mother was charged with ill-treating a child over this incident. Child 5 and his/her siblings subsequently became subject to care and protection orders and were removed from the care of their parents.

The evidence pertaining to Child 5's traumatic early years contained serious allegations of physical and sexual abuse towards them. I do not intend to recount them. I am satisfied that Child 5 was, from a very young age, subject to extensive abuse and exposed to family violence and neglect.

When Child 5 was nine years of age, a Care and Protection Order was made placing Child 5 in the care of the State until the age of 18 years.

Child 5 lived with a number of foster families and then rostered care. Child 5 was separated from his/her siblings, although CPS planned eventual reunification of the children. Due to Child 5's extreme and uncontrollable behaviour and violence towards

others Child 5 moved homes and placements frequently. Child 5 moved approximately 15 times over a period of two years.

In 2008 Child 5 was placed with foster carers (together referred to as the “carers”). It appears that by that stage CPS had exhausted all avenues for Child 5’s care.

These carers provided remarkable care to Child 5 and devoted themselves to Child 5’s treatment and healing until death.

Child 5 was seen by numerous medical professionals. Child 5 was unable, as a rule, to engage with those tasked to treat, assist or support him/her due to his/her antagonism and resistance to professional help. Child 5 refused to take medication, but the evidence indicates that medication would not have assisted Child 5.

In about 2006 Child 5 was diagnosed as having Reactive Attachment Disorder as a result of childhood abuse and neglect over many years. The trauma, abuse and neglect resulted in a lack of secure attachment in relationships. The result of the disorder was a marked disturbance in developmentally appropriate social relatedness, marked by serious behavioural issues, difficulties trusting others and regulating emotions. Child 5 was also diagnosed with a severe Anxiety Disorder and Post Traumatic Stress Disorder - both diagnoses also relating to their childhood experiences.

Child 5’s symptoms associated with his/her conditions were of the most severe type. The medical evidence was that, in addition to childhood trauma and neglect, Child 5 probably had a genetic load due to severe mental illness on the maternal side of his/her family. Additionally, it is likely that Child 5 had a poor in-utero experience and poor nutrition in the early months of life. Both of these factors are likely to have further compromised Child 5’s brain development and increased the risk of suffering mental illness and learning difficulties.

Child 5’s symptoms were high end behaviour and violence, and severe nocturnal enuresis (bed-wetting). Child 5 was unable to trust, was combative in adversity or under threat – real or perceived, and they felt a need to control others.

Child 5 attended numerous schools throughout his/ her life.

Child 5’s schooling was plagued by problems due to his/her behavioural and psychological issues. Numerous strategies were tried at various schools with differing

degrees of success. The main problem with Child 5's behaviour at school was Child 5's propensity to act violently when distressed, causing risk to other students. Child 5 made some good progress with an understanding principal and support persons at one of the primary schools until the principal left. Child 5 also made progress at high school with reports noting that she/he was polite and increasingly considerate towards others. At high school Child 5 received one-on-one full-time support and was not exposed to the school population without a support person.

Child 5 came to the attention of Tasmania Police in 2006 with the allegation of an assault upon him/her by the mother, as previously described. The later reports concerning Child 5 on the police system relate mostly to their emotional issues in their placements rather than conventional criminal offending. In 2009 police were notified when Child 5 set fire to hay bales in a shed on the property belonging to his/her carers in an attempt to burn down the shed and be removed from their care.

Child 5 was supported by IAST in 2008 and 2009. The meetings were attended by representatives from Tasmania Police, CPS, CAMHS and the Education Department. By the last meeting it was noted that Child 5 was no longer coming under police attention. Whilst the evidence did not focus upon police involvement with Child 5, it appears that the IAST meetings were a very useful forum in the exchange of information between the various agencies supporting Child 5, making decisions in their interests, and monitoring Child 5 in terms of preventing future offending behaviour.

Dr Geoff Donegan, Child 5's paediatrician, expressed the view that the only two ways to assist Child 5 were ongoing stable foster care and high level psychotherapeutic work.

In 2009 Child 5 was provided with therapeutic support from the ACF, funded by CPS, initially from Dr T'Meika Knapp of the Child Trauma Service. In 2012 Child 5 was provided with an intensive therapeutic care package (TCP) in recognition that the therapy required by Child 5 was of the highest order. Again, the TCP was provided by the ACF and funded by CPS. The TCP continued for 12 months. ACF applied for an extension to the program but funding to continue was declined. Nevertheless, counselling through the Child Trauma Service continued until Child 5's death. The issue arose in the inquest as to the circumstances of funding being declined to continue the TCP and the consequences to Child 5 of the cessation of the package about three months before Child 5 died. In a separate heading below I deal with the nature of the TCP and the issues surrounding it.

Child 5 had a large Therapeutic Care Team who met frequently to discuss strategies and progress. Dr Stephen Morgan, child and adolescent psychiatrist, stated that Child 5's foster carer *"had an exemplary understanding of Child 5's emotional needs and an outstanding patience and skill in her efforts to engage Child 5, even if she at times felt extremely stressed by their needs for monitoring and support".*

Child 5's emotional state was so fragile that any inflammatory words or gesture could cause Child 5 to lash out in a violent rage. In the latter period of Child 5's placement she/he often engaged in self-harming behaviours such as cutting and pinching themself.

I accept that fostering Child 5 was a significant challenge and at times Child 5's foster carers were occasionally in need of respite, which they stated was frequently not available to them. Child 5 was physically violent towards them and was often verbally abusive. One of the carers states that she had lost count of the number of times that Child 5 had hit her whilst in the grip of a violent episode. On one occasion Child 5 attacked the carer by holding her against a wall and spitting on her and punching her. The carers had agreed to take into their home another child for several weeks as respite care. During the assault by Child 5 upon the carer, Child 5 stated that she/he would keep the other child up until it was removed from the home. After this incident, the carers felt it necessary to place Child 5 at Langford Support Services to allow them to consider Child 5's placement with them.

Shortly after this episode of violence Child 5 returned to his/her carers. However, in a subsequent incident one of the carers made physical contact with Child 5 in the back seat of the car on the way to a respite centre. The carer's account was that Child 5 was kicking him in the back through his car seat. The carer, already having a bad back, flung his arm around behind his seat in an attempt to get Child 5 to stop kicking to avoid an accident. His arm connected minimally with Child 5's face. Child 5 reported the incident to another carer. CPS investigated the incident and found the complaint to be made out. This investigation appeared to further fracture the relationship between CPS and the carers, who were of the view that they were not adequately supported for a child with such high needs. I am firmly of the view, having received the evidence, that the carer was an excellent foster parent to Child 5, who must have been a trying child even to those with the ultimate patience. I am satisfied that this was an isolated event in an attempt to stop Child 5 from kicking the seat and causing an accident. In all respects the carer cared for Child 5 and was an exemplary role model as a parent.

Despite the extreme challenges, the carers kept Child 5, nurtured him/her and loved him/her. Child 5 bonded with and trusted the carers, and in particular was interested in the farm activities and gradually started to show affection to the animals. Child 5 showed talent at various mechanical things, such as building and re-building push bikes. Child 5 could drive the ute and round up cattle on their own.

During Child 5's time of living in this stable foster arrangement Child 5 achieved significant progress. The carers and Child 5's care team were remarkable for their persistence and devotion. During 2012, as Child 5 felt safe and loved, Child 5 started to disclose his childhood sexual abuse to the carers. The bed-wetting stopped. During 2013 Child 5 eventually became able to identify, on occasions, when she/he was losing control and to use techniques learned in therapy to settle themself. Child 5's behaviours became less extreme. Child 5 learned to drive on the farm and helped one of the carers with the farming work. Child 5 felt safe in the home. Child 5 seemed to be improving and even commenced a relationship with a young person with whom she/he was friends. Previously, Child 5 had only had online girlfriends whom they had never met in person. Unfortunately, the decrease in outward aggression created an increase in internalising behaviours that resulted in self-harm. Child 5 would cut themself or otherwise cause themself pain.

Ms Sonya Pringle-Jones, ACF therapist stated in her report:

> "In the course of ACF's intervention, what was shown to occur was a decrease in Child 5's outwardly aggressive behaviour as he/she gradually became more settled and his/her sense of safety and belonging grew. As these externalising behaviours decreased, Child 5's depressive symptomology and intropunitive behaviours increased, typifying the progressive stages of trauma work – once safety and stabilisation are achieved, the second phase moves to incorporating therapy to promote integration of trauma memories. The overarching goal of the therapeutic work was to steer Child 5 into a space whereby she/he would be amenable to trauma processing work. Child 5 was extremely resistant to this, and as a result, as signs of depression grew, the care team included child and adolescent psychiatrist Dr Nicky Beamish. The intention was for a pharmacological approach to be taken, as it was evident that Child 5's symptoms would not improve given his/her conflict with other methods. Having said this, Child 5 was equally averse to medication, but it was considered a point of last resort. Dr Nicky Beamish became involved with the

care team, to be on the periphery of Child 5's case as opposed to a treating professional, and be ready for when Child 5 was willing to engage with her.

From June 2013, the primary goals for meeting Child 5's therapeutic needs were gently seguing Child 5 into contact with Dr Beamish, and systemic work to move towards a Transfer of Guardianship to his carers. Child 5's relationship with Child Protection Services was extremely fraught. Having experienced numerous workers, placement changes and mixed messages over the 7 years since Child 5's removal from [a] natural family, he/she was extraordinarily antagonistic, suspicious and fearful of contact with Child Protection. For Child 5 to continue under the guardianship of DHHS, this was in and of itself a significant trigger and destabilising factor for him/her. ACF deemed that it was in Child 5's best interests for a transfer of guardianship to Child 5's carers to be pursued, but to do this, better working relationships between Child 5 and the foster family with the Child Protection Worker needed to be facilitated by ACF to enable this to occur. This was just beginning to progress at the time Child 5 passed away."

Circumstances Surrounding Death

In the six months leading to Child 5's death, the carer describes Child 5's behaviour as becoming "manic". For instance, Child 5 came to police attention when she/he was located in possession of a knife after she/he had sent a female friend photos of the knife. Child 5 had stated to the friend that she/he intended to kill himself/herself. When police located Child 5 they ascertained that Child 5 had no intention of self-harming but wanted to scare the girl.

Child 5 had a close relationship with a young boy whose mother formed part of the Care Team. The young boy appeared to not like the close relationship his mother had with Child 5 and the two children began a rivalry. The boy would verbally challenge Child 5 and Child 5 would respond with abusive comments. I accept that the arguments bothered Child 5 but after the carer spoke with the young boy the comments ceased. A close friend of Child 5's told police that Child 5 was being bullied at school about their weight during the last two months of his/her life. However, other evidence, including that of the carer, suggests that it did not seem to bother Child 5. There is little other evidence to suggest that Child 5 was being bullied despite Child 5's assertions at the time of their death.

In September 2013 Child 5 cut his/her arms superficially. The carer stated that Child 5 made it “look bad” and then took photos which were posted on Facebook. The carer stayed up to check on Child 5 during the evening. On this same day Child 5 spoke to his/her girlfriend about killing themself.

On the following day Child 5 posted on Facebook that he/she had consumed a bottle of bleach and had ended up in hospital for the night. This was untrue, and appeared to be done to seek attention.

On the following day Child 5 requested that the girlfriend join him/her in the act of killing himself/herself, and also contacted an ex-girlfriend and told her that she/he was going to take their own life.

On the following day Child 5 was in the car with the carer on the way to school, telling her how much (emotional) pain she/he was in. Child 5 punched the car and became agitated. Child 5 spoke of Child 3 and that recent death and stated that he/she did not want to go to school that day.

On that same day Child 5 posted on Facebook that they was *"gonna to do what [they] meant to do last night".* Child 5 spoke to the girlfriend for some minutes. She was staying with a friend and her friend convinced her that Child 5 was just seeking attention. They then said goodbye. Child 5 then posted a voice message on Xbox Live stating:

> "yeah, this is a message to all my friends as this will be my last night as I can't take the pain anymore. I am literally giving up Xbox live and my own life because I can't deal with the bullying, I get bullied so much I can't deal with it."

When a friend on Xbox Live received this message he thought it similar to Facebook posts Child 5 had posted over previous months and that Child 5 would not actually do it. He had had perfectly normal conversations with Child 5 earlier in the evening that did not indicate tan intention to end their life. Child 5 and this friend had plans for him to visit the next morning but Child 5 cancelled the plans that evening.

The following morning Child 5’s carer checked on Child 5 and found Child 5 apparently dead. One of the carers commenced CPR and called ambulance and police.

Ambulance paramedics arrived and confirmed that Child 5 was deceased.

Dr Donald Ritchey, forensic pathologist, conducted an autopsy upon Child 5. I accept his conclusion as to cause of death. Dr Ritchey also noted that there were superficial cuts present on both wrists, and the left forearm. These cuts evidenced Child 5's recent self-harm.

There was no evidence of Child 5 using alcohol or drugs on the evening he/she died, and toxicological testing of Child 5's blood revealed no alcohol or drugs present.

Further investigation revealed that Child 5 would frequently post his/her Facebook status as "Goodbye Everyone". Child 5's friends believed it was a reference to suicide but did not believe that Child 5 would actually go through with the act. Attending police officers saw various messages on Child 5's mobile phone stating that he/she wanted to harm themself. The friend who received these messages offered Child 5 help, but Child 5 replied that it was too late.

Conclusions Regarding Death

The tragic death of Child 5 and the path of his/her life, serves to highlight the damage, dysfunction and emotional pain caused directly by the severe abuse and neglect of a young child. It also highlights that deep seated damage can be incapable of repair, even with love, tolerance, nurturing and therapy.

During the times that Child 5 felt safe, the carer described Child 5 as caring, funny, loving and insightful.

Child 5 may have understood the concept of finality of death, but perhaps only in a somewhat theoretical and disconnected way. Ms Pringle-Jones stated in evidence that Child 5 had suffered death in his/her life and therefore perhaps had some understanding that it was final. I note also in a conversation Child 5 had with the girlfriend shortly before death Child 5 revealed some understanding of the finality of death.

However, Ms Pringle-Jones gave evidence that Child 5 acted emotionally at times as a five year old, citing tantrums, and a propensity to catastrophise and sensationalise, and to engage risk-taking and experimental behaviour. At times when Child 5 spoke about

suicide she/he focussed on the impact, or lack thereof, his/her death would have on others. Child 5's carers did not believe that Child 5 truly understood the finality of death.

One of the carers suggests that Child 5's death may have not been intended but in fact may have been another attempt to attract sympathy and attention on social media. Ms Pringle-Jones stated that for Child 5 the pain of living was very hard but that she did not believe Child 5 took his/her actions understanding the finality of death. I accept the evidence of Ms Pringle-Jones, and Child 5's carers. They were the ones closest to Child 5 and knew intimately Child 5's thought processes and behaviour. Dr O'Donnell gave evidence that a developmentally delayed adolescent may not understand the concept of death being final.

Whilst I am satisfied that Child 5 did intend to take the action that took their life, I am not satisfied that Child 5 had a full understanding of the finality or gravity of death, or that Child 5 genuinely appreciated the significance of what they were doing. Child 5 was developmentally delayed. His/her actions were likely risk taking and attention-seeking, and done with recklessness as to the consequences, but nevertheless driven by the mental anguish that Child 5 constantly endured.

It is difficult to know what triggers may have operated upon Child 5 to cause them to end their life. Ms Graves, counsel for the carers, has suggested a number of factors such as the delay in the transfer of guardianship, upsetting social media contact with members of his/her family, alleged bullying incidents, and fraught conversations with the girlfriend. I would also add the possible impact of Child 3's death upon his/her mindset. However, it is very difficult to know the ultimate trigger and I cannot make positive findings in this regard.

I find that Child 5 had serious risk factors for suicide - trauma, neglect as an infant and child, a lack of stability in subsequent foster placements until the last, and a history of self-harm and suicidal ideation.

I am satisfied that a thorough investigation took place into Child 5's death. There are no suspicious circumstances surrounding the death or any indication that any other person was involved in the actions.

I express my gratitude to investigating officer Constable Derek Turnbull for his many hours of work and his comprehensive report to me.

Comments on Care Pursuant to Section 28(5) of the Act

If a coroner holds an inquest into the death of a person who died whilst that person was held in care the coroner must report on the care, supervision or treatment of that person while that person was a person held in care. Child 5 was a person held in care by virtue of the Care and Protection order to which they were subject and by which they were under the guardianship of the Secretary within the meaning of the *Children, Young Persons and Their Families Act 1997*. My comments mainly relate to the quality of the care by CPS and are set out under the heading "Comments and Recommendations".

As described in this finding, the care, supervision and treatment provided to Child 5 by the carers was of high quality, loving and selfless.

Contagion by Media Coverage

Child 5's death occurred only 16 days after Child 3's death. Child 5 attended the same school as Child 3. Child 5 spoke about Child 3 on the day he/she died. Child 5 also spoke of Child 3 on another occasion as a "friend who died". Child 5 was a prolific user of social media - the method used to promote the anti-bullying campaign sparked by the death of Child 3. Ms Graves submitted that it was only after the media and social media proliferation of information relating to Child 3's death that Child 5 started to talk about a specific means of suicide. It also appears that Child 5, possibly being aware of the link (incorrectly) perpetuated between bullying and Child 3's death, cites bullying as a reason for their own death for effect. The significant coverage of Child 3's death by the media and social media is likely to have impacted upon Child 5's thoughts before they took their own life. However, it cannot be said to have caused Child 5's death.

General Concerns Raised by Child 5's Carers

The carers raised as general issues the importance of early intervention if children are to recover from trauma and abuse. They also raised the importance of service providers and their staff having the skills and expertise to engage in and sustain a therapeutic relationship with young people. They also seek that CPS staff be able to develop relationships with families, foster carers and children to develop a problem-solving and empowering approach to their work. I have dealt with some of these issues under the heading "Comments and Recommendations".

CHILD 6

I find, in accordance with section 28(1) of the Coroners Act, that:

(a) The identity of the deceased is is to be known as Child 6;

(b) Child 6 died in circumstances described in this finding;

(c) Child 6 died in March 2014 in southern Tasmania; and

(d) Child 6 was a high school student.

Background

Child 6's parents separated in about 2006. After the separation, the mother remained with the main care of Child 6 and her/his sibling.

In 2009 the mother took her children to Latin America for about 12 months with a friend. When returning from the trip in 2010 they lived on the mainland for a short time before moving to live with the mother's parents for 4 years.

Child 6 had troubled periods in high school on mainland Australia. Child 6's mother stated that Child 6 suffered some bullying at the hands of a male student. Child 6's mother also stated that Child 6 began associating with a group of peers, some of whom were having difficulties at home and were cutting themselves.

The mother states that Child 6 was a kind-hearted and caring young person who would often listen to the problems of his/her peers and empathise with them. Child 6 showed distress for his/her friends' situations. Child 6 began to cut themself on the arms, legs and stomach as a teenager.

In 2013, the mother was notified by the school of a problematic relationship between Child 6 and another student. Child 6 saw a counsellor regarding the stress of this relationship and also some bullying at school. The counsellor, Kim Gillespie, noted that Child 6 had experienced a difficult period relating to her sexuality but the difficulties had resolved.

Child 6's counselling sessions in 2013 improved Child 6's state of mind. Child 6 built a good rapport with Ms Gillespie.

In late 2013 Child 6 was diagnosed with photosensitive epilepsy and was treated with Lamotrigine. In the inquest the mother raised concerns about the side effects of Lamotrigine upon Child 6's suicidal ideation. I will discuss that issue shortly. The medication appeared to work as intended in improving Child 6's epilepsy. Child 6 was progressing well and no longer suffering persistent symptoms of anxiety and depression.

In December 2013 the mother decided to move the family back to Tasmania for financial reasons. Initially, Child 6 was excited about the move but soon after the family's arrival in Tasmania, Child 6 stated that they wanted to return to the grandparents' home on the mainland. People close to Child 6 noticed a change in his/her behaviours.

Child 6 began attending high school. Although Child 6 struggled to adjust to the move, she/he began settling into a group of friends. Child 6 received a musical scholarship and joined a soccer team. Child 6 also stayed in close contact with friends from the mainland. Child 6 saw a school counsellor, as he/she was feeling some sense of loss over the move.

Circumstances Surrounding Death

In March 2014 Child 6 posted a comment on her/his Facebook wall to the effect that they were not happy with their life. However, Child 6 later posted a photo with a friend looking like they were having a nice time at a barbeque. Whilst attending the barbeque, the mother noticed fresh cuts on Child 6's arms. This was the first time the mother became aware of Child 6 self-harming again. The mother said that, at the barbecue, Child 6's attitude was sullen.

On the following day the mother took Child 6 to the Salamanca Market. Child 6 was excited for the outing. After eating lunch at the market Child 6 left the mother to spend his/her pocket money. Child 6 returned fifteen minutes later with three badges. Two of the messages on the badges were "Kill me now" and "If you mess with me I'll go all bitch on your ass".

The mother explained to Child 6 that these messages were inappropriate, that she did not want Child 6's younger brother seeing them. The mother offered to buy them from

Child 6 so Child 6 could spend her/his pocket money on something else. This offer did not appeal to Child 6 and Child 6's mood darkened.

The mother spoke to Child 6 about her concerns that Child 6 was not coping and confronted her child about the self-harming. Child 6 confirmed the self-harming but said they were seeing a counsellor at school.

When they arrived home, Child 6 said they were going for a walk. Child 6 had done this on other occasions when they were feeling grumpy. Before Child 6 left the mother put a new SIM card in an old iPhone of hers for Child 6 to take. Child 6 used the phone briefly and left for a walk. The mother thought Child 6 would go next-door to use their friend's Wi-Fi as Child 6 often did and Child 6 said that they would be home at 5.00pm.

Child 6 did not return home at 5.00pm so the mother tried calling and texting. This resulted in no response. The mother drove around the area but, as she was running low on fuel, she drove to a fuel station before returning to her search of the area by car.

At approximately 6.40pm the mother reported her child missing to local police.

Paragraphs redacted.

The mother checked Child 6's Facebook page that Child 6 had left logged in on the mobile phone. There was a Facebook discussion between Child 6 and a friend from the mainland where the friend had said that he/she was contemplating suicide and had self-harmed. Child 6 said to the friend that she/he had also started to cut themselves since the move to Tasmania. Child 6 had commented in this conversation that the friend should "hang on" until the holidays when Child 6 would visit him/her. This evidence indicates that, at this time, Child 6 was perhaps intending a future for themselves. The mother also indicated that Child 6 was contemplating joining a local soccer team and a yoga class to assist with dancing.

At 4.20pm on the day after Child 6 went missing, Child 6 was found deceased by a SES volunteer assisting in the search.

Dr Chris Lawrence, State Forensic Pathologist, performed an autopsy upon Child 6. I accept his opinion as to cause of death. I also note that Dr Lawrence observed scarring upon Child 6's arms consistent with self-harm. Child 6's blood contained Lamotrigine, being the epilepsy prescription medication.

Conclusions Regarding Death

The circumstances of Child 6's death have been thoroughly investigated. I am grateful to investigating officer Constable Tony Cooper for his report to me. I am satisfied that there are no suspicious circumstances surrounding Child 6's death and that no other person was involved.

Although Child 6 had a history of self-harm and some intermittent bouts of sadness, the death came as a shock to the mother, friends and family. Child 6 left no note of her/his intention. I find that Child 6 understood the finality of death and had formed the intention to die. Child 6's decision was likely to be impulsive. The activity on Child 6's Facebook account ceased upon the disappearance. I find that Child took their own life shortly after they left home.

It could not have been predicted that Child 6 would take their own life when they did. The evidence indicates, however, that there were risk factors in Child 6's life. Child 6 had experienced feelings of isolation and had, over her/his life time, a lack of stability in living arrangements. A protective factor was the close relationship with the mother. Whilst Child 6 suffered stress and sadness in bouts, Child 6 was under the care of a general practitioner and counsellor on the mainland, and Child 6's state of mind improved significantly.

However, Child 6 was unhappy about returning to Tasmania. After a gap of 6 months, Child 6 resumed self-harming just before her/his death. Child 6 also refused to eat properly a few days before death, an issue that had previously signalled unhappiness.

Child 6 said nothing to her/his mother that indicated she/he wished to take their life. Conversations with a friend from the mainland indicate the ease with which the friend spoke about taking their own life in the context of a somewhat frivolous conversation. Child 6 said to the friend on 28 February 2014 that she/he had had suicidal thoughts since moving to Tasmania and was self-harming because he/she felt unhappy, with no one to comfort her/him when he/she "did not want to smile". No other expressions of suicidal intent were uncovered in the investigation. The school counselling records indicate that the school was conscious of Child 6's desire to return to the mainland and a past of self-harm. However, there were indications from Child 6 to the counsellor that self-harm was not occurring at that time, that they were not distressed and that they were not presenting with any concerning signs. Child 6 did not indicate suicidal ideation

to any school counsellor. I am satisfied that the school was diligent in monitoring Child 6 and assisting them. I do not consider, in examining the school file, that there was a need for the school to make contact with the mother to discuss the contents of Child 6's counselling.

Paragraphs redacted.

Prescription of Lamotrigine

Child 6's mother raised concerns about the possibility that the drug Lamotrigine caused suicidal tendencies in Child 6. The mother states that two pamphlets were provided with the drug - the American one listing suicidal tendencies, with the Australian one not listing this as a consequence. The mother stated in evidence that the prescribing doctor did refer to risk of suicide but did not give further advice on how that risk should be dealt with.

This concern has been reviewed by the coronial medical consultant, Dr Tony Bell, whose detailed report is in evidence. His conclusions, based upon the medical literature, are as follows:

1. Child 6 displayed no continuous suicidal behaviour or ideation for the period of time that Lamotrigine was taken;
2. The drug does not appear to have caused a depressive illness;
3. The elevated risk of suicidality (0.43% versus 0.22%) is small; and
4. The conclusion of a later comprehensive study is that the current use of anti-epileptic drugs was not associated with an increased risk of suicide-related events among patients with epilepsy, but it was associated with an increased risk of such events among patients with depression and among those who did not have epilepsy, depression or bi-polar disorder.

Child 6 required Lamotrigine to alleviate his/her considerable symptoms. This was successful. I make no criticism of the prescribing doctor. The dosage given was correct. In light of Dr Bell's conclusions, which I accept, I am not able to find that Lamotrigine increased Child 6's suicidal ideation.

Contagion by Media Coverage

I discuss further in this finding the possible impact of the media coverage surrounding Child 3's death, including the anti-bullying campaign, upon the deaths of Child 4, Child 5 and Child 6.

Child 6 attended the same school as Child 3 and Child 5. There is no evidence that Child 6 knew either of them. Child 6 enrolled in the school after the deaths of both Child 3 and Child 5.

It is possible that Child 6 was affected by Child 3's death. Child 3's death remained an issue at the school and media coverage of the anti-bullying campaign continued at the time of Child 6's death. The evidence of the articles shows heavy reporting on 28 February, 1 March and 2 March 2014.

Child 6's mother has expressed strong concerns about the way in which the publicity occurred surrounding Child 3's death, describing it as "looking narrow and irresponsible". As discussed further, the significant media coverage on the anti-bullying campaign sparked by Child 3's death may have impacted on Child 6's state of mind but it cannot be said that such coverage led in a direct manner to Child 6's decision to take their own life.

Comments and Recommendations

Introduction

Section 28 of the *Coroners Act* 1995 provides as follows:

(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.

As a result of the valuable evidence received at inquest by family members of the young persons, their friends and associates, professionals and experts, I now make comments and recommendations pursuant to sections 28(3) of the *Coroners Act* 1995. These relate to improving the mental health of young people and consequently the prevention of suicide.

It is well accepted, and the evidence at inquest demonstrates, that the treatment and support of mental health problems in young people is the key factor in preventing their suicide. It is appropriate to place this proposition into a wider Australian and international context.

Australia's obligations under the United Nations Convention on the Rights of the Child (CRC) highlight this country's obligations in respect of prevention of suicide in young people.

The CRC is a human rights treaty which sets out the civil, political, economic, social, health and cultural rights of children under the age of 18 years of age.

Nations that ratify this convention are bound to comply with it by international law. Compliance is monitored by the UN Committee on the Rights of the Child, which is composed of members from various countries around the world. Australia ratified the CRC in December 1990. Governments of countries that have ratified the Convention are required to report to, and appear before, the United Nations Committee on the Rights of the Child periodically to be examined on their progress with regards to the

advancement of the implementation of the Convention and the status of child rights in their country.

Article 6(1) of the CRC states that parties recognise that every child has the inherent right to life.

Article 6(2) of the CRC states that parties shall ensure to the maximum extent possible the survival and development of the child.

Article 19 of the CRC states that:

> "Parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parents, legal guardians or any other person who has care of the child.
>
> Such protective measures should, as appropriate, include effective procedures for the establishment of social programs to provide necessary support for the child and for those who have the care of the child, as well as the other forms of prevention and for identification, reporting, referral, investigation, treatment and follow-up instances of child maltreatment described heretofore, and, as appropriate, for judicial involvement."

Article 25 of the CRC states that parties recognise the right of the child who has been placed by the competent authorities for the purposes of care, protection or treatment of his or her physical or mental health, to a periodic review of the treatment provided to the child, and all other circumstances relevant to his or her placement.

Other articles in the CRC seek to address breaches of children's rights that are connected to factors associated with self-harm and suicidal behaviour. Such factors are homelessness, imprisonment, substance abuse, physical and mental health problems, out-of-home care, child abuse and neglect, domestic violence, peer victimisation, increased rates of family breakdown, and sexual abuse: (Articles 27 (1), 33, 37 and 39). Most of these factors referred to have been present in the lives of one or more of the young people the subject of this inquest.

The National Children's Commissioner, Megan Mitchell, released the *Children's Rights Report 2014*.[1] In the report, the Children's Commissioner notes that intentional self-harm and suicidal behaviour relates to Australia's obligations under the CRC.

The Children's Commissioner notes that the Australian Bureau of Statistics has reported that intentional self-harm is the leading cause of death among Australian children and young people aged 15 to 24 years. The Commissioner states that research suggests there are higher rates of intentional self-harm and suicidal behaviour in children and young people in out-of-home care compared to the general population.

In August 2015, just before the publication of this finding, the Australian government's report on the *2nd Australian Child and Adolescent Survey of Mental Health and Well-being* was released. This report is based upon a survey conducted in the homes of over 6300 families with children and/or adolescents aged four to 17 years. The report is stated by the Federal Minister for Health to present a comprehensive picture of the mental health of young Australians. It documents the prevalence and type of mental health problems, the impact of those problems on families and young people themselves, and the role of health and education services in providing assistance.

The survey defined suicidal behaviours as including suicidal ideation (serious thoughts about taking one's own life), suicide plans and suicide attempts. These differ from self-harm in that the self-injury is intended to end in death. Concerningly, about one in 13 (7.5%) of 12 to 17-year-olds had seriously considered attempting suicide in the previous 12 months. This is equivalent to around 128,000 young people aged 12 to 17 years. One in 20 (5.2%) had made a plan. One in 40 (2.4%), or around 41,012, 17-year-olds reported having attempted suicide the previous 12 months. One quarter or 0.6% received medical treatment as a result of their injuries. Suicidal behaviours were more common in females than males and in 16 to 17-year-olds compared with younger adolescents. Around one in seven (15.4%) of females aged 16 to 17 years had seriously considered attempting suicide, and one in 20 (4.7%) had attempted suicide in the previous 12 months. The rates of all suicidal behaviours were markedly higher in young people with major depressive disorder.

[1] See http://www.humanrights.gov.au/our-work/childrens-rights/projects/childrens-rights-report-2014

In the Foreword of the Report, the Minister stated that the survey highlights the need for continued effort by governments and the broader community to improve the mental health of children and young people and to continue collaborative work to achieve more effective prevention. The Minister states: *"A continued focus on suicide prevention and early intervention must be central platforms of the service systems that the government builds in the health, education and welfare sectors".*

The Tasmanian Coronial database shows that between the year 2000 and the date of this inquest, 31 young persons between the ages of 12 and 17 years have taken their own lives. A further 12 young people aged 18 years took their own lives in the same period.

Dr Fiona Wagg, child and adolescent psychiatrist employed by the Department of Health and Human Services, stated in her affidavit tendered at the inquest that the Tasmanian population is regionally distributed and is of low socio-economic status; and such factors often contribute to a range of health and mental health problems. As such, Tasmanian children and adolescents are more vulnerable to social exclusion, and therefore mental health disorders, and are at a higher risk of suicide. She states that up to 15% of the teenage population have mental health problems placing them at risk of suicide; although suicide is a low frequency event. She states that teenage suicide is often related to complex psychosocial problems with roots in early childhood development and family experience rather than major mental illness. The experience of several of the young people the subject of this inquest bears out this fact.

Research has consistently identified risk factors that distinguish young people with suicidal behaviour from other young people. These main factors are: (a) they tend to come from socially and educationally disadvantaged backgrounds and from dysfunctional or unhappy family and childhood backgrounds; (b) almost all will have some recognisable mental health or adjustment disorder prior to the suicide attempt, and often these mental health problems will be associated with more general personality difficulties; (c) suicidal behaviours may run in families, suggesting a possible genetic basis; (d) immediately prior to the suicidal behaviour, there is often a life stress crisis which often, though not always, centres around the breakdown of an emotional or supportive relationship. The research shows that, while suicidal behaviour can occur in young people with unproblematic life histories, serious suicide attempt behaviour is not usually the consequence of one risk factor, but instead represents the culmination of

adverse life course consequences which have been marked by accumulations of risk factors from the domains of social disadvantage, childhood adversity, personality difficulties, psychiatric disorders and adverse life events.[2]

The sad cases of the six young people the subject of this inquest bears out the existence of the relationship between some or all of these factors and the action ultimately taken to end their own lives. In the individual findings I have set out pertinent details of the lives, risk factors and triggering events associated with the death of each of the young persons. In this way these comments and recommendations are able to be viewed in the context of the lived experiences of the young persons and their families.

As stated in the literature and as acknowledged by the implementation of suicide prevention strategies, a focus upon reducing risk factors can significantly reduce the rate of youth suicide, even if it cannot be known whether different treatment, support or protection of each individual young person could have produced a different outcome. In his report for the inquest, Mr Nick Goddard, Chair of the Tasmanian Suicide Prevention Committee at the time of the inquest, stated that the Tasmanian Government has announced funding over three years, from 2014 to 2017, for suicide prevention strategies, one of which is the proposed Youth Suicide Prevention Strategy (YSPS) for Tasmania. Mr Goddard states that the development of the YSPS will include identification of key stakeholders, the establishment of a reference group to provide advice, a steering committee, engagement of a consultant to complete a literature review and draft the strategy, as well as consultation with young Tasmanians. The YSPS will focus on mental health, resilience and well-being. Mr Goddard states that it is anticipated that the YSPS will provide a range of actions that will help communities to respond to young people in crisis and prevent youth suicide, raise awareness and understanding of risk and protective factors in mental health, build resilience and coping strategies, improve access to mental health treatment, reduce rates of self-harm and consider suicide risk assessment.

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[2] See statement by Nick Goddard, former Chair of the Tasmanian Suicide Prevention Committee, citing Beautrais, AL, *A Review of Evidence: In Our Hands – The New Zealand Youth Suicide Prevention Strategy*, Ministry of Health, 1998, Wellington: New Zealand.

Dr Len Lambeth, Chief Psychiatrist for Tasmania, gave evidence that government-led suicide prevention programs decrease suicide rates with a particularly strong effect in both the elderly and young.

The evidence in this inquest and my findings, by necessity, must focus significantly upon the issues associated with the six young persons. The detail of their lives and circumstances surrounding their deaths can provide insight into important issues, as can the lived experiences of the families. As further discussed, many common issues have emerged both in terms of their lives and of their care and support. It is hoped that these findings will inform and contribute to the proposed YSPS.

Counsel for the State, Mr Turner, submitted that care should be exercised before I make recommendations, particularly those requiring significant expenditure of resources. He further submitted that it cannot be said that the outcome for any of the young persons would have been different, had one or more of those things that counsel submit should be recommendations, been operational at any relevant time during the life of the young person. Mr Turner submits that the deaths were impulsive but accepts that risk factors existed that would cause the young person to be at greater risk of suicide. However, it cannot be determined prospectively whether a young person at risk will end his or her life. I accept that this is unfortunately the case, and it presents a significant challenge in the development of suicide prevention strategies.

I do not accept that I am constrained by resource considerations in making otherwise appropriate recommendations. If recommendations are made but cannot, for good reason (financial or otherwise), be implemented, then that is a decision for the recipient of the recommendation. A coroner is not and cannot be fully apprised of all budgetary and resourcing considerations of government. I accept however, that recommendations should, of course be made thoughtfully and upon a solid evidentiary basis. Comments and recommendations are made in the public interest, and with the aim of preventing further loss of life. Comments may properly be made on all the implications of circumstances similar to those surrounding the deaths; see *Matthews v Hunter [1993] 2 NZLR 683* per Heron J at 687-688.

It is appropriate as a coroner to comment upon and to make recommendations concerning important aspects of the treatment, support, care and protection received by each young person; and, in the case of deficits in that treatment, how improvements could be made. Such comments are connected with the deaths as required by section

28(3). The recommendations are also "appropriate" as required by section 28(2). Improved or different treatment and support may have reduced the risk factors and thus reduced the chance of, or prevented, death. As stated, improvement in the care of young people's mental health is a central tenet of Australia's obligations under the CRC and also underpins research-based suicide prevention strategies.

I will now deal, under headings, with the issues arising at inquest.

Media Reporting of Suicide and Contagion

Following Child 3's death a family member commenced a campaign agitating for the enactment of anti-bullying laws. The campaign, prominent on social media, became identified via the name of Child 3. Between September 2013 and August 2014 36 articles and editorial pieces concerning Child 3's death appeared advocating an anti-bullying law and message. Child 4, Child 5 and Child 6 all took their lives at a time when Child 3's death and the campaign were given prominence in the media and social media.

Child 3's father and aunt expressed in evidence to the inquest great concern about the manner in which Child 3's death was reported. Child 6's mother and Child 4's mother have also raised concerns about the impact of the reporting upon their respective children and other young people.

Jaelea Skehan, psychologist and Acting Director, Hunter Institute of Mental Health, gave expert evidence to the inquest. Her evidence concerned the nature of the reporting of Child 3's death; whether the reporting breached guidelines for suicide reporting; and the manner in which reporting may be associated with further deaths. The question also arose as to whether and how the reporting and social media campaign may have impacted on the decisions of Child 4, Child 5 and Child 6 to take their own lives.

Ms Skehan has expertise in the prevention of mental illness and the prevention of suicide. Ms Skehan has worked for 12 years in the area of media reporting and its association with suicide. Her report for the inquest thoroughly examined the media issues arising from the publicity associated with Child 3's death. Her oral evidence elaborated upon her conclusions in the report. The substance of her expert evidence

was not challenged. I accept her expertise. In the following section of the finding I rely heavily upon passages from Ms Skehan's reports.

Ms Skehan stated that media reporting of individual deaths has been associated with increased rates of suicidal behaviour following that reporting. The potential for "contagion" or "copycat suicide" (referred to in this finding as "contagion") appears to increase following prominent and/or repeated coverage, coverage that focuses on the individual who died, and when the method or location is detailed. Research suggests that young people may be particularly vulnerable to contagion. Higher rates of suicide have been reported during periods when suicide stories are run in newspapers. However, research shows association only as it is difficult in any individual case, to link the fact of specific media reporting directly to a death, particularly without direct evidence of both exposure and influence.

Ms Skehan states that over 100 studies have looked at media reporting of suicide and its impact on suicidal behaviour; 85% of the studies have shown an association between media reporting and increases in suicidal behaviour following it. In general, the risk of contagion is increased where the story is prominent, is about a celebrity, details method and/or location and where it glorifies the death in some way. Whilst healthy members of the community are unlikely to be affected, people in despair are often unable to find alternative solutions to their problems. People may be influenced by the report, particularly when they identify with the person in the report.

Ms Skehan gave evidence that the media has an important role to play in raising awareness of suicide as a public health issue and that evidence shows that appropriate media reporting of suicide can be helpful. Ms Skehan told the inquest that personal stories about someone who has managed suicidal risk are protective, as are stories that focus on the impact of suicide. Adding the correct help-seeking information and information about risk factors and warning signs can be helpful. In his report for the inquest Dr Lambeth endorses appropriate media reporting that emphasises these elements and recommends against reporting that increases the risk of contagion as detailed in the preceding paragraph.

Mindframe Guidelines

In 2002 the Mindframe National Media Initiative, an Australian government initiative managed by the Hunter Institute of Mental Health, commenced. The Mindframe

initiative is based upon the fact that the media has an important role to play in shaping and reinforcing social attitudes towards, and perceptions of, suicide and mental illness. It aims to promote reporting that reduces potential harm from contagion and enhances community understanding about suicide and mental illness. It aims to build a relationship with both the Australian media and mental health sectors to enable a more accurate and sensitive portrayal of suicide and mental health issues across all news media in Australia.

An important part of Mindframe is the publication of practical guidelines ("Mindframe guidelines" or "the guidelines") for the reporting of suicide and mental illness. Ms Skehan stated that while media has had consistent codes of practice or guidelines for reporting suicide for more than 12 years, the extent to which journalists understand and apply them are variable. Mindframe guidelines are consistent with the research evidence into the effect of reporting on suicide rates and with standards that the Australian Press Council provides. However, Mindframe guidelines are not compulsory or enforceable. The Hunter Institute of Mental Health has instead worked in partnership with media organisations to disseminate them and embed them into journalistic practice. The guidelines are found on the Mindframe website.

The main guidelines determined by Mindframe for reporting of suicide, as I have extracted them from the resources, are as follows:

- Assess whether the story is clearly in the public interest, consulting experts for advice about the impact of reporting a specific case.

- Take care not to imply that the death was spontaneous or preceded by a single event, as research suggests most people who die by suicide have underlying risk factors, including mental health issues, a drug-related illness or other social influences.

- Prominent and repeated reporting of suicide is not recommended, and therefore give consideration to the number of recent stories relating to suicide.

- Where possible, obtain informed consent from appropriate relatives or close friends before identifying the person who has died.

- Disclosing explicit content from a suicide note may impact on vulnerable people, including those bereaved. This information alone, without context, may not tell the whole story.
- Limit promotion of public memorials, including online memorial pages, as these may inadvertently reinforce suicide as a desired outcome for people at risk of suicide.
- Choose more general images of the person rather than images of the funeral, grieving family or memorials as these may glorify the death. Ask for permission from the family before using images.
- Minimise details about the death including method and location, use appropriate language and promote help-seeking information.
- Extra care is required when reporting celebrity suicide. This coverage has the potential to glamorise and normalise suicide and may prompt copycat behaviour.
- To minimise risk, ensure the story does not glamorise suicide or provide specific details about the method or location of death. Instead consider focusing on the wastefulness of the death, its impact on family and friends, general risk factors for suicide and help-seeking options for people who may be vulnerable.
- Coverage that focuses on personal stories about overcoming the suicidal thinking can promote hope and may encourage others to seek help.
- Reports that show the impact of suicide on individuals and communities as a health and community issue can increase understanding about the experiences of those affected by suicide.
- It is helpful when the community is informed about the risk factors of suicide, including warning signs, and the importance of taking suicidal thoughts seriously.

The Tasmanian newspaper reporting

Ms Skehan reviewed articles and editorials. She concluded that there were areas in which the reporting aligned with the guidelines. However, she told the inquest that there were a number of areas of concern including elements that did not align with guidelines.

Below, I replicate Ms Skehan's analysis of the ways in which the reporting did not align with the Mindframe guidelines:

- The reporting about Child 3's death was prominently placed in the newspaper for the first two days of reporting and on four subsequent occasions. The coverage was also extensive between September and October 2013. Daily coverage, sometimes over four pages, occurred in September. The story also attracted editorial coverage.
- It could be argued that the reports glorified the suicide death through the following:
    - Constant publication of images of Child 3, often large and on the front page and multiple images in one story;
    - Publication of the original front page image in subsequent stories;
    - Use of celebrity quotes from late September onwards; coverage of the funeral with reports of hundreds of people attending; details of activities held with the funeral;
    - Language was at times glorifying – for example: *"beautiful girl gone too soon*" in September; *"In honour of [Child 3]"* in September; *"Child 3's greatest fear was being forgotten…it was obvious [Child 3] would be remembered"* in March 2014;
    - The campaign itself had Child 3's name, her image and her favourite colour as core components. The campaign was linked directly to Child 3's death rather than the issue of bullying more generally. The paper often reported that people were encouraged to wear blue as it was Child 3's favourite colour.
    - Every single report about the anti-bullying campaign referred to the suicide death of Child 3.

- There was a link made between the death of celebrity Charlotte Dawson and the death of Child 3 in reports in February 2014 with repeated images of Child 3.

- The reporting made a strong and direct link between bullying and the subsequent death of Child 3. The reporting initially cited *"alleged bullying"* and then began to use more definitive language from late September onwards. For example, the newspaper wrote ". . .*[this publication} revealed how [Child 3], endured three years of physical and verbal abuse and cyber bullying before taking [their] life…"* Child 3 was also referred to as a *"bullying victim"* in subsequent reports. Comments from Department of Education and mental health services reinforced the fact that it was a matter for the Coroner to establish the facts and whether bullying was a contributing factor, but the main narrative of all stories reinforced the link between bullying and suicide and supported the campaign.

- It appears from the coverage that the media reporting increased the reach of the campaign and facilitated additional traffic to the Facebook page. This page included many images of Child 3, messages of grief and many comments from the community that appeared to be unmoderated.

I accept Ms Skehan's analysis. The reports relating to Child 3's death and the anti-bullying campaign were in evidence. Ms Skehan's conclusions accord with the contents of the reports. Ms Skehan's report and oral evidence was careful and moderate. In her role with the Hunter Institute she is responsible for fostering close educative relationships with media outlets so that the Mindframe guidelines are promulgated to the greatest effect.

With respect to Ms Skehan, her analysis in evidence did not convey the full intensity or cumulative effect of the reporting of Child 3's death. Child 3 was a very attractive young person. After the death, effectively the whole of the front page of the relevant publication was occupied by a colour photo of Child 3 with large blue eyes and an appealing smile. On the same date the editor, in the editorial column, urged the reader to *"look deeply into the pearlescent [sic] eyes of [Child 3] and you can see the unmistakable sparkle of youth, full of potential and hope"*. Later in the column he stated *"[Child 3's] ambitions and dreams, all [their] hopes, and all the possibilities for … life are now gone. It appears [Child 3] was a victim of physical, mental and cyber bullying."*

The anti-bullying message and the assertion that Child 3 died as a result of bullying continued to be linked with attractive photos of Child 3 in prominent parts of the publication. The publication aligned itself with and vigorously promulgated the anti-bullying campaign in Child 3's name. In its totality, the manner of reporting was sensational, repetitive and single-minded. Child 3 was glamorised and eulogised by the words and images. The evocative phrases portrayed, and were designed to portray, a tragedy caused by bullying.

In a spread appearing on page 9 of the publication after the death of Child 3 the headline *was "… spirit now free, teen whose cause will now live on forever"*. The reporter in that spread stated that the publication revealed how Child 3 *"endured three years of physical and verbal abuse and cyber bullying"* before taking their own life. On the day after the publication of that spread, another attractive, almost full page photograph of Child 3 appeared with the first paragraph of the reporter's story reading *"the tragic story of bullying victim [Child 3] has struck a chord with people around the world".*

The link between Child 3's death and bullying should not have been made. The asserted role of bullying in the death was ill-informed. The publication was well aware that the coronial investigation into Child 3's death was in its infancy, and that it is a matter for the coroner, upon all of the evidence, to determine the reasons for Child 3's death. Nevertheless the campaign persisted unabated, based almost entirely upon the account of a family member of Child 3.

The newspaper had an existing and positive relationship with Mindframe at the time of Child 3's death. It should have been fully cognisant of the fact that the reasons for suicide are complex and are rarely due to any single cause. Yet it promoted the campaign based upon Child 3's death being due only to bullying. In the coronial investigation links between Child 3's death and bullying were very thoroughly investigated and considered. No evidence of a sustained course of bullying existed. Further, the issues surrounding the minor assault upon Child 3 was short lived and, in the context of Child 3's other issues, did not appear to be of significant concern to her/him. One of the ongoing factors in Child 3's life causing despair, and that which they expressed in their final words, was the loss of a mother and the unmet need to feel part of a loving family. This was not referred to, even on one occasion, in all of the many stories in the publication.

The publication engaged in a sustained course of prominent reporting of Child 3's death in conjunction with anti-bullying campaign. The reporting significantly glamorised Child 3, used glorifying language and celebrity quotes, linked Child 3's death to a celebrity death, and persistently asserted incorrectly that the death was caused by bullying. The Mindframe guidelines were not complied with in the manner described by Ms Skehan. The publication did not call evidence to counter Ms Skehan's evidence which was unchallenged.

It is clear that the reporter and/or editor, or both, understood the importance of adhering to the Mindframe guidelines in reporting Child 3's death and the campaign. This is evidenced by episodes of contact by the publication with the Hunter Institute for advice and assistance, as well as efforts to moderate some coverage. As described below in more detail, the publication did not sufficiently moderate the coverage to comply with the guidelines, nor did it give proper consideration to the views of close family members, including Child 3's father, and numerous professional persons who requested moderation in reporting.

Evidence was presented to the inquest in the form of a statement by paediatrician Dr Michelle Williams, made with the support of the paediatricians of Hobart. She referred to research that media reporting of suicide can increase the risk of completed suicide in other people in a vulnerable state. Dr Williams stated, in relation to the reporting of Child 3's death:

> "Unfortunately this link appeared to be significant in both some of the subsequent adolescent presentations to hospital with suicidal ideation and also in the cluster of youth suicides after the media coverage of the initial suicide. Unfortunately the ... newspaper was not receptive to advice offered about the impact of their extensive and often inaccurate reportage. This issue has been of concern to many of the paediatricians in Hobart."

Dr Wagg also gave evidence that, in the week after the death of Child 3, CAMHS had an increased recording of self-harming incidents which she attributed to the effect of contagion. She stated that the Chief Executive Officer of the Tasmanian Health Organisation South and Chief Psychiatrist were notified and steps were taken to limit the media response. Dr Wagg noted the vulnerability of young people to the experience of their peers and the fact that media coverage can have an impact upon vulnerable young people seeing how other young people make choices in relation to how to solve

their difficulties. She said that professionals are increasingly concerned about social media as a factor in suicide contagion. She said that in young people considered to be vulnerable it is her practice to talk to those young people and their parents about sensible use of social media.

Both Dr Wagg and Dr Williams are highly experienced paediatricians. Their evidence was not challenged. I accept their evidence that there was an increase in self-harming incidents in the period shortly after Child 3's death and subsequent publicity.

Ms Skehan stated that Mindframe had contact with a number of concerned local services, such as Headspace and the Department of Education, during the period of the most intense publicity immediately after Child 3's death.

Ms Skehan provided file notes that showed that Headspace made contact with Mindframe in September regarding the publication and the Facebook page mentioned in the article. Mindframe supported Headspace to make contact with the publication. The file note reads:

> "The editor is on the Mindframe Media Advisory Group and the reporter, Emma Hope, made contact with Mindframe (sic) 18th September, at the editor's suggestion, for advice about writing this story. We encouraged the reporter to make contact with Young and Well and Headspace for expert comment.
>
> As a result of the communication with the paper, the details of the death were removed from the story and there was a focus on the negative impact of the death, promotion of help seeking, and discussion about the risk factor of bullying. It is also worth noting that there may be further coverage of this story."

Ms Skehan also provided to the inquest an extract from an email dated 26 September 2013 written by Mindframe to update the Standby National Response Service. Part of the extract reads as follows:

> "We are aware of the story and have had some communication with Headspace and the [the publication] prior to the first story being run …
>
> "Marc Bryant has spoken with the [publication] editor Andrew Holman (who's on our media advisory group) re use of images and he was very supportive about

> mitigating any negative impact on the local community and will work with local health agencies."

A further Mindframe file note dated 3 October 2013 stated as follows:

> "[Anti-bullying] campaign started. Local agencies expressed concerned (sic) about the campaign focus as the issue was more complex than bullying based on the information they had and were concerned about the impact on other local young people. Headspace requested that Mindframe make contact with the [publication] about the repeated use of [Child 3's] image.
>
> Mindframe spoke with Andrew Holeman (sic) on October 3rd, relayed the local concerns (in relation to the impact of media coverage potentially on other young people and the bullying angle simplifying a complex issue). Andrew informed Mindframe he was becoming more aware of the background surrounding [Child 3's] death, and agreed to limit impact by removing the image".

In her oral evidence, Ms Skehan was unsure of the timing and content of some of Mindframe's discussions with the publication, but subsequently provided the above file notes and email extracts. There were likely to have been other telephone discussions. However, the file notes and emails that were produced provide contemporaneous, accurate details of the timing and content of the contact to which they refer.

Despite Mr Holman's assurance that Child 3's image would not be published, it nevertheless appeared in the publication in February 2014 (page 9), in the Sunday edition of the publication in March 2014 (page 6) and in the publication in April 2014 (page 6). These are smaller sized photos. In June 2014 a large photo of Child 3 appeared in the Sunday edition of the publication.

Child 3's aunt wrote to the reporter in September 2013 on behalf of Child 3's father. In her email she questions whether the publication had a policy of fact checking and consulting with next of kin where a minor is at the centre of the story. She stated that while Child 3's close family had no difficulty with the anti-bullying message, she requested that the focus be taken from Child 3 and pointed out that Child 3's father has been greatly upset at the *"shattering and highly emotive images"*. In his reply, Editor Andrew Holman states:

> "Indeed I was quite hesitant to run [Child 3's] story when we first were approached. But given the overwhelming social media movement, the already high public awareness, I hoped the story could be told as a force for good….Reporting of suicide is covered by strict criteria and it's an issue I normally shy away from. We went to great pains to deliver it with sensitivity, while respecting the privacy of [Child 3's] father. We never included the word death on page 1, settling on the word tragedy instead. The story was vetted by [a family member], who began the highly public Facebook movement, before it was published."

Clearly Mr Holman appreciated the guidelines but in running the story concerning Child 3 repeatedly and prominently, did not give proper consideration to those seeking to moderate the coverage. The practice of allowing a family member invested in the campaign, to be effectively the only person to check the story was most inadequate in such sensitive circumstances.

Child 3's aunt, a retired school principal, stated in her email to Mr Holman on October 2013 that the question arose whether, over recent weeks, some of the reports had contributed to other tragedies like that of Child 3. She raised the issue of glorification of alleged "victims" and the fact that the anti-bullying reporting runs counter to what health professionals were trying to do "to keep vulnerable young lives on an even keel".

Both Mr Mackie, counsel for the mother of Child 6, and Mr Geason, counsel for the publication, attempted to elicit the nature of the advice given by Mindframe relating to the guidelines and when that advice was given with respect to the publication of the first story. As stated, the editor of the publication was well aware of the guidelines, as was the reporter concerned, before the publication of the first story. The Mindframe guidelines provide very clear, practical advice to journalists and are easily accessible. Briefing sessions had been undertaken by Mindframe with the relevant publication on prior occasions regarding the guidelines and the reasons for complying with them. The guidelines specifically state that the reporting of suicide should be reduced to the inside pages so as to decrease risk. In my view, it matters not whether that advice was reinforced to the publication reporter just prior to the first story appearing on the front page. There ought to have been strict compliance. The breach was gross and inexcusable. The potential ramifications, being an associated increase in suicide and self-harm, were well-known by the publication by virtue of its Mindframe training.

Mr Mackie stated that there were deliberate breaches by the publication of the Mindframe guidelines, and that censure should occur for the publication not calling evidence from the editor or other person who could assist further with the circumstances of the publication. Mr Geason stated that deliberate breaches by the publication are not able to be proved to the requisite standard, and that the evidence supports that at all times the publication was trying to comply with the Mindframe guidelines. He further submitted that there was no requirement to call a representative of his client to give evidence about the breaches.

Representatives of the newspaper were not compelled to attend on the basis that the expert evidence of Ms Skehan, together with the articles, amply demonstrated the sequence of reporting and breaches of the guidelines.

I am, however, surprised that the publication ultimately chose not to call a representative who could genuinely assist the inquest. The publication left its position open as to whether or not it would call such evidence until late in the inquest. In hindsight, when it chose not to do so, it may have been appropriate to require the editor to give evidence to more completely expose the actions and reasoning of the publication in reporting as it did. My conclusions, however, would remain the same.

I do not ultimately need to make a finding as to whether the lack of compliance was deliberate. I would accept that the standard of proof required may not allow such a conclusion. However the manner of reporting, by failing to adhere to the guidelines, was conducive to a contagion effect. That fact should have been patently obvious to those concerned in the continuing publication of the stories. If the breaches were not deliberate, then the failure by those involved to turn their minds to careful adherence to the guidelines for safe reporting is a very serious matter. Additionally, those persons and organisations expressing concerns about impact appeared not to have had any effect on appropriately moderating the extensive and sensationalist coverage that the publication was determined to pursue.

None of my criticism of the relevant publication should detract from the pervasive and harmful consequences of bullying, nor that possible law reform may be a proper topic for discussion. The issue of whether “anti-bullying laws” are desirable and workable was not within the scope of this inquest due to lack of connection with death.

A contagion effect was in fact observed following Child 3's death in terms of increased rates of suicide and episodes of self-harm. I am unable to find that the newspaper reporting specifically contributed to the deaths of Child 4, Child 5 and Child 6. Child 5 attended the same school as Child 3 and was a prolific user of social media, where Child 3's death was a prominent topic. These factors may have had an impact upon Child 5 rather than the media reporting. Similarly, the fact that Child 4 attended Child 3's funeral and had a relationship with Child 3 online may have impacted upon him/her independently of the media reporting of Child 3's death. In relation to Child 6, she/he attended the same school as Child 3 and may have been subject to talk about Child 3 independently of the media publishing pertaining to the anti-bullying campaign at the time Child 6 died. The facts remain that: the newspaper reporting was prolific and in many respects did not align with the Mindframe guidelines; the deaths of Child 4 and Child 5 occurred at the height of the reporting; and all deaths occurred in the same manner as that of Child 3. Whilst the linkage cannot be made positively, the possibility remains that the newspaper reporting, combined with the online Facebook campaign sponsored and actively supported by the publication, impacted upon the minds of the three young people who ended their lives subsequently to Child 3. As Ms Skehan told the inquest, there was substantial media, online and community discussion of Child 3's death. It would be hard to determine the way that other young people received messages about the death of Child 3 and the impact it had on them. The media coverage was not done in isolation, but the media coverage drove more people to the campaign Facebook page and generated interest in the campaign more broadly. This was one of the aims of the reporting.

Ms Skehan provided the following evidence, which I accept, in her report summary:

- This case highlights a current challenge for both media and the suicide prevention sector around how to work with and support families bereaved by suicide who want to tell their story within the media or in other avenues (such as online).
- A better connection between local services and the media is needed to manage the full impact of a suicide death and to determine an approach that supports both the family and the broader community.

The suicide prevention sector needs to work quickly to develop ways to support community messaging about suicide going through online and community-based memorials or campaigns.

Suicide reporting on social media

In her evidence Ms Skehan discussed the topic of social media, which she states is completely unregulated and has the capacity to reach huge numbers of people. Memorials and campaigns are often established online to honour friends and family who have died. In the case of suicide, such pages are not usually reviewed by experts in suicide prevention. As such there is a substantial risk that the type of effect which *Mindframe* seeks to minimise will occur.

Ms Skehan stated that the Hunter Institute wishes to conduct further research to develop resources, guidelines and support to assist those people considering online suicide prevention campaigns. She stated that it is very difficult for "lay people" generating campaigns to know whether their message is a good message or harmful message. Monitoring of such campaigns by the Hunter Institute or Mindframe is not possible and yet Ms Skehan sees it as the role of the Hunter Institute, with appropriate funding, to support and educate the public in this important area of suicide prevention.

Ms Skehan stated that whilst not a lot is known about the effects of online campaigns, it is appropriate to assume that the guidelines applicable to media would directly apply to any kind of broad online communication because the principle of contagion is associated with mass exposure to the detail of a suicide. In this regard, contagion also occurs outside the traditional media through schools or in other small communities. Contagion through Facebook pages could similarly occur. Therefore, logically, details of an individual's death or repeated exposure to details and images would produce the same risk. However it is important that research is conducted in this area outside the traditional media.

Television current affairs story

A television current affairs program aired a story on the anti-bullying campaign that used the name of Child 3 in November 2013. Before that, on 8 October 2013, Child 3's father emailed the producer of the current affairs program stating that he was aware that there was to be an imminent story on the anti-bullying campaign. He stated that the

matter required sensitivity and was currently before the coroner. He stated that the producer had not consulted with him as Child 3's legal guardian, and did not have his permission to refer to Child 3 on the program. After further email correspondence in which the father further emphasised that he did not wish his child to be mentioned, the producer of the program replied that *"[A family member] speaks beautifully about [Child 3] and as you know is very strong on anti-bullying".* There was clearly no intention to remove Child 3's identity from the story.

On 8 November 2013 I wrote to the same producer advising that the death was the subject of a current coronial investigation and also that a contagion effect was a possible consequence. As such, I requested that the producer not run the story at that time. No reply was received to my correspondence.

The Hunter Institute provided advice to the current affairs program. Ms Skehan gave evidence that compliance with the Mindframe guidelines was substantial. She met with the chief-of-staff and producer prior to the broadcast as services were concerned about the threat of contagion that could emanate from the story. In particular, Ms Skehan stated that focusing on youth suicide on national television may sensationalise the issue by providing prominence and reinforce some young people's suicidal ideation. She recommended that a delay to the broadcast may limit the risk. She also discussed that focusing on one issue, bullying as a single factor in suicide, was problematic. However, Ms Skehan noted that the program used many images of Child 3 and details of their life. The story also made a direct link between bullying and suicide. There was no information from a suicide prevention expert included. Ms Skehan states that it is clear that the current affairs television coverage provided the campaign with national reach with the Facebook likes jumping to almost 300,000 following the report.

It is concerning that requests by both Child 3's father and the coroner were either ignored or downplayed. It is also concerning that, despite advice from Ms Skehan, the story was run with images of Child 3, details of their life and asserted that the death was as a result bullying. Again, I can only conclude that, unfortunately, the single-minded desire to produce and air the story originally proposed caused a disregard of these extremely important considerations in a contagion effect.

I observe that the *Coroners Act* 1995 does not contain a power to order suppression of the identity or personal details of a deceased person during an investigation (as opposed to inquest proceedings). Child 6's mother raised this as an issue at inquest. It

was the personal details and photographs of Child 3 that featured so strongly in the impact of the stories and that created the greatest risk of contagion. I also note that the inaccurate and repetitive assertion that bullying caused the death of Child 3 tended to undermine the coronial investigation that was then underway. It is therefore strongly arguable that a coroner investigating youth suicide should have suppression powers available relating to the identity of the deceased young person during a coronial investigation. This would be consistent with provisions in other legislation protecting the identities of young people. There may well be a need to commence a review of the suppression provisions generally in the *Coroners Act* 1995.

Recommendations

1. I **recommend** that newspapers and all media organisations, in publishing articles and editorial on suicide, ensure complete compliance with the Mindframe Guidelines, including publication on their associated websites and social media.
2. I **recommend** that newspapers and media organisations provide staff with ongoing regular training in the *Mindframe National Media Initiative*, or similar evidence-based guidelines that is designed to reduce the effect of contagion.
3. I **recommend** that newspapers and media organisations develop relationships and strategies with mental health and suicide prevention services and schools to manage the potential impact of suicide reporting, and to determine an approach to publication that supports both the family and the broader community and reduces the risk of contagion.
4. I **recommend** that newspapers and media organisations consult, where possible, with mental health and suicide prevention services and schools immediately prior to the first publication of a story relating to a particular death, particularly the death of a young person, with a view to obtaining requisite balanced opinions and information for appropriate reporting.
5. I **recommend** that the Hunter Institute for Mental Health or a similar expert body, conduct research into the effect of social media (including memorial pages or online campaigns) on suicide contagion and prevention, with a view to promulgating advice on suicide reporting to those considering online memorial pages or campaigns and users of social media generally.

6. I **recommend** that relevant agencies consider the establishment of public education with a view to creating greater awareness of the potential effect of online reporting or discussion of suicide.
7. I **recommend** that a review of suppression powers under the *Coroners Act* 1995 be undertaken, including consideration of provision to allow coroner power upon the opening of an investigation, to suppress the names and personal details of a young person who has taken their own life.

Child Protection Issues

Legislative framework of Child Protection Services

The *Children, Young Persons and Their Families Act* 1997 provides the framework and mandate for notifications of harm to and response by CPS. The mandate of CPS to protect children at risk of harm from abuse and/or neglect arises from the reporting of notifications in respect of children. The *CYPF* Act, sections 13-16, provides for confidential notifications, including mandatory notifications, in respect of risk to a child. The powers under the CYPF Act are reposed in the Secretary of the Department.

By section 8, the *CYPF Act* is founded upon the following principles:

(a) the primary responsibility for a child's care and protection lies with the child's family;

(b) a high priority is to be given to supporting and assisting the family to carry out that primary responsibility in preference to the Secretary commencing proceedings for a care and protection order in respect of the child;

(c) if a family is not able to meet its responsibilities to the child and the child is at risk, the Secretary may accept those responsibilities.

Under the 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

(c) (ba) the child is an *affected child* within the meaning of the *Family Violence Act* 2004 (*affected child* means a child whose safety, psychological wellbeing or interests are affected or likely to be affected by family violence); 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; or

(d) the child is under 16 years of age and does not, without lawful excuse, attend a school, or other educational or training institution, regularly.

The task of assessing risk in relation to notifications can be very difficult. The issues in this inquest relate to the assessment of risk and response by CPS to particular notifications regarding Child 1, Child 2 and Child 3. In relation to Child 5, I am required to comment upon his care, supervision and treatment under the Child Protection Order.

In a setting such as an inquest, findings and comments are necessarily made with the benefit of hindsight and with knowledge of the eventual outcome. As stated previously, caution is required in such circumstances before finding that a different decision should have been made. I recognise that at the time of a decision being made regarding a notification, there is often a difficult weighing process of risk and protective factors before a judgment is made as to response.

General evidence by Deputy Secretary, Children and Youth Services

Mr Tony Kemp, Deputy Secretary, Children and Youth Services, provided a statement of evidence for the inquest. He also gave sworn evidence relating to the involvement of CPS in respect of Child 1, Child 2, Child 3 and Child 5, as well as general evidence regarding the organisation. Mr Kemp is a qualified social worker with a Master's degree in social policy. His career in child protection commenced in 1993. Mr Kemp did not occupy the position of Deputy Secretary, nor occupy any position in CPS at the time of CPS involvement with the four young people concerned. Nevertheless, Mr Kemp presided over a review of the child protection response. He had familiarised himself with the files and was able to give evidence relating to the particular areas identified for the inquest.

At the outset, I am grateful for the assistance given by Mr Kemp, the time taken by him to review the documentation and prepare evidence; and for the open and informed manner in which he dealt with the issues arising. I note that Child 5's carers and the mother of Child 2 expressed particular appreciation for the candid manner of Mr Kemp's evidence. The inquest was not able to call the many CPS workers and managers involved for the purpose of reviewing the decision-making by CPS in respect of the young people. However, the inquest defined certain aspects of CPS action for examination. Mr Kemp's evidence responded to these key matters. His evidence was helpful and has assisted in understanding the issues surrounding CPS involvement with the young people concerned. The cooperation of CPS has been to a high standard in all aspects of this inquest.

There is no requirement any longer for a coroner to find the identity of any person who contributed to death. A finding of contribution was a requirement at the time of the inquest but has been repealed as at the time of this finding. It was not envisaged, whilst determining the scope of the inquest that CPS or any of its employees could be, on the evidence, subject to a finding of contribution. After hearing all of the evidence there is no evidence to suggest any finding that any person whether an employee of the State or otherwise has contributed to the deaths of the young people. I need say no more given the abolition of the requirement for a formal finding of contribution.

Mr Kemp stated that "this phenomenon (youth suicide) presents us as a society with an extraordinary challenge, one which needs to be met holistically and urgently. Youth suicide in Australia remains the leading cause of death of young people aged 15 to 24

years." He further states that for those young people in contact with child protection services, the risk factors for self-harm, suicidal ideation and suicide are more likely to be present. These children will more likely have an absence of protective factors such as family connectedness and support and adaptive coping and problem-solving skills. He notes that a New South Wales review undertaken in 2014 found that children with a child protection history had 4.1 times the mortality rate by suicide than those without such a history. Mr Kemp notes that unresolved trauma and harm in childhood can create entrenched harm. He noted the difficulty in predicting which young people with risk factors will ultimately take their own lives. He also noted the problem of trying, often unsuccessfully, to have young people engage with services and support. Mr Kemp gave evidence that there is no "standard solution" to prevent youth suicide.

In his evidence Mr Kemp stated that CPS received 12,800 notifications in the financial year ending in June 2014. He noted the constant trend upwards and the indication for that to be ongoing in the years to come. Mr Kemp stated that the demand for CPS far outstrips the capacity of the organisation. He stated that, given the CPS's limited capacity, the propensity is to respond to notifications involving infants and the most vulnerable children. He stated "regrettably, we must make demand management decisions based upon what is available to us to respond at any given time." Ultimately, Mr Kemp was of the opinion that, in general, the notifications in respect of the young persons in isolation were dealt with in compliance with policy but the analysis of the information was insufficient. Whilst Mr Kemp did not, in his evidence, place the blame for inadequate protective responses upon lack of resourcing, it was clear to me that many CPS actions and responses were limited by lack of time, lack of staff, and lack of training.

The organisational issues and developments raised by Mr Kemp that touch upon CPS's care and protection of youth generally are as follows:

(a) Currently there is a "generic" response to child protection that favours the younger at-risk child over the youth at risk cohort. This is having a deleterious effect on the CPS response capacity and capability for youth at risk. In response, CPS has started to design an overarching governance structure that sets up three discrete portfolios of child protective work – babies in early childhood, the middle years and a youth portfolio. The youth portfolio will be headed by a manager, providing a single point of accountability for the strategic and operational responsibility relating to youth at risk.

(b) In recognition of the difficulties surrounding young people residing in youth shelters, CPS have released draft protocols between CPS and youth shelters, involving consultation to clarify expectations, responsibilities and common practices for all young people under 16 years of age who are accommodated or supported by youth shelters. The proposal envisages a liaison officer within each out-of-home care placement team to act as a contact for the shelters and to record a “homeless alert” where a formal notification is not appropriate. If there are multiple homeless alerts then these may be escalated to a notification to recognise the risks associated with episodic homelessness. The protocol was to be implemented by mid-2015 and therefore should have been completed by the date of this finding.

(c) A strengthening of CPS practice in relation to the concept of cumulative harm applicable to adolescents is required. He stated that the concept of “cumulative harm” is recognition that the risk to the child is formed by the totality of their whole experience. If children have experienced multiple episodes of or variations on an issue of neglect or abuse, subsequent single episodes must be considered in light of the whole experience of that child to gain the complete picture of risk as opposed to simply looking at remedying the immediate situation of risk. Mr Kemp stated in evidence “It’s about joining the dots and saying not what this incident is about but what does this whole story tell us about this child. And I think that there is room for improvement in that most definitely.” He noted in this area that CPS is committed to reviewing practices, processes and systems, including the assessment of cumulative harm, to improve outcomes for young people.

(d) A major reform of out-of-home care is currently underway relating to the provision of specialised care services – being sibling group care, residential care types, specific response care packages and therapeutic services. He states that specifically, residential care for older children with challenging behaviours should be in a therapeutic environment staffed by professional carers with specific skills to provide flexible support relevant to adolescents. Other developments will focus around providing the skills and support needed to carers who are caring for children with challenging behaviours. The other developments are that services will be provided through a trauma informed, evidence-based model by specialist teams equipped to address the therapeutic needs of children and young people in out-of-home care and will deliver a

> structured range of interventions. Specific training will be provided to carers, families and CPS staff to address the needs of individual children. Mr Kemp stated that consideration of models of "professional" foster care for hard to place young people and processes to ensure that care capacity is matched to the needs of children are key areas of the reforms.

As I have referred to further on, major areas of deficit in CPS practice pertaining to young persons relate to (a) deficiencies in recognising and assessing cumulative harm and responding to it adequately; (b) lack of staff skilled to engage with young persons; (c) deficiencies in dealing with youth homelessness. The recognition of such issues by CPS and the proposed initiatives set out above are positive developments in the care and protection of young people at risk.

I now turn to the main areas of CPS involvement in respect of the four young people concerned. My conclusions are listed under the individual headings.

Child 1

In 2001, when Child 1 was six years of age, the first notification was received by CPS. By 2003 CPS was fully aware of the significant risk factors in respect of Child 1, including suicidal ideation. In 2007 and 2008 there were nine notifications to CPS in respect of Child 1, with only the last three being subject to further investigation and assessment. In total, Child 1 was the subject of 18 CPS notifications involving, variously, Child 1's suicidal ideation, family dysfunction, homelessness, mental health issues, police involvement, alcohol and substance use.

I have set out below my comments on CPS processes over a period of nine years in respect of Child 1. I accept that CPS responses during the earlier notifications may not be representative of current CPS practice, which is evolving. However, the issues relating to identifying and responding to cumulative harm, inadequate risk assessment, and overreliance upon Gateway support without follow-up remain relevant.

Despite the number of notifications, seriousness of the risk, and the significant extent of CPS involvement in Child 1's care, CPS closed most of the notifications without further investigation. It also withdrew an application for a care and protection order and closed case management in June 2009 on the basis of the making of a family agreement. All

subsequent notifications, including a notification of a potential suicide attempt 10 days before Child 1's death, were closed.

At an early stage in the continuum of notifications there should have been a review of arrangements for ensuring an ongoing plan of care for Child 1. Instead, the file reveals many attempts to persuade the mother to continue in the parental role in the face of overwhelming evidence that she was unable to adequately care for Child 1. Further, it appears that the decision made by CPS to withdraw the application for the 12 month care and protection order was based largely upon the fact that Child 1 and Child 1's mother did not want CPS involvement and that Child 1's family were willing to take responsibility for the child. The family agreement was in basic terms only and contained no level of detail to indicate proper consideration of the mutual obligations involved.

Given the evidence of inconsistency in Child 1's mother and family members providing care for Child 1, the family agreement was unrealistic and unlikely to be adhered to without significant ongoing support. Child 1's mother had already indicated on many occasions that she did not wish to accommodate or take responsibility for Child 1. Further, CPS notes indicate that Child 1's mother only engaged when in crisis and via telephone and would not allow workers to access or visit her home. This was a clear indicator that CPS should not have persisted with Child 1 returning to the mother unless she was fully supported. Risk issues for Child 1 in this situation were unacceptable. The approach adopted by CPS was superficial and unlikely to address the long term issues affecting Child 1 and his/her family.

It does not appear that ongoing effective engagement between Child 1 and his/her family on the one hand, and Gateway Services on the other, occurred. CPS should not have allowed Gateway to deal with Child 1's difficulties without further investigation or oversight by CPS. To do so was not an adequate response to the risk posed to Child 1 as a result of many problems in their life.

CPS was well aware of Child 1's suicidal ideation, expressed on many occasions from November 2008 onwards. There is no adequate reasoning documented as to why CPS did not proceed with the care and protection order when it was apparent that the family agreement was a failure. Child 1's file is replete with examples of CPS closing notifications or ceasing involvement because other agencies were purportedly working with Child 1 and on the basis that the mother would take responsibility for the child. The number of closed notifications is concerning. The fact that Child 1 was the subject of

many notifications, investigations and assessments between September 2008 and June 2009 should have brought home these significant risk issues relating to Child 1. These included homelessness, police involvement and suicidal ideation. Additionally, Child 1 struggled to engage with services attempting to help.

Notwithstanding the fact that CPS was sufficiently satisfied of risk to apply for a care and protection order, the application was withdrawn on 2 June 2009 and Child 1's case formally closed on 5 June 2009. Nevertheless, notifications relating to persistent offending, family dysfunction and suicidal behaviour continued, with nine subsequent notifications, the last being three days before Child 1's death on 17 December 2010. This notification was closed on the same date. It related to Child 1's attendance at DEM having taken an overdose of Nurofen tablets in what appeared a clear attempt to self-harm. Child 1 then refused treatment. It was also reported that Child 1 was not staying with his/her sibling, and thus likely homeless. Nevertheless the notification was closed on the basis that Child 1 was to be referred for Gateway support with his/her sibling whose referral to Gateway was still to be allocated. In my view this response to the risk posed was not adequate.

I observe that out of 19 IAST meetings in respect of Child 1 between 24 April 2009 and 18 February 2011 (post his death) CPS had a representative at only five meetings. At the meeting of 16 April 2010 the CPS worker reported that Gateway Services had become involved and she undertook to provide an update to the next IAST meeting. I cannot see that any update was provided, or even that any CPS representative attended the next seven IAST meetings before Child 1's death. The lack of CPS involvement in a very important collaborative forum was most unsatisfactory.

Mr Kemp stated that CPS practices could have been strengthened in various ways. These included a clear assessment and intervention response by ceasing the reliance on historical information and assessments to inform assessment of the current situation, greater clarity and recorded decision-making in relation to roles and responsibilities to Child 1, when the child resided in supported accommodation services; and seeking mental health assessment for Child 1 where risk indicators are present.

Mr Kemp also stated that more could have been done in response to the cluster of five notifications in 2007 that did not trigger further investigation. I agree with his conclusion. It appears that, despite the serious nature of the 2007 notifications, the outcome as a result of a further notification on 25 February 2008 was that the file was closed. This

notification involved breakdown of the relationship with the mother, lack of support financially, homelessness and school absenteeism. It was closed on the basis that another agency was working with Child 1 and there was therefore no need for CPS intervention. It is noted that the other agency would be in contact if there were any further issues where an assessment or response may be required by CPS. At this stage CPS should not have delegated its responsibility to another agency but, on the basis of this and the earlier multiple notifications, undertaken its own comprehensive assessment as to risk and appropriate response.

Mr Kemp acknowledged that in relation to a number of CPS notifications referred to Gateway, Child 1's issues, particularly emerging mental health issues, required child protection assessment. He stated that the response did not have full regard to what CPS knew at that stage, which included that Child 1's mental health issues were beginning to spike at that time. Again, I agree with his comment.

Gateway referrals by CPS occurred on 20 July 2009, 23 September 2009 and 3 December 2009. On 20 July 2009 it was noted by CPS that there have been numerous notifications regarding Child 1 who presented with "multi-issues" and many notifications regarding risk of homelessness. It was also noted that Child 1 experienced significant trauma from a young age especially following the suicide of Child 1's father.

On 23 September 2009 Child 1 took an overdose of drugs and presented to DEM. Child 1 told hospital staff that 5they were not concerned if they died. Child 1 was violent at the hospital. On this occasion CPS decided to take no further action as Gateway was following up with Child 1. On 2 December 2009, 23 December 2009, 6 January 2010, 17 February 2010 CPS received notifications of Child 1 being violent, homeless and self-harming. On 17 February 2010, after Child 1 had self-harmed and refused to give a razor blade to police, CPS closed the notification on the basis that everything possible had been offered to the family and that if Child 1's mother was unable to find accommodation for Child 1 she could seek a CPS placement. This was an unrealistic requirement of Child 1's mother in all of the circumstances.

In summary, the main areas of CPS deficiency in respect of Child 1 were as follows:

- CPS did not recognise sufficiently early the risk factors and investigate with a proper long term strategy for Child 1's care and protection, including mental health assessments as appropriate;

- CPS did not fully recognise and respond to the cumulative harm suffered by Child 1;
- CPS failed to fully investigate multiple notifications, particularly those in 2007;
- In withdrawing the application for a care and protection order, CPS relied on a family agreement that was inadequate in its terms and that had little prospect of success;
- Upon the immediate failure of the agreement, CPS did not pursue the care and protection order;
- CPS relied on Child 1's mother to provide adequate care and protection for the child over a long period of time. The circumstances illustrated that she could not do so; and
- CPS consistently relied on Gateway and outside service providers to resolve risk issues, and closed the CPS notification without monitoring whether the service providers could successfully engage with Child 1.

Child 2

Child 2 was known to CPS from the age of four years. Between 2000 and 2006 there were several notifications relating to exposure to family violence. Child 2 was burdened with intergenerational risk factors, as referred to in my findings. Child 2's parents' periods of incarceration and family instability, possible drug use and family violence were examples of such risk. From the age of 12 years there were multiple notifications to CPS relating to Child 2 engaging in age-inappropriate sexual relationships, being the victim of sexual assault, alcohol use, non-attendance at school, drug use of parents, suicidal tendencies, self-harm, and homelessness. Finally, 12 months before her death, Child 2 was the subject of a serious family violence incident whereby CPS was notified that her/his boyfriend had threatened to kill Child 2 with a knife, physically assaulted Child 2 and destroyed Child 2's property.

All notifications relating to Child 2 were closed at intake based on the involvement of other agencies and services to meet identified risks.

Some of the later CPS notifications in respect of Child 2 require examination.

On 28 September 2010 CPS received a notification that Child 2 had been sexually assaulted, with details of the assault being provided. CPS closed the notification on the basis that the matter was notified as a criminal matter and that no protective concerns were noted regarding the care of Child 2 by the grandparents. Further reasoning for closing the notification was that Child 2 was supported by school staff, police were to deal with the alleged assault through appropriate channels, and that Child 2 was old enough to seek help via the various agencies if they needed.

On 24 November 2011 CPS received a further notification that the family had not engaged with Colony 47 Youth Connections program, that Child 2 had recently again been sexually assaulted, and that they had not attended school for six months.

On 27 January 2012 CPS received a notification that Child 2's adult boyfriend was living in the home with Child 2 and Child 2's mother. A cumulative harm review occurred noting the mother's acceptance of Child 2 repeatedly being involved in age-inappropriate relationships. At this point, having determined the occurrence of cumulative harm, it was the responsibility of CPS to take effective steps to mitigate the risk to Child 2. CPS had significant information regarding serious ongoing risk factors in Child 2's life. The CPS documentation indicates a consideration of all previous notifications. In the conclusion the worker assessing cumulative harm states that *"it appears that [Child 2] has been exposed to a broad range of neglect, sexual abuse, and emotional abuse throughout [their] life, relating to [their] mother's instability, alleged drug use and family violence experience. Both mother and [child] have experienced sexual assaults and [Child 2] continues to engage in sexual behaviours with older men victimising the child."*

After the cumulative harm assessment, a CPS team leader wrote to a Senior Quality Practice Advisor to the following effect:

> "I don't feel there is anything further that CP can accomplish with a referral to response given the notified concerns relate to allegations regarding Child 2 being in a relationship and living with a 21 yr old male; this issue has been referred to police and is a police matter."

The senior practice consultant agreed to closure. For this notification the risk was assessed as "high risk", the notification was closed on the basis of it being a police matter, and a comment that this pattern of behaviour was likely to continue. Whilst the

cumulative harm assessment was conducted, CPS appeared to treat the risk issues to Child 2 as simply one of engaging in age-inappropriate relationships. In closing the notification particular attention was not given to understanding the complexity of Child 2's experience and that CPS should therefore have considered a multi-systemic response to engage and coordinate services to assist her.

On 15 March 2012 CPS received a notification relating to concerning events at the home of Child 2's mother as well as the fact that Child 2's older boyfriend was still visiting Child 2. The intake assessment of harm consequences was assessed as serious, harm probability likely, future risk high and that there was an immediate risk to safety. Nevertheless CPS did not undertake further investigation or refer to response but again completed a police referral and closed the notification.

On 14 June 2012 CPS received the final notification before Child 2's death relating to a serious episode of family violence against Child 2. This reportedly involved the boyfriend entering Child 2's home as a trespasser, assaulting Child 2, and threatening to kill Child 2. It was reported that he was located at his home, arrested, charged and a police family violence order was made. A cumulative harm review was completed. In assessing cumulative harm CPS staff recognised that Child 2 had been exposed to family violence as a child. Staff expressed concerns about the need for therapeutic intervention in light of Child 2's "trauma background". They also questioned whether Child 2's mother sanctioned Child 2's relationship. However, the notification was closed on the basis that the risk was alleviated by a family violence order and referring Child 2 to family violence counselling.

In relation to the determination of cumulative harm, Mr Kemp gave evidence that from the file it is not clear how that assessment was translated into action and a plan for intervention to mitigate the risk. I find that such a plan was not formulated. The notification was dealt with superficially with a failure to act upon a clear sign that a pattern of family violence would replay itself in Child 2's life. In many of the notifications there is the same pattern of closure at intake without a plan to mitigate risk. Mr Kemp stated that in respect of Child 2 there were opportunities to apply stronger analysis and identify a series of interventions that were necessary. In particular he stated that notifications regarding Child 2 indicated an unfolding story in regard to their mental health, and there was an opportunity to have a formal assessment in that regard and possibly ongoing work in that area. He particularly indicated that the notifications in

2010 would have presented an opportunity for CPS to look at Child 2's mental health issues to alleviate future risk. I accept his comments.

An examination of the notifications in respect of Child 2 indicates deficits in follow-up by CPS as to the efficacy of the referrals. Mr Kemp agreed with the proposition that CPS has a role to play in assessing the efficacy of the referrals if a notification is to be closed on the basis that another organisation is providing services to mitigate risk. He noted the pointlessness of simply making a referral without a comprehensive understanding of whether the referral will deal with the needs of the child, has the capability to meet that need and will mitigate the risk. In my view the notifications relating to Child 2 are striking examples of a lack of analysis of the issues and analysis of whether the existing services were appropriate. I accept that CPS was aware that Child 2 was receiving counselling from Jai Friend at Clare House and that Child 2 was engaging well with Ms Friend. However, given Child 2's history of trauma, self-harm, parental instability and homelessness, an investigation at response level was clearly required for Child 2 in order to plan a fully informed multi-systemic approach to his/her ongoing risk issues and to cover the event that Child 2's engagement with the counsellor ceased (which ultimately it did several months prior to death). It may have been that an investigation would have led to an application for an assessment or a care and protection order.

Ideally, Child 2 and the parents required intensive intervention when Child 2 was an infant to reduce or eliminate the risk factors that caused Child 2's mental health and behavioural issues that emerged in adolescence. In Child 2's case obvious family risk issues were present at the time of birth. No such intervention occurred.

It is only speculation as to whether more intense CPS involvement, with or without court orders, would have changed the course of Child 2's life. It was certainly required in accordance with the CPS mandate under the *CYPF* Act.

In summary, the deficiencies in CPS practice regarding Child 2 are as follows:

- CPS did not appreciate the totality of risk factors and investigate with a strategy for Child 2's care and protection, including mental health assessments;
- CPS failed to properly analyse and respond to the cumulative harm suffered by Child 2, including consideration of the protective and parenting capacity of the mother;

- CPS did not investigate and respond to notifications at response in 2010 onwards, and therefore did not sufficiently consider all available protective interventions; and
- CPS consistently relied on outside service providers to resolve entrenched risk issues, and closed the notifications without monitoring whether the service providers would successfully engage with Child 2 and alleviate the risk to them.

Child 3

Child 3 was known to CPS since 2007. There were 13 notifications in respect of Child 3 with only one referred to response for further assessment, being a notification on 10 July 2012.

At the time of Child 3's death there was an open notification as a result of Child 3 reporting that they wished to live in foster care as well as concerns about Child 3's lack of consistent engagement with school.

The concerns reported about Child 3 in the notifications involved family dysfunction and homelessness; an ongoing relationship with a 20-year-old person; alcohol and marijuana use; self-harm by cutting and a suicide attempt; concerning emotional presentation at times; inability to engage with services; and concerns regarding mental health.

On 22 November 2011 CPS received a notification that Child 3 was living away from the father and was in a sexual relationship with a boyfriend. This notification was closed, with CPS noting that follow-up was to occur through the school.

On 10 May 2012 CPS was notified that Child 3 was living with a sibling and that the sibling drank alcohol and smoked marijuana in front of Child 3. There were further concerns that Child 3 was self-harming and presenting with suicidal ideation. CPS on that occasion noted the involvement of learning services (and possibly other services) and deemed there was no role for CPS.

On 10 July 2012 CPS received a notification that Child 3 was still living with a sibling and in a sexual relationship with a 20-year-old boyfriend who was also residing in the home. There was a notification that Child 3 was consuming significant amounts of

alcohol and possibly marijuana on this occasion. CPS referred the notification to the response level for investigation. The assessment on this notification was that the harm consequence was serious, harm possibility likely and future risk was high risk.

Two further notifications, on 14 August and 28 August 2012, involved Child 3 using marijuana daily, that there was limited food and clothing at home for Child 3, that there was a lack of adequate guardianship at the home of Child 3's siblings, and that the siblings refuse to engage with referrals.

As part of the investigation, a family meeting was arranged and Child 3 was encouraged to move to an accommodation facility due to concerns regarding Child 3's living arrangements, relationship with older boyfriend and drugs. After Child 3 moved to the accommodation facility, the relationship with the boyfriend continued. CPS made contact with Child 3's father and he committed some financial support for Child 3. The police intervened in the relationship between Child 3 and the boyfriend to attempt to end it. CPS determined that a family group conference was not necessary at this time and that CPS had no further role. The case was closed on 29 November 2012.

Just 11 days later, on 10 December 2012, CPS received a notification that Child 3 had overdosed on medication. CPS understood that the motivation of Child 3 was to "get high" and not to self-harm. Whilst CPS was given an indication that the incident was due to misadventure, it should have been obvious to CPS that Child 3 was in a position of serious risk. Child 3 had previously been involved in self-harm, did not engage with services, used alcohol and/or drugs and was effectively homeless. The accommodation facility should not have been considered a long term accommodation prospect for Child 3 such that the notification could sensibly be closed at intake without further investigating Child 3's mental health and opportunities for stable accommodation. By this stage it was apparent that Child 3's home was completely unsuitable for Child 3 and that she/he had no appropriate guardian there. For this notification the harm probability was assessed as unlikely and future risk assessed as low risk.

On 14 January 2013 a further notification was received by CPS whereby Child 3 reported that they had been drugged and that a friend had been raped. The notification was closed as CPS assessed that Child 3 was able to reside with the father but chose to live at the accommodation facility and that the father was financially supporting this. The basis for closure was tenuous. There remained outstanding allegations of physical abuse by Child 3 and a refusal to live with the father. This therefore was not a realistic

possibility and the accommodation facility was not suitable as accommodation for any extended period of time. By this stage CPS should have been well aware of the very significant risk factors in Child 3's life, the fact that she could not stay in the accommodation facility for much longer and the fact that serious notifications were continuing to be received by CPS.

On 27 February 2013 a further notification was received by CPS relating to Child 3's ongoing relationship with the 21-year-old boyfriend, levels of intoxication (such that Child 3 had been found lying on the side of a road) and self-harming. The harm consequence was assessed by CPS as serious, the harm probability as likely and the future risk as high risk. The notification was closed on the basis that Child 3 was to be supported by community organisations. This was despite significant evidence that Child 3 did not engage to any effective extent with such organisations.

The next day, on 28 February 2013, CPS received a notification that Child 3 re-presented to the accommodation facility the previous night after a period of time. Child 3 was distressed and hyperventilating but refusing to engage with mental health services. A cumulative harm assessment for the purpose of formulating a detailed and comprehensive intervention plan for Child 3 would have been obvious at this stage.

On 23 July 2013 CPS received a notification relating to Child 3 claiming income support from Centrelink. Centrelink had sought information from CPS to support them not needing to contact the father. The notification indicates that the relationship between Child 3 and the father appeared to have broken down. CPS assessed that this fact did not appear to increase the risk to Child 3. This conclusion is surprising. Child 3's mother had passed away, Child 3's siblings were inappropriate guardians, and Child 3 was homeless. Child 3 had other significant risk factors. The fact that the relationship with the father had significantly deteriorated should have, at least to some extent, been seen as an issue detrimental to Child 3's mental state. Nevertheless, the notification was closed. The harm possibility was assessed as unlikely and future risk low risk.

In September 2013 Child 3 told staff at the accommodation facility that he/she wished to find out about living with a foster carer. As indicated in this finding, the facility contacted CPS to ask that a CPS worker be allocated to Child 3 as they wished to have support to get their life "back on track". Eight days after this contact had been made no response had been received from CPS. Whilst this is a relatively short period, if Child 3 had had some preliminary indication that issues relating to their welfare were being progressed

by CPS then that may have made a difference to Child 3's state of mind. I accept, both on the basis of Mr Kemp's evidence and common sense, that to find a foster carer for Child 3 would be difficult. However, some steps could possibly have been actively taken to find Child 3 suitable accommodation. If a comprehensive intervention plan for Child 3 had existed then CPS would have had a clear direction and confidence in the manner in which it provided care and protection to Child 3. I accept that the work involved in assisting Child 3 would have been intensive, and there were likely competing time considerations to CPS staff. However over a period of two years this strategic approach should have been considered in response to Child 3's significant risk factors.

Mr Kemp gave evidence that a review of the notifications for Child 3 found that practice could have been strengthened by a stronger risk assessment, including clear documentation of information gathered, analysis and judgement. I agree with his comment. Child 3's case shows that CPS had a pattern of responding minimally to notifications. Mr Kemp stated that the assessment should have recognised the "fluid and changing" nature of risk and safety. There were indicators that Child 3's situation required further investigation. He stated that clear intervention plans to address identified risks could also have been implemented. He stated that, for Child 3, case conferencing with other involved agencies could have established clear agreements and responsibilities for referrals and follow-up. He stated in evidence that what was missing in the assessments was a consideration of the totality of the changes in Child 3's life and the effects upon Child 3's mental health. He stated that all of the impacts of their experiences combined with the immaturity of their age and their mental health were not, in the overall scheme of things, considered as part of the CPS intervention plan. Mr Kemp stated that, like Child 2, the response to the notification entirely focused on the immediate risk facing Child 3, for example obtaining of accommodation for the night.

Mr Kemp stated that in May 2012 there was a need, after a number of closed notifications, to undertake a cumulative harm assessment in respect of Child 3 to contribute to CPS's overall understanding of risk. During this time Child 3 was effectively homeless with all of the additional risk that such a situation entails, and therefore the notifications were serious and deserved depth of investigation. Notably, CPS was advised that Child 3 was living with an adult female who was not a registered foster carer, maintaining a relationship with a 21-year-old boyfriend, drinking alcohol and self-harming. No attempt was made to determine Child 3's safety with this adult

female even in light of documented concerns regarding Child 3's lack of supervision due to the female working shifts and being absent from the home. Mr Kemp stated that if this stronger assessment process and understanding of Child 3's situation had occurred this may have triggered other interventions.

The CPS file pertaining to Child 3 indicates few direct contacts personally between Child 3 and CPS. In my view direct contact and rapport would have been essential for a full assessment of Child 3's needs and risks. There was also little contact between CPS and Child 3's father. Although Child 3 reported not wishing to live with the father, and made allegations that he was physically abusive, CPS had a role to play in assessing the allegations and opportunities for some reunification with him. The evidence indicates that Child 3 did speak to the father and at times met with the father. An assessment of any depth and efficacy would have determined the nature of the relationship and opportunities that existed for reunification.

In summary, the main areas of CPS deficiency in respect of Child 3 are as follows:

- No clear intervention plans were implemented to address risk;
- Generally there was inadequate investigation with no cumulative harm assessment undertaken at appropriate times;
- CPS relied upon outside providers to engage with Child 3 in the face of evidence that Child 3 did not and would not sufficiently engage;
- CPS had insufficient contact with Child 3 or the father to gain understanding of the risk and protection issues; and
- CPS did not sufficiently address Child 3's homelessness.

Child 5

I have already set out in some detail in the finding pertaining to Child 5's history of care and protection. Child 5 was a most traumatised child whose resultant emotional and behavioural difficulties required enormous support, time and resources. A care and protection order, with guardianship being granted to the Secretary, was made in respect of Child 5 on 18 June 2008. I have found that Child 5's carers were dedicated, loving and, in all respects, admirable. Given the complexity of Child 5's life and difficulties, it is an impossible exercise to analyse all decisions made pertaining to his care, protection and supervision. I deal below with the main areas raised at inquest. These are the

areas of CPS involvement that impacted most significantly upon the care of Child 5. Mr Kemp provided a detailed and helpful summary of Child 5' course and care with CPS, including the particular features requiring comment. I set out the separate headings below.

Transfer of guardianship

The timing around the transfer of guardianship was not communicated adequately to Child 5's carers. Mr Kemp stated that the guidelines indicate that where a family or child is receiving intensive interventions or support, the transfer should not take place at that time. This guideline is not inflexible, but he stated that it is important "to separate out concepts of capability versus timing". Mr Kemp stated that the case notes do not provide a proper analysis of the reasons for opposing guardianship despite it being sought by the carers, the ACF and the primary CPS worker. I accept the soundness of Mr Kemp's interpretation of the records. It is unsatisfactory that no clear reasons are documented. There is no question that the transfer was a matter of real importance to Child 5and his sense of safety and security, as stated by the carers and Ms Pringle-Jones. The carers had been Child 5's carers since February 2008. Those professionals closest to Child 5 supported a transfer of guardianship. One of the carers had qualifications in adolescent health and welfare. The TCP in its intensive form had ceased. In this case, there was every reason to expedite the transfer. Even if the transfer was delayed to monitor Child 5's condition for a further period, the timing issue should have been discussed and documented with a firm indication communicated to Child 5. The relationship between CPS and the carers appeared to affect the decision-making and communication process between both parties such that no clear path was identified for the timing of the transfer of guardianship. The responsibility to make a reasoned decision and to communicate it fell upon CPS, particularly given that it would have been in Child 5's best interests to have such knowledge and certainty.

In evidence, Ms Pringle-Jones stated that she had recommended that the transfer of guardianship be finalised before any reduction in the removal of funding in respect of the TCP. It is surprising that the views of Ms Pringle-Jones, a specialist therapist with much knowledge of Child 5, did not appear to have been accepted notwithstanding the usual guidelines regarding the transfer of guardianship. I note that the out-of-home care document indicates that the CPS plan is to strengthen permanency planning, including the transfer of guardianship process for children whom reunification with parents is not possible.

Relationship between CPS and the carers

A fractious relationship between the CPS staff and the carers had developed. Mr Kemp acknowledged that some of the staff did not act professionally in the relationship and did not adequately communicate with the carers. One of the carers stated that they believed their work as an advocate for a group called Family Inclusion Network and their persistence in pursuing resources associated with Child 5's care resulted in animosity towards the carer by staff. CPS management stated that the carer had a lack of trust in CPS staff that worsened at the time of the complaint in care relating to the other carer. The carer submitted that this impacted upon decisions made by CPS to the detriment of Child 5. It is an impossible task to determine how the difficult nature of the relationship impacted upon Child 5 or the degree of responsibility of each party. CPS had a responsibility to act professionally and in the best interests of Child 5. There are many examples on Child 5's voluminous file demonstrating that CPS was trying to manage Child 5's extremely difficult case as best it was able, constrained by lack of resources. Equally, there may have been occasions where the carer's approach to CPS was not conducive to harmonious relations. The transfer of guardianship was affected by the difficult relationship, and impacted upon Child 5. However the evidence indicates that CPS and the carers had an enormous burden of care placed upon them in respect of the care of Child 5, and, for systemic and resourcing reasons, the task was monumental.

Withdrawal of funding for the Therapeutic Care Package

In June 2012 Child 5 was provided with an intensive therapeutic care package, details of which are contained in the finding pertaining to Child 5. The TCP was provided by the ACF and funded by CPS. The TCP continued for 12 months until June 2013, after which its funding was withdrawn.

Mr Kemp stated the cost of this specialist package for Child 5 was $57,000. He gave evidence that programs such as this have been in existence in other jurisdictions for a number of years for children of Child 5's very high needs. However Child 5's package was unique in Tasmania. Child 5's carer submitted that the way in which these funds were utilised was not efficient and the funding was only provided after a number of years of receiving little therapeutic support from CPS. Mr Kemp was not in a position to comment upon the desirability of ceasing the intervention. However he indicated that it was important to review it, particularly given the fact that funding was limited. I accept

that a review was appropriate. Mr Kemp stated that he would have expected there to be consultation with the carers before the package was ceased, but noted that there was nothing on the file relating to any consultation process. Ms Pringle-Jones states that the ACF advocated for an extension of the TCP but this was not accepted. She did not know why this decision was made. However, she stated that at no extra cost to CPS she maintained therapy for Child 5 but could not maintain the sessions with the carers.

The question arose in submissions as to whether “extraordinary” resources were devoted to assist in the amelioration of Child 5’s challenging behaviours and his ongoing development. Mr Turner submitted that this was the case. Ms Graves submitted that the carers did not receive significant or extraordinary resources from CPS and that they repeatedly raised concerns about the lack of both financial and practical support that they received from CPS. I accept the submission that, even though the funding package was unique and specialised, in the context of Child 5’s needs it was necessary. Also necessary was ongoing, intense support whilst his/her behaviours were becoming internalised. Evidence of the lack of resources in CPS touching upon Child 5’s care was given by the carers, Mr Kemp and Ms Pringle-Jones. A lack of resources and lack of existing intensive programs for a child of such high needs meant that Child 5 could not receive a proper care strategy, and assistance to the carers could not be continued with the intensity required.

Ms Pringle-Jones gave evidence that one of the most fundamental and common themes to issues for youth at risk are unresolved issues of insecure attachment relationships in the early years, including abuse and neglect. Ms Pringle-Jones gave evidence that she believes that a formal therapeutic care program needs to be implemented rather than operating as it stands on an ad hoc case-by-case basis. She stated that a formal and stable program would allow for better outcomes for high needs children, increased value for money due to improved economies of scale and improved placement support and education leading to fewer placement breakdowns and the opportunity to grow secure attachment relationships. Ms Pringle-Jones has considered the Out of Home Care Reform Review of Children and Youth Services which acknowledges that the Out of Home Care system is stretched to capacity, unsustainable and lacks a strategic plan for its future. She agrees with the issues defined in the document and agrees with the focus of the reform as a trauma-informed framework to ensure trauma-based intervention options and a comprehensive needs assessment for all children in care.

Multiple child protection workers and lack of contact with Child 5 and Child 5's carers

Child 5 had five CPS workers. As Mr Kemp stated, a number of workers in a case where the child has attachment disorder can create problems. He stated that continuity of workers is important for adolescents in this type of relationship as it is often adults who have let the children down. It is also desirable that there be a consistency of resolving issues. Child 5's carers submitted that the CPS workers lacked skill and experience in working with their foster child. Without making a finding relating to each worker I accept this proposition in general terms. Mr Kemp and Ms Pringle-Jones both gave evidence that specialised workers are needed for the cohort of traumatised youth and that CPS have not been able to adequately provide consistency or specialised workers.

Further, there were lengthy periods of time, being up to 6 months, when Child 5 and the carers were not contacted by CPS workers. There should have been monthly contacts in light of the significance of Child 5's needs. It was no answer to the lack of contact to rely on third parties supporting the family. I note that the Out of Home Care Reform review recognises that child protection practice that marginalises carers from participation in the care team is stated to be a lost opportunity to best meet the child's needs and to engage carers in understanding and supporting the care plan. The document states that research indicates that an "us" and "them" practice is divisive and adversarial and impacts on child outcomes and carer recruitment and retention. Mr Kemp states that prior to Child 5's death a thorough, revised support plan was in place and a new child protection worker was working very sensitively and collaboratively with the foster carers and the ACF worker to support the carers.

The attendance by a CPS representative at care team meetings was not as regular as it should have been which is not desirable. CPS should have been the central, coordinating point for Child 5's ongoing welfare.

Summary of main issues regarding Child 5's care

(a) The complexity of Child 5's case involved extremely difficult issues for CPS that stretched its skills and resources;

(b) The foster carers were not adequately supported to cater for the extraordinary needs of Child 5;

(c) During the years of the care and protection order Child 5 was assessed and treated by psychiatrists, psychologists, paediatricians, social workers and support workers;

(d) The turnover in CPS workers was too great, particularly given Child 5's need for stability. In general the CPS workers did not have sufficient contact with Child 5 or the carers;

(e) The specialised TCP was an excellent development and recognised the level of Child 5's trauma. The manner in which was it implemented by the ACF is to be commended;

(f) The communications surrounding the end of the TCP were not sufficiently consultative with the carers or Ms Pringle-Jones. However, given the continuing effort by Ms Pringle-Jones and the ACF with Child 5 before his death, Child 5 was fortunate to continue to receive the support. This continuation was supported by CPS. The evidence does not permit me to find that the withdrawal of the funding impacted directly upon Child 5's state of mind before death; and

(g) The communications surrounding the guardianship issue were not sufficiently consultative or clear, nor clearly documented. There was a good case for guardianship to have been transferred to the carers before Child 5's death. The ongoing lack of certainty is likely to have impacted upon Child 5's state of mind.

Recommendations

1. **I recommend** that CPS implement a dedicated adolescent/youth portfolio, providing a single point of accountability for the strategic and operational responsibility relating to youth at risk.
2. **I recommend** that CPS continues to educate its workers on the cumulative harm policy and its practice, in particular education on the need for:

(a) The risk assessment of cumulative harm to be applied strictly as required by the policy;

(b) Assessments of cumulative harm to occur additionally when the key indicators for cumulative harm are present;

(c) An extensive investigation as set out in the policy to properly assess cumulative harm; and

(d) An adequate response to the risks identified as a result of the suffering of cumulative harm.

3. **I recommend** that CPS conduct regular audits of its files to determine whether the cumulative harm policy in risk assessment of notifications at intake is being conducted in accordance with (a) to (d) above.
4. **I recommend** that CPS develop a mechanism for review of closed notifications and/or consider whether closure of notifications could be delayed until CPS has ascertained that the referral service is effective in reducing the assessed risk.
5. **I recommend** that CPS implement as a priority the Out of Home Care Reform in accordance with its review and, in doing so, specifically consider the most effective and economical manner in which to deliver intensive trauma-based interventions for high needs children.

Accommodation for homeless young people

The deaths of Child 1 and Child 3, in particular, highlighted the significance of homelessness as a risk factor in the suicide of a young person. Homeless young people are at increased risk of poor outcomes across a range of domains including poor mental and physical health, involvement with the criminal justice system and poor educational outcomes affecting future quality of life. Therefore appropriate and ongoing continuity of care in a stable and therapeutic environment is vital. The evidence indicates that appropriate accommodation and stability of accommodation are crucial factors in the support of youth at risk of suicide.

Shelters are by nature unstable environments, particularly for young people who are vulnerable and require stability. Child 3's case demonstrates such inadequacy. The age mix and presenting behaviours of other residents can expose vulnerable young people to further harm through being introduced to, or being encouraged to participate in risk taking behaviours that are detrimental to positive outcomes. Specialist homelessness services are a safety net and are not appropriate for long term care of young people.

Further, the evidence at inquest indicated that the depth of CPS assessment of allegations of homelessness, exploration of safe and appropriate accommodation options and timely follow up of housing issues, is often poor for adolescents. Once an adolescent involved with CPS is in a place of safety, CPS diverts its attentions to other cases of need. Understandably, this is dictated by lack of adequate resources. However, such an approach is not conducive to ensuring the best accommodation possible for the young person. The situation is exacerbated by frequent change of CPS workers. As submitted by Mr Barclay, a frequent turnover of case workers results in no consistent oversight or continuity of care for young people who are known to CPS, noting that the relevant accommodation facility had contact with five different CPS workers regarding Child 3 in three months.

Additionally CPS is mandated only to respond to notifications and assess risk to the child and does not become involved where it deems there is no risk to the young person from the family. Under the CYPF Act, the primary responsibility for a child's care and protection lies with their family. However, in some cases families are unwilling to have the young person return home; or, whilst the family is willing to have the child home, the

child feels unable to live there, for example, where allegations by the child of abuse have been made but are not substantiated.

On the evidence, there exists a cohort of young persons who are not overseen by CPS but who nevertheless are homeless. Data captured by the relevant accommodation facility documents family breakdown as the primary reason for this cohort to access supported accommodation.

A young person in Child 3's situation usually stays for a short period in unstable accommodation and then returns to a cycle between different accommodation facilities. The accommodation facility where Child 3 stayed does not have an investigative role in finding voluntary accommodation for a young person. Ms Shari Scott gave evidence that 75% of people who leave the facility do not have appropriate accommodation to go to, and 20% return to the facility.

Additionally, Jai Friend gave evidence that youth shelters and current residential care facilities in Hobart do not have the capacity to manage young people with mental health difficulties. Their funding does not provide sufficiently for adequate staff training, supervision or staff ratios that this work requires.

A further issue exists in respect of young persons aged 15 years or older. Upon attaining the age of 15 years young people who have been assessed by Centrelink as having an "unreasonable to live at home" status are eligible for an income support payment . This payment means they have an independent income paid directly to them. However, Ms Scott stated that young people in this cohort are ineligible for services that provide access to housing options. In Southern Tasmania, there is a single access point, being Housing Connect, for homeless people to seek support to transition from homelessness into long term appropriate and affordable housing. The minimum age to access Housing Connect services is 16 years. The gap between the receipt of a homeless allowance at 15 years and the eligibility for assisted housing at 16 years is a cause for concern and exposes adolescents to risk. Logically, there should be the capacity to access homelessness services to obtain accommodation at the same time as it is identified that it is unreasonable for the youth to live at home (when the youth is entitled to the allowance). It is incongruous that the two do not align.

Ms Scott stated that the above observations are based on consistent experience from accommodation facility staff. She stated that contact with other shelters indicates that

these issues are not isolated. Mr Barclay submitted that there is a wider systemic issue to be addressed enabling the provision of timely and therapeutic support to adolescents and their families, and that the issue of provision of an appropriate living environment is crucial to such support. I agree with his submissions. He submitted that the options should be assessed holistically and tailored to each young person's individual circumstances; options could include access to adolescent foster care placements, independent accommodation with intensive support, semi-independent or share house placements with support.

Recommendations

1. **I recommend** that Housing Connect amend the criteria for access to Housing Connect to replace an age minimum with an independent income criterion so as to enable young persons in need to access that service.
2. **I recommend** that CPS in implementing its proposed youth portfolio review all aspects of its processes in assessing notifications involving youth homelessness, so as to effectively respond to homelessness as a risk factor for vulnerable youth.
3. **I recommend** that the relevant government agencies review the adequacy of accommodation and living options for homeless youth under the age of 18 years.

Tasmania Police involvement with youth at risk

Tasmania Police provided detailed evidence in respect of Child 1, Child 2, Child 3, Child 4 and Child 5, all of whom had contact with police. Examination of the individual information reports from the police system demonstrates the extensive police contact and resources involved in dealing with incidents and ensuring the safety of young people.

As stated in the individual findings, Child 2 was subject to 20 information reports, 9 referrals to CPS, 3 search returns, two crime car logs and 2 missing persons reports. Child 3 was the subject of 11 information reports, 7 referrals to CPS and 2 search returns. Child 4 was the subject of 2 information reports and 2 referrals to CPS. Child 5 was the subject of 5 information reports, 2 referrals to CPS and one fire report. Child 1 was the subject of 38 information reports, 10 referrals to CPS, 10 search returns, 3 crime car logs and 3 fire reports.

As seen, many CPS referrals were made by police. Sergeant Peter May, who is attached to the Southern Early Intervention and Youth Action Unit, provided evidence to the inquest as follows:

> "Adequacy of response to referrals cannot be judged by police as Police do not keep detailed records and do not have access to Child Protection records.
>
> As a working practice, Child Protection do not provide Police with detailed feedback of interactions with clients.
>
> A memorandum of understanding exists between the Police and Child Protection allowing the exchange of information "to benefit the youth".
>
> This information is placed on the information data management (IDM) system.
>
> Notifications to Child Protection from the Tasmanian Police are propagated from this system.
>
> There is no provision to send back information on any police investigation.
>
> There is currently no developed system to share additional intelligence holdings or exchange case notes with child protection or CFS [Child and Family Services].

A possible solution to this problem is to have a police intelligence officer embedded within CFS for the purpose of correspondence between these agencies.

It is my recommendation that in order to improve the service provided to youth at risk the following enhancements could be made within the system:

a. simple provisions to electronically forward both IDM CFS Referral Case Notes and relevant IDM information reports to Child Protection that
   i. benefit the youth,
   ii. do not prejudice any investigation, and
   iii. do not adversely disclose the identification of an informant.*"*

Sergeant May, in his evidence, stated that as there is no shared database, police are not often able, on their own records, to ascertain whether a child is subject to a child protection order, a fact being crucial knowledge upon police contact with the person. Sergeant May also gave evidence that information reports by police on young persons at risk need to be able to be sent to CPS very quickly, which is currently not able to be done except by the generation of a specific CPS referral. It would appear that, if the systems allowed free exchange of information with the above conditions, CPS would be armed with a significantly greater amount of information regarding the particular youth's contact with police, which in turn is crucial in assessing risk as per its mandate under the *CYPF* Act. There are several examples of CPS not receiving police information regarding the young persons the subject of this inquest.

Sergeant May indicated that a sergeant of police with information analysis experience could provide a vital role in information-sharing between the two organisations leading to a great deal of mutual assistance. This role would particularly serve the interests of the "at risk" youth cohort. He notes that, in particular, suicidal behaviour or ideation known to police would be accessed by CPS immediately, in addition to other important information such as rate of offending, number of cautions and other information provided by the youth to police.

Inter-Agency Support Teams

Both Child 1 and Child 5 received assistance from the Inter-Agency Support Teams.

IASTs are non-statutory committees based in local communities throughout the State that bring together relevant State and local government service providers to work collaboratively towards developing practical, multi-agency responses to support children, young people and their families with multiple complex problems. In his affidavit, Sergeant May provided evidence that 254 youths were engaged with IASTs around the state. The IASTs focus upon young people experiencing a range of behaviours indicating risk – mental health issues, problematic substance use, family violence, neglect or other parenting issues, accommodation issues, difficulties with engaging in learning and education, anti-social behaviour, and offending. The IASTs are an initiative of Tasmania Police. While they do not deliver services directly to young people they provide a forum in which participating agencies responsible for delivering services can devise the most appropriate support strategies in a co-ordinated, timely and effective manner. The IAST model is based upon early intervention where the intention is to focus on targeted children, families and the community to prevent and mitigate negative outcomes.

Whilst the inquest did not specifically focus upon the workings of the IASTs in respect of Child 1 and Child 5, the minutes of the monthly meetings are recorded clearly and the meetings were well attended by representatives from appropriate agencies and organisations. It can be seen from the minutes that support strategies are developed and progress monitored. Tasmania Police and those agencies participating in the IASTs are to be commended for the time and effort put into risk prevention strategies and assistance. IASTs have been an excellent initiative and remain integral in coordinating assistance for young people at risk.

Recommendations

1. **I recommend** that Tasmania Police enhance the IDM system to include provision to electronically forward relevant IDM information reports to CPS where such information benefits the youth, does not prejudice an investigation and does not adversely disclose the identity of an informant.
2. **I recommend** that consideration be given by Tasmania Police and CPS to the embedding of an officer of Tasmania Police in CPS for the purpose of facilitating

the mutual exchange of crucial information between the organisations in the best interests of young persons having contact or potential contact with either organisation.

General Practitioners

The inquest heard from general practitioner Dr Christine Boyce, Child 4's general practitioner. Dr Boyce is an experienced general practitioner working in family practice. For three years Dr Boyce worked in a specialised adolescent health centre in Hobart and was part of a team that piloted a project involving secure web-based access to GP advice by adolescent students at a school in Hobart. Dr Boyce retains a specific interest in adolescent mental health. Dr Boyce coordinates a Mental Health Professionals network for her practice. She also acts as the Clinical Director of the Southern Tasmania Refugee Health clinic. She is a clinical tutor and clinical examiner at the University of Tasmania and GP supervisor with General Practice Training Tasmania.

Dr Boyce stated that where a GP is involved with an adolescent who is identified as being at risk of suicide it is important that the GP is part of the wider treating team, whatever other services are utilised. She stated that in treating a young person through a period of high risk of suicide it is a matter of setting up a tight safety net around the young person with his or her consent, involving all of the relevant people. This safety net incorporates partners, parents, family, teachers, GPs, psychiatrists, psychologist and other professionals involved with the young person. Dr Lambeth agrees that the GP is important in the treatment of adolescent mental health issues.

Dr Boyce states that, at the very minimum, information should flow from the service to the GP in a timely and responsive way. She notes that the GP is a key point of reliance by the young person and the family and that a GP can assist greatly in maximising engagement between the young person and services by using the rapport that already exists. She notes that this can only be achieved if the GP is kept "in the loop" by the particular service. Dr Boyce was of the view that at her own practice she does not receive significant communication from CAMHS when treating her patients. Dr Wagg agreed that it is important for the GP is to be kept informed and provided with documentation. Whilst I accept that Dr Boyce has had difficulty in communicating with CAMHS, I am not in a position in this inquest to determine the effectiveness of communication generally by CAMHS with GPs. Given the clear lack of adequate resourcing it would be understandable if communication with GPs has suffered in favour of direct treatment of adolescents with mental illness.

Dr Boyce stated that there are a number of services in a constantly changing arena that can assist young people at risk of suicide and their families. She said that from a GP's perspective the biggest issue is knowing about the existence of these services, how to access them, and how to refer. She was of the view that the information about available services should be updated regularly.

Dr Boyce further noted that there is great variation among individual GPs as to the knowledge of services available. There is no single information point known to GPs. She also stated that there is a significant lack of adolescent psychiatrists in private practice and this is an area of serious need in the south of the state.

I set out below a significant passage from Dr Boyce's affidavit regarding her view on the way that GPs can better assist high risk youth:

"Support from specialist colleagues and training –

(a) communication from specialist colleagues should not be limited to referral but needs to include the ability to discuss particularly complex or high risk cases with relevant professionals, for example psychiatrists or psychologists. There also needs to be an acknowledgement by the specialist that the GP is part of the team in an ongoing way reflected in communication regarding the care of the young person.
(b) Further, services should acknowledge the GP's opinion if there is a direct approach from a GP about a young person at high risk; this assessment should be given weight and recognition.
(c) GPs receive training on adolescent mental health during their undergraduate training. Training providers provide training to GPs according to a curriculum set by the Royal College of General Practitioners for the postgraduate course. This training does not necessarily include adolescent mental health. Ongoing professional development training for general practitioners has a wide range of resources available but a GP can choose the area of training and there are no compulsory requirements. A GP has a choice whether to undertake further training in adolescent mental health.

Supportive practice environment –

This is important when dealing with youth at risk that the GP practice allows flexible and understanding appointment and billing arrangements with the young

person. Training of support staff within GP practices regarding this is often necessary.

Knowledge of available services and specialist interest register –

(a) There is no one point where knowledge of all services for adolescent mental health is available at no single information point known to GPs. Having a good knowledge of available services is obviously important in the care of young people at risk. There is also no information readily available to GPs about which GPs have a specific interest in adolescent mental health.

(b) A register would be extremely useful if available to GPs so that they have the ability to inter-refer to GPs who have a subspecialisation in this area.

Coordination of care –

(a) A lack of coordination is a major issue throughout our multilayered health system. It is particularly erosive in adolescent mental health where a young person will quickly lose faith with a team they realise is not effectively communicating, further exacerbated by the real risk of receiving conflicting messages from their different practitioners.

(b) Disenfranchisement of the young person often results in terminating of therapeutic relationships and families are left feeling they have nowhere to go.

(c) The barriers to reduction of fragmentation are significant including the different funding model for general practice, non-government services and state funded services. However there are mechanisms by which better teamwork can occur, for example Medicare rebateable case conferencing available to GPs. In a small city like Hobart it lends itself to collaborative models."

She indicated that the role of the general practitioner is vital in assisting a young person, particularly where the youth is well engaged with that practitioner and where that practitioner acts as a liaison and is able to coordinate services for the youth.

Dr Boyce gave considerable thought to her analysis. It is persuasive. In the circumstances of Dr Boyce's experience and interest in adolescent mental health and her detailed evidence, it is appropriate to make recommendations regarding a number

of matters relating to GPs. I acknowledge that further consultation would be required before such recommendations are implemented.

Recommendations

1. **I recommend** that government agencies, GP organisations or organisations providing services for adolescent mental health consider compiling a comprehensive register of services available to assist adolescents with mental health issues; the register to be regularly updated; to contain information regarding the nature of those services and how young persons may be referred to those services; to be made easily accessible to general practitioners and other health professionals treating the mental health of young people.
2. **I recommend** that GP organisations or relevant bodies consider compiling a register of general practitioners with an interest, or subspecialisation, in adolescent mental health; such register for distribution to general practitioners for the purpose of inter-referring, and/or to other health professionals for referral purposes.
3. **I recommend** that general practitioners consider the increased use of case conferencing with other mental health professionals and specialists in respect of patients who are young persons with mental health issues engaged with multiple health professionals.
4. **I recommend** that general practitioners consider ways in which flexible and understanding appointment and billing arrangements can occur such as to maximise engagement by young persons requiring treatment for mental health issues.
5. **I recommend** that CAMHS consider, and if appropriate implement, measures for important patient documentation and treating information to be consistently provided to general practitioners to assist with their treatment of young persons with mental health issues.

Schools

The inquest did not touch directly upon the role of schools. However, schools are a crucial part of suicide prevention and adolescent mental health. School psychologist Rebecca Strong, an experienced school psychologist, gave impressive evidence relating to her treatment of Child 1. She gave evidence that for young persons at risk engagement with school is a major protective factor and that intensive therapeutic intervention is very important. She said that if a young person can gain the support of a key teacher as a mentor, this can be further protective. She noted that schools are ideally positioned to play a lead role in effective intervention and to ensure children develop close and protective relationships with teachers. She said that early intervention programs are efficient and effective if they are run through the school. She noted, however, that there has been some reduction in these programs.

I have also received in evidence a statement and two volumes of policy documents from Suzanne Pennicott-Jones, the principal policy officer from the Department of Education in Tasmania. Ms Pennicott-Jones reported that the Education Department works with the *"Learners First Strategy 2014 to 2017"*, being policy documents that outline the Department's vision to develop "successful, skilled and innovative Tasmanians". She also provided in her evidence the department's policies and procedural documents that were in existence at the time of the deaths of the young people. She noted that in 2014 a support team was established which provided schools with additional specialist services, including a behavioural school psychologist, a behavioural learning leader and teaching and learning leader. Further, each school has a minimum 0.2 FTE support teacher for students with complex and challenging behaviours. She stated that all schools are supported by school psychologists, social workers and speech pathologists employed by the Department.

The manner in which schools might better collaborate with other services, such as CPS, or streamline adolescent mental health interventions and treatment, is beyond the scope of this inquest. Similarly the post-vention response of the school that was attended by three of the young people the subject of this inquest was not the subject of criticism, and any further comments are beyond the scope of the inquest.

The issue of involvement of parents in school counselling and information sharing with parents arose in the context of Child 6. As stated in the finding pertaining to Child 6, I

was not satisfied that there was a need for the school counsellor to make contact with Child 6's mother. It can be envisaged that tension may arise in the context of school counselling between the need to keep the young person's confidence on one hand and to notify parents of risk on the other. Mr Turner submits that the Education Department is happy to review its policy concerning the involvement of parents in what has been described as the "counselling space".

The cooperation provided to the inquest by the Department of Education has been significant in relation to the provision of the school records and information for the young persons. I extend my appreciation to Ms Catherine Gavan, Legal Services Advisor, Department of Education, for her assistance.

Recommendations

1. **I recommend** that the Department of Education review its policies concerning the involvement of parents generally in the area of school counselling, including a review of circumstances in which it may be appropriate to inform parents or carers of disclosures by young persons to school counsellors.

Availability of services to young persons at risk of suicide

Parent, family and carer concerns

A number of common themes arose from evidence of the parents, families and carers of the six young people regarding their experience with services and supports for adolescent mental health. They are as follows:

(a) There is a serious gap in mental health services for adolescents in Tasmania. It is difficult to access adequate well-resourced treatment and support.

(b) Part of the treatment gap is the lack of a residential facility for mental health care.

(c) Services should be better coordinated with each other and ensure that there is information sharing between them for better outcomes.

(d) It is very important that service providers and their staff have the skills and expertise to engage and sustain a therapeutic relationship with young people. Currently there is a lack of expertise in this specialised area.

(e) Services need to be specially designed to meet the needs of this cohort; therefore there must be a strong emphasis on outreach and on flexible ways to engage with young people.

(f) Young people are blamed for disengaging with services. Such blame should cease and careful consideration be given as to why young people disengage.

(g) Early intervention is very important to minimise the risk factors that lead to mental health issues and suicide.

(h) Families and carers wish to be involved in treatment and support, and receive communication from treaters, and not be “kept out of the loop”.

The evidence of the professional witnesses as to improvements closely accords with the above. I will discuss their evidence in this section.

Every professional witness gave evidence that there are limited resources and services available in Tasmania to help and support young people and their families who are suffering emotional distress and social adversity and are at risk of suicide.

I now set out the main areas for discussion.

Early Intervention

The cases of Child 2 and Child 5 in particular highlight the lasting trauma that can occur in the first few years of life. When CPS is aware of risk, trauma or intergenerational dysfunction, it is crucial that appropriate action is taken to prevent irreparable emotional consequences. In the cases of Child 2 and Child 5 the consequence was ultimately suicide.

Dr Wagg gave evidence of factors that are known to contribute to a teenage group at high risk of suicide are often determined early in the life-cycle. Adverse in-vitro experience, such as exposure to drugs and alcohol, malnutrition, maternal stress and mental illness are factors affecting the child's development once born. Severe disturbances of infant–parent relationships, specifically termed "disorganised attachment" create adverse circumstances. Dr Wagg states that scientific studies have shown that the critical period for brain development is during pregnancy and the first two years of life. In particular, the function of physiological regulation of sleep and appetite, emotional and behavioural regulation, self-identity and capacity to relate to others, empathy and reflective functioning are laid down in this period.

Dr Wagg gave evidence that during these early years the child needs a safe and stable relationship with a primary care giver in order to develop normally. A lack of a stable and appropriately responsive parental figure relationship causes defects in development such as emotional dysregulation, poor self-esteem, unstable and untrusting relationships with others, sleep and eating disorders, impaired cognitive development and problems with impulse control including self-harm and aggression.

Dr Wagg said in evidence that parental capacity for reflective functioning is crucial in the development of secure attachments with a stable and appropriate care giver. Reflective functioning in a parent minimises the risk of abuse or neglect of the child. Dr Wagg noted that once the defects in development occur, they are difficult to remedy. There are other points of possible therapeutic intervention through a child's life but interventions at these later points are less able to effect change. In making this point Dr Wagg noted that assessment of attachment at 12 - 18 months of age can reliably identify infants with disorganised attachment who are at high risk of developmental progression to mental health problems and suicide risk in teenage years. She said that the developmental trajectory is from a disorganised attachment at age 12 - 18 months to serious emotional disorder and conduct disorder in childhood (6 to 12 years old) to

borderline and antisocial personality disorder in teenagers and young adults. The latter is associated with suicide.

Dr Wagg gave evidence that early intervention and prevention approaches in pregnancy and early childhood are the most clinically effective, and cost effective approaches to addressing these difficulties. She stated that intervention at later stages of development is more expensive and less clinically effective than interventions early in the life span. Dr Georgina O'Donnell, clinical psychologist, also gave similar evidence as to the efficacy of early intervention strategies.

Dr Wagg stated that there is less robust evidence for evidence-based interventions to prevent or address suicide risk in the teenage years. Some studies have found multisystemic therapy to be effective in teenagers with developing personality difficulties but these studies have not been replicated. Nonetheless clinical expert opinion suggests that a multisystemic approach is necessary to address the needs of this high risk group. This type of therapy involves collaboration between all relevant services to provide intensive case management and outreach to young people and their families. As highlighted by this inquest, the amount of resources and coordination required cause this to be very difficult to achieve.

Dr Michelle Williams, paediatric consultant at the RHH provided evidence in the form of a statement to the inquest. With the support of the paediatricians of Hobart, Dr Williams stated that:

> "Many young people who attempt or commit suicide have suffered from emotional or developmental trauma early in life. Many will have evidence of behavioural or emotional problems from the pre-school years. Socio-economic disadvantage is a common factor in these young people, as is school disengagement. Many adolescents with emotional and behavioural problems will have exhibited difficult or concerning behaviours from a very young age.
>
> Paediatricians seeing children exhibiting behavioural problems at a young age unfortunately have few resources available to assist them in managing these children and their families."

Dr Williams further stated:

> "Often the family of a child with behavioural or emotional problems experience difficulties in parenting. Assisting the parents in managing their children's emotions and behaviours is a key part of assisting the child. This may involve parenting support and education, psychoeducation of parents, or ongoing coaching. Assisting parents in managing early problems can prevent the development of more severe behavioural and emotional issues."

In his evidence, Dr Lambeth was asked his view as to the major areas for improvement in youth mental health. He testified that with respect to self-harm and suicide if it is to be reduced substantially then the perinatal period and very early period where relationships are formed with caregivers is the first area that needs to be addressed. He indicated that he agreed with the evidence of Dr Wagg in this regard, and also observed that "all of the literature" points to intervening at this stage.

Dr Wagg stated in evidence that within the very small CAMHS resource 76% of funding was devoted to 14 year old and above teenagers. She stated that there is a definite need as is demonstrated by the whole inquest, for support for young persons with complex difficulties in that point of their lifespan. However Dr Wagg proceeded to state that if a difference can be made in the long term, resources are required for the early intervention period. She stated that the benchmarking conducted around resources required for the early intervention period of conception to age two years is five practitioners per 100,000 people. She stated that in the south of the State, therefore, 12.5 practitioners would be required which is in effect the whole resource of CAMHS at present. If the benchmarking resources were applied, Dr Wagg indicated that change could be effective. She indicated that even with a small amount of extra resource, CAMHS would be able to identify the children at the highest risk with a small team to offer evidence-based interventions that would support parents to care for their own children and to avoid child protection intervention. The other savings for the community would include decreased health, welfare and justice costs and improved health, educational and occupational outcomes.

Dr Williams gave evidence that intervening when childhood behavioural or emotional problems become evident and supporting families or foster carers in parenting children more effectively is clearly essential if we are to change the trajectory and outcome for many vulnerable children. She stated that with the services available in Hobart, this is difficult to achieve. Paediatricians and general practitioners are therefore unable to refer

to appropriate help in the early years when it is most likely to be effective, and are left attempting to help disturbed and distressed adolescents and their families.

Jai Friend, Child 2's counsellor, gave evidence that the State needs better early intervention strategies for at risk infants and young children and their parents. Child 2 suffered trauma due to exposure to the parents trauma related mental health difficulties and family violence in infancy. Child 2's life would have been significantly different if the parents' difficulties had been alleviated by adequate service provision and intervention.

All of the expert evidence emphasised the crucial importance of fostering good attachments in the very early years in the prevention of youth mental health issues and suicide. This is not only in terms of the ability at that stage to make a difference to the young person, but the savings to the community in terms of unsuccessful interventions in later life as well as all of the other costs and effects of dealing with youth displaying traumatised behaviour.

CAMHS

Child and Adolescent Mental Health Services (CAMHS) have primary responsibility for the delivery of mental health services to young persons in Tasmania.

Dr Wagg stated that not all young people who are at risk of suicide ideation, estimated at 15% of the 12 - 18 year old population, can be seen by CAMHS. In most jurisdictions CAMHS-type organisations are resourced to directly care for the 2 – 4% of young people with the most severe and complex mental health problems. CAMHS South is resourced to care for less than 1% of the 0 – 18 year population. The services provided include highly specialised medical and clinical interventions that are aimed at reducing risks for clients with complex presentations and their families, thus improving their immediate and longer term function and well-being. Dr Wagg stated that generic services to children and young people do not have the specialist expertise and resources to address the needs of this high risk group. Additionally, there is no dedicated child or youth mental health inpatient facility to safely monitor and support young people in a developmentally appropriate and therapeutic environment who are suffering suicidal ideation. She stated that the intervention required to address these difficulties in high-risk teenagers is multisystemic, intensive and expensive. Resource allocation to CAMHS in Tasmania does not provide for the provision of such services.

Dr Wagg stated that CAMHS is the most under-resourced service in mental health services in the State. She also stated that there has been significant inequity in the distribution of the mental health budget in this State with CAMHS South serving 25% of the population but receiving only 5% of the mental health budget. While nationally there has been a discrepancy in CAMHS budgets compared to adult mental health services, in other States services equivalent to CAMHS receive half the budget allocation of adult mental health services; whereas in this State, CAMHS receives less than one quarter of the adult mental health service budget. The national mental health report in 2013 identified that CAMHS in Tasmania was the most poorly resourced CAMHS of any State in Australia.

Jai Friend gave evidence that it is becoming quite unusual for Clare House to work with a client for three years as she did with Child 2, because of severe funding limitations and long waiting lists which pressure clinicians into shorter term work.

Rates of mental illness are consistent throughout the lifespan from early childhood, with 50% of mental illness presenting by age 12 and 75% by aged 24. She stated that CAMHS has developed a Perinatal and Infant Mental Health Team (PIMH) by accessing federal grants and winning research funds and redirecting resources from the CAMHS budget. The PIMH team of 2.5 clinicians currently accesses and treats 118 new clients per month.

Dr Wagg stated that another cost effective intervention in the 5 to 12 year age group is based around school education, together with therapeutic support to young persons and their families. She stated that CAMHS sees this as its role but is unable to effectively undertake this due to lack of resources. She stated that the efficacy of a school based multisystemic approach for this age group is based upon the fact that school is about being part of the community, forming peer relationships, and having a sense that life is meaningful. Young people not engaged with school become isolated and lonely and may engage in risk taking behaviour and criminal activity – and therefore the trajectory from that point of time is a difficult one for them. She stated that CAMHS is trying to encourage liaison with education and undertake outreach but both education resourcing and CAMHS resourcing is required for this to be effective. She gave evidence relating to the desirability of day programs for very disturbed children who might be excluded from school. The programs would deliver education and therapy and support families to try and implement similar strategies.

Dr Wagg paints a very bleak picture of the ability of CAMHS to implement cost-effective programs.

She also noted that there are no disability services that focus on the needs of children up to the age of 18 years and that this work falls to CAMHS which struggles to meet those needs.

Dr Wagg gave evidence that a centralised mental health outreach service for adolescents is needed, provided either by Clare House or a community service organisation. An outreach step down service could then be provided to young people finishing therapy at Clare House. Dr Wagg stated that trying to engage teenage children in individual therapy has not been found to be effective as they find it very hard to attend and to trust. They do not tend to benefit from that type of approach. The basis of multisystemic therapy is to try and help these young people engage in life, and to have a safe and stable place to live. On providing that sense of safety, managing risk behaviours and ensuring meaningful engagement with others, then they might gradually be able to form trusting relationships. They may then be able to engage in individual therapy with their families to support them. She noted that these young people find it especially difficult to manage their impulses because their developmental experience has impacted on their brain development and therefore they need much external support to provide them with regulation that they are not able to provide for themselves. She testified that outreach is crucial in that process. That means meeting the young person at a time that suits them and working with them on a flexible basis. This outreach concept would involve one key caseworker for the youth who would assist in an intensive service response and who would deliver all of the services to the youth rather than the youth being required to go to multiple services run by different persons. She stated that this outreach component is currently difficult to deliver because if CAMHS spends time trying to go out and locate the young people concerned, there is less time to see those on the waiting list. She stated that it is a very difficult compromise; ideally CAMHS would have enough resources to have one person seeing five people on an outreach basis and not one person trying to see 25 or 35 people, which is the current case load.

Dr Wagg also noted that CAMHS does not have a Clinical Director as a formal position. She stated that informally she performs that role or at least the role of trying to offer some level of clinical governance. She stated that in trying to perform that role she is

also carrying 100% clinical caseload. She stated in evidence *"It is a complete stretch. Not only clinical supervision but also trying to provide reports like I do to the committee or this inquest, information to service development, attending meetings – these compromise the level of support I can provide to the clinicians in the service".*

Jai Friend provided evidence that CAMHS has no outreach capacity due to a severe lack of funding, and best practice models for youth mental health services require an outreach facility. She stated that CAMHS cannot currently meet the waiting list demand in a timely manner. Other alternatives such as Pulse, The Link or DEM also have no outreach capacity.

Dr Williams stated that obtaining assistance for families with children suffering behavioural or emotional problems is difficult. CAMHS can only cater for children with diagnosed mental health problems. Many of the precursors for poor adolescent or adult mental health or behavioural problems are not deemed severe enough to warrant allocation.

The need for an in-patient facility

The expert evidence overwhelmingly supports the need for an inpatient facility for the assessment and treatment of adolescents who present with serious mental health issues. This evidence is summarised as follows.

Dr Lambeth stated that an optimal service would be a small inpatient unit specifically designed around the needs of adolescents. This is the type of arrangement being considered in most areas of Australia now. He noted that it is inappropriate to place young people under the age of 18 years in an adult psychiatric care unit. A paediatric ward is also not an optimal placement because the youth is then in a ward with many other younger children with services not aligned for them.

Dr O'Donnell stated as follows:

> "Tasmania desperately needs a child and adolescent mental health multidisciplinary inpatient facility to assist families to keep children safe while they are in an acute state of mental illness or suicidality.

> The facility needs to have a comprehensive through-care and after-care model to provide ongoing community-based risk management to children and families in need.
>
> The model has been adopted interstate and been successful through either general psychiatric facilities or issue focused facilities such as psychosis clinics for children and adolescents.
>
> Under the Mental Health Act 2013 (Tas) children can be placed in a secure facility but there are currently no child/adolescent only facilities.
>
> Mental health clinicians may be reluctant to refer children to these facilities as they are exposed to and socialise with psychiatrically unwell adults.
>
> Often there is a 24 to 48 hour turnaround from presenting patients where suicidality is the presenting issue in hospital emergency rooms. It therefore often falls on the families to deal with the at risk person on their own at home 24/7.
>
> Provisions are needed for immediate intervention strategies, and inpatient therapeutic facilities for children and adolescents would be a solution to reducing that immediate risk, and provide support and advice for families to prepare safely for the child's return home. An inpatient stay allows the needs of the child to be fully assessed, through multidisciplinary care to be provided to reduce risk, and after-care networks established to manage any ongoing risks more safely."

In evidence to the inquest, Dr O'Donnell stated that about 200 young people in her practice alone are at risk of suicide and at the most severe point of their crisis would all benefit from an inpatient facility. She stated that 50 children are at high risk of suicide in her practice at some time during the year.

Jai Friend is of the opinion, as set out in her statement of evidence, that there is a need for an adequately funded therapeutic residential program in Hobart based on the Hurstbridge trauma informed relationship-based model of Victoria. She also suggested an adolescent ward at the Royal Hobart Hospital as well as several beds in a secure facility managed within the hospital or other appropriate place.

I note that on 24 September 2010 the then Minister for Health (Tasmania) wrote to the mother of Child 4 as a result of correspondence from her. The Minister stated that in

late 2009 the government committed to construct a dedicated child and adolescent inpatient facility within the Royal Hobart Hospital, which would include a small number of beds for children and adolescents with mental health issues. She stated that it is recognised that this would need to be effectively staffed and to include dedicated therapy, educational and diversional resources if it is to provide the best outcomes for patients and their families. It appears therefore that the concept of a dedicated child and adolescent facility has been the consideration of the government in relatively recent times.

Suicide assessment in hospitals

Dr Lambeth stated in evidence that not all patients presenting to DEM following suicidal or self-harming behaviour suffer from a serious mental illness. However in each presentation there is an element of risk – minimal, low, moderate or high and each requires a comprehensive and formal assessment to establish the clinical risk categorisation. Such a formulation informs management of the assessed risk and allows both the monitoring of risk and the development of a management plan to mitigate the risk. In his evidence at the inquest Dr Lambeth reiterated the importance of forming a risk judgement based upon a structured, transparent clinical process. He gave evidence that it is desirable across public hospitals that there is consistency in the clinical assessment tool used to assess risk. He stated that a psychiatrist or psychiatric registrar, or possibly psychiatric nurses and psychologists, could administer the risk assessment. In conjunction with the results of the risk assessment, he indicates that a good clinical examination is required. A management plan should then be devised. He stated that a clinical risk assessment should be consistent in all hospitals in the State. Dr Lambeth emphasised the importance of formulation of the suicide management plan, monitoring and reassessment of the risk, discharge and follow-up. In the period following discharge where the risk of suicidal behaviour is elevated, follow-up care is a recognised suicide prevention measure. Dr Lambeth stated that during this period assessment by an alcohol and drug professional where required could assist in a comprehensive management plan aimed at risk reduction. Similarly, the assistance of a trained social worker to contribute to a crisis management plan and help problem-solve at this time may lower the potential risk.

Outreach and flexible services

During the inquest one of the most prominent themes for suggested improvement in adolescent mental health was the need for flexibility in treatment and services, including outreach. The evidence indicates that currently the appointments-based model of treatment and support is not conducive to the engagement of young persons. Dr Wagg stated that a mobile youth outreach service providing a multi-system intervention to teenagers at risk of suicide and their families is the only evidence-based approach aimed at addressing the difficulties of youth at risk.

Four of the young persons were admitted to DEM in crisis after self-harm. The evidence demonstrates that a flexible and coordinated approach to care, involving outreach, is particularly important after discharge from a DEM admission.

In September 2015 the National Mental Health Commission Centre of Research Excellence in Suicide Prevention released its report entitled *"Care After a Suicide Attempt". ("CRESP report").* The report concludes that there is a need for substantial reform in the way the health system and health professionals respond to people following a suicide attempt. Despite health system policies regarding follow-up of people after hospital discharge, in many instances this contact is not made. The report states that ongoing education and systems improvements are needed to support the implementation of improved care at this critical time in people's lives. It is noted in the report that previous research has identified that the period immediately after discharge from psychiatric inpatient care represents a very high risk of death by suicide, and that failure to provide outpatient follow-up care after suicide attempts is associated with increased risk of re-attempt and ultimately death by suicide.

It is notable that the findings in the report are consistent with much of the evidence received in this inquest. Dr Lambeth testified that the period following discharge from a mental health inpatient unit or at the conclusion of outpatient treatment is a period of elevated risk for suicidal behaviour. Effective follow-up care is a recognised suicide prevention measure.

The findings in the CRESP report from online surveys and interviews consistently revealed low levels of satisfaction with health care services after a suicide attempt. In particular satisfaction with emergency department care is particularly low; and dissatisfaction increased at discharge. Discharge planning and its communication, or

lack thereof, to patients and caregivers, continues to be a major hurdle to effective ongoing care. Lack of information after discharge was the subject of evidence at inquest. For example, Dr O'Donnell stated that hospitals do not routinely send discharge summaries to her practice. She stated that discharge plans should also be given to families.

The findings indicated also that support for individuals who have made a suicide attempt and their families must be enhanced with care tailored to the needs of the particular patient. Noteworthy is that the caregivers participating in the study consistently expressed a desire to be involved in treatment planning following a suicide attempt. Again, this finding mirrors the wishes of the parents and carers involved in the inquest.

A particularly important finding from the CRESP report is the urgent need to identify ways of delivering treatments that are more effective than the presently offered 'stand-alone' psychological and psychopharmacologic therapies, and instead deliver a collaborative model of after-care that includes caregivers and matching of personal supports with the treatment programme. The report concludes that nationally consistent practice standards should be developed to support the assertive follow-up of all patients discharged from hospital following a suicide attempt. Patients and caregivers should be encouraged to be involved in treatment planning prior to discharge and with their general practitioner. This is consistent with the evidence of Dr Boyce regarding the importance of informed and effective treatment and care by a general practitioner.

Co-ordinated care needs to be facilitated, perhaps with the benefit of an individual who can help people to navigate the health system. In addition to co-ordinated care and support post discharge, E-mental health programs and other online services for suicide prevention should be integrated into the referral systems of hospital clinical staff and general practitioners. The experience of email to health services in Australia is that they are clinically effective and attract consumers who may not otherwise utilise or adhere to face-to-face treatment programs. Furthermore, caregivers may find online or mobile application information in support of greater benefit than printed materials or conventional face-to-face interactions.

Dr Lambeth proposed the need to establish positions of suicide prevention coordinators. This proposal appears to be in line with the recommendations from the CRESP report. The establishment of such positions working across DEMs and public mental health

service inpatient settings would aim to ensure effective and supported discharge to early intervention and other support services as required. Such an approach would ensure that young people who have exhibited suicidal thinking or behaviour or have self-harmed would be supported to safely reengage with their community through a streamlined approach to discharge planning, a commitment to continuity of care and an acknowledgement that recovery can be supported through a range of providers both within and outside of the health sector.

Recommendations

1. I **recommend** that a dedicated inpatient unit for adolescents or young persons between the ages of 12 and 25 years be established, designed around the needs of that cohort including for the treatment of those suffering from an acute state of mental illness or suicidality.
2. I **recommend,** additionally or alternatively to 1 above**,** that consideration be given to the establishment of a multi-disciplinary facility for young persons suffering from an acute state of mental illness or suicidality; such facility to have a comprehensive through-care and after-care model to provide ongoing community-based risk management.
3. I **recommend** that CAMHS be staffed to the equivalent of best practice for such an organisation, so as to provide an adequate service for children and adolescents with mental health issues, and to:
    a. Ensure that there is no “freeze” in accepting referrals;
    b. Eliminate a “wait list” for referrals;
    c. Provide for clinical directorship of the Service;
    d. Allow access to a wider group of adolescents suffering mental health issues;
    e. Develop a comprehensive early intervention program for the 0 to 3 years age group and their families, including to identify those children at high risk and focusing upon early intervention in the infant attachment period; and
    f. Develop a school based multisystemic approach to developing mental health disorders for the 5 to 12 years age group.
4. I **recommend** that the Department of Health and Human Services establish statewide positions of suicide prevention co-ordinators to provide necessary outreach between discharge from hospital and entry into appropriate services; such

positions to assist with a streamlined approach to discharge planning, collaboration between service providers and continuity of care.

5. I **recommend** that hospitals offering emergency medicine consider developing and implementing a suicide risk assessment tool, to be applied consistently on a statewide basis where suicidal risk assessment is required.
6. I **recommend** that hospitals consider implementing a policy of providing patients and their guardians with discharge summaries and contact details for follow-up treatment together with appropriate services to contact, in the event of the admission of a youth in crisis.