OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of a 12 year old boy at Kowanyama**
TITLE OF COURT:	Coroners Court
JURISDICTION:	Cairns
FILE NO(s):	COR 196/04(5)
DELIVERED ON:	19 September 2008
DELIVERED AT:	Cairns
HEARING DATE(s):	1 April 2008, 15-18 September 2008
FINDINGS OF:	Mr Michael Barnes, State Coroner
CATCHWORDS:	CORONERS: Inquest, Department of Families, remote Indigenous community, child suicide

REPRESENTATION:

Counsel Assisting:	Mr James Henry SC
Department of Child Safety:	Mr Michael Fellows instructed by Crown Law

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The *Coroners Act 2003* provides in s45 that when an inquest is held, the coroner's written findings must be given to the family of the person who died, each of the persons or organisations granted leave to appear at the inquest and to various specified officials with responsibility for the justice system or other agencies with responsibility for the areas of administration referred to in any comments or recommendations. These are my findings in relation to the death of a 12 year old boy at Kowanyama. They will be distributed in accordance with the requirements of the Act and posted on the web site of the Office of the State Coroner. For the purposes of the published findings, the child whose death is the subject of this inquest will be referred to as the 12 year old boy.

Introduction

On 19 January 2004, in accordance with an arrangement brokered by Department of Families' officers in the preceding week, the 12 year old boy moved from the house where he had been living with his adoptive mother to another residence in Kowanyama because of concerns about inappropriate behaviour by the adoptive mother's husband.

The day after, the 12 year old boy returned to his adoptive mother's house on a number of occasions. On the last occasion, at around sunset he was obviously upset and sulking and said he did not want to return to his new placement. Later, at some stage during the evening, he went missing and extensive searches failed to locate him.

The next morning the 12 year old boy was found hanging in a wardrobe in the bedroom he had previously occupied in his adoptive mother's house. It was apparent that he had been dead for some time.

These findings seek to explain how the death occurred and consider whether the Department of Families adequately discharged its responsibility in relation to the child.

The Coroner's jurisdiction

Before turning to the evidence, I will say something about the nature of the coronial jurisdiction. Because the 12 year old boy's death was sudden and unnatural it was reported to the Cairns coroner for investigation pursuant to sections 7 and 8. Pursuant to s28 I decided that an inquest was warranted.

The scope of a Coroner's inquiry and findings

A coroner has jurisdiction to inquire into the cause and the circumstances of a reportable death. If possible he/she is required to find:-

- whether a death in fact happened
- the identity of the deceased;
- when, where and how the death occurred; and
- what caused the person to die.

There has been considerable litigation concerning the extent of a coroner's jurisdiction to inquire into the circumstances of a death. The authorities clearly

establish that the scope of an inquest goes beyond merely establishing the medical cause of death but as that issue was not contentious in this case I need not seek to examine those authorities here. I will say something about the general nature of inquests however.

An inquest is not a trial between opposing parties but an inquiry into the death. In a leading English case it was described in this way:-

> *It is an inquisitorial process, a process of investigation quite unlike a criminal trial where the prosecutor accuses and the accused defends… The function of an inquest is to seek out and record as many of the facts concerning the death as the public interest requires.* [1]

The focus is on discovering what happened, not on ascribing guilt, attributing blame or apportioning liability. The purpose is to inform the family and the public of how the death occurred with a view to reducing the likelihood of similar deaths. As a result, the Act authorises a coroner to make preventive recommendations concerning public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in future.[2]

A coroner must not include in the findings or any comments or recommendations statements that a person is or maybe guilty of an offence or civilly liable for something.[3] However, if, as a result of considering the information gathered during an inquest, a coroner reasonably suspects that a person may be guilty of a criminal offence; the coroner must refer the information to the appropriate prosecuting authority.[4]

The admissibility of evidence and the standard of proof

Proceedings in a coroner's court are not bound by the rules of evidence because s37 of the Act provides that the court "*may inform itself in any way it considers appropriate."* That doesn't mean that any and every piece of information however unreliable will be admitted into evidence and acted upon. However, it does give a coroner greater scope to receive information that may not be admissible in other proceedings and to have regard to its provenance when determining what weight should be given to the information.

This flexibility has been explained as a consequence of an inquest being a fact-finding exercise rather than a means of apportioning guilt: an inquiry rather than a trial.[5]

A coroner should apply the civil standard of proof, namely the balance of probabilities, but the approach referred to as the *Briginshaw* sliding scale is applicable.[6] This means that the more significant the issue to be determined,

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[1] *R v South London Coroner; ex parte Thompson* (1982) 126 S.J. 625
[2] s46
[3] s45(5) and 46(3)
[4] s48
[5] *R v South London Coroner; ex parte Thompson* per Lord Lane CJ, (1982) 126 S.J. 625
[6] *Anderson v Blashki* [1993] 2 VR 89 at 96 per Gobbo J

the more serious an allegation or the more inherently unlikely an occurrence, the clearer and more persuasive the evidence needed for the trier of fact to be sufficiently satisfied that it has been proven to the civil standard.[7]

It is also clear that a coroner is obliged to comply with the rules of natural justice and to act judicially.[8] This means that no findings adverse to the interest of any party may be made without that party first being given a right to be heard in opposition to that finding. As *Annetts v McCann*[9] makes clear that includes being given an opportunity to make submissions against findings that might be damaging to the reputation of any individual or organisation.

The investigation

The matter was initially investigated by police in Kowanyama. A general duties constable who had been sworn in for less than four years and who had no detective or specialist investigative training was given responsibility for the task with oversight or advice from her officer in charge, a general duties sergeant. No scenes of crime officers or other specialist police were involved. A doctor attached to the local clinic attended but she had no forensic experience either.

The investigating officer did her best to collect statements from members of the household where the death occurred and others in the community who might have been expected to have contact with the 12 year old boy on the night in question. Her efforts were hindered by the reluctance of people to speak about the issue for cultural and other reasons.

On 5 May 2004, the investigating officer forwarded the last of nine scant statements to the coroner. The statements contained insufficient detail. No statements were provided by numerous other relevant witnesses. I intend no criticism of the investigating officer; she had insufficient experience and/or support to effectively investigate this matter.

The decision to leave the matter with an inexperienced general duties officer was made by the officer in charge of the Kowanyama station in conjunction with the District Inspector based in Cairns. It was based on the assumption that the death was a suicide.

As will become apparent later, there are a number of suspicious aspects to the death which together with its highly sensitive circumstances should have resulted in it being rigorously investigated by specialist detectives and forensic officers. It seems the decision not to detail the matter to suitably qualified officers was based on the assumption that the death was a suicide and the desire to avoid the cost of doing the job properly, if that could be avoided. It may be the initial presumption that the boy killed himself was an accurate

[7] *Briginshaw v Briginshaw* (1938) 60 CLR 336 at 361 per Sir Owen Dixon J
[8] *Harmsworth v State Coroner* [1989] VR 989 at 994 and see a useful discussion of the issue in Freckelton I., "Inquest Law" in *The inquest handbook*, Selby H., Federation Press, 1998 at 13
[9] (1990) 65 ALJR 167 at 168

assessment. However, my ability to be more definitive on that seminal issue has been compromised by that being presumed without the matter being appropriately investigated from the outset.

In addition there was an external child death review commissioned by the Department of Communities. That examination was undertaken by an independent expert with wide ranging experience in child welfare matters and the delivery of child protection services. It was insightful and highly relevant to some of the issues I was required to consider but could not ameliorate the deficiencies in the initial police investigation. It was nonetheless very helpful.

I regret to acknowledge that the coronial system's response to this death has also been suboptimal. After receiving the police investigation report in May 2004, a Cairns coroner quite properly awaited the independent child death review referred to earlier. That report was provided in early 2005. The matter then languished for some time, before findings were made "*on the papers*" in April 2006. Three different coroners took various steps in the matter between it being reported and that stage being reached.

In accordance with usual procedures, the matter then came to my office for review. In August 2006, I directed the matter should go to inquest. After discussing the matter with a Cairns coroner for some time, in June 2007 I assumed responsibility for it. At that stage, further statements were taken from some witnesses, others were interviewed for the first time and records relating to the 12 year old boy were obtained from the local health clinic, the Department of Families and Education Queensland. The police service records relating to investigations of child sex offences alleged against one of the adults in the 12 year old boy's home were also reviewed.

I will return to the deficiencies in aspects of the investigation in the recommendations section of these findings.

The inquest

On 1 April 2008 a pre-inquest conference was convened in Cairns and Mr James Henry SC was appointed counsel assisting. Leave to appear was granted to the Department of Child Safety as it was the successor of the Department of Families.

Prior to the directions hearing, contact was made with the Aboriginal and Torres Strait Islanders Legal Service and the Kowanyama Justice Group with the view to either or both organisations assisting family members during the course of the inquest. The family of the 12 year old boy was also of course advised that the pre-inquest conference was proceeding. There was no appearance by any of the individuals or organisations.

The inquest then proceeded in Kowanyama on 15 and 16 September 2008. Further evidence was heard in Cairns on 17 and 18 September. In all, 23 witnesses gave evidence and 41 exhibits were tendered.

The evidence

I turn now to the evidence. Of course I can not even summarise all of the information contained in the exhibits and transcript but I consider it appropriate to record in these reasons the evidence I believe is necessary to understand the findings I have made.

Family background

The boy was born in Cairns on 12 February 1991 making him 12 years old at the time of his death.

It is likely that the 12 year old boy suffered foetal alcohol syndrome at birth; he certainly suffered intrauterine growth retardation; he was born with a mild intellectual disability and he acquired a profound emotional disability.

A perusal of his medical file reveals a long list of ailments, diseases and disorders of varying severity far beyond what could be considered normal.

He also suffered from severe antisocial tendencies that made it difficult for him to form meaningful relationships. He made very little scholastic progress at school and was frequently in conflict with teachers and classmates. He had few close friends and was often seen alone at school and in the community.

He lived all of his life in Kowanyama. His mother was only seventeen when he was born and could not care for him. Her congenital intellectual impairment was apparently exacerbated by alcohol and substance abuse. It was arranged for an older relative, variously described as his mother's grandmother or his mother's great aunt ("*adoptive mother*") and her husband ("*adoptive mother's husband*") to informally adopt the 12 year old boy when he was a baby.

The 12 year old boy had two sisters who at the time of his death were eight and six. They also were adopted by the same couple, although it seems that on occasions they lived with their biological mother in other houses.

The 12 year old boy's father was at the time of his death living in Mareeba and apparently had only sporadic contact with the boy during his short life.

Prior contact with police and welfare authorities

In August 2002, the Department of Families had some contact with the 12 year old boy on account of his being part of a group of pre-adolescent boys questioned in relation to allegations to "*inappropriate sexual behaviour*". Tests for sexually transmitted diseases were negative. It seems no other action was taken by police or the Department of Families in relation to these concerns.

In early 2003, the local school referred the 12 year old boy to the Child & Youth Mental Health Team as a result of concerns about his disruptive outburst at school and his difficulty with the work and integrating with the other children. A formal plan was devised to respond to these issues but it seems he addressed his difficulty with fitting in at school by simply absenting himself.

In the school year 2003, he was absent for 150 of the 190 days. It is of concern that none of the authorities took any action in relation to this.

In June 2003, one of the 12 year old boy's sisters tested positive to chlamydia, a sexually transmitted disease ("STD"). This was investigated by police officers from Cairns Juvenile Aid Bureau and referred to the Cairns SCAN team. The sister was interviewed on two occasions but made no disclosures. As a result, of intelligence reports and previous incidents of STDs among children living in his house, suspicion fell on the adoptive mother's husband. He was interviewed and denied any offending behaviour. No further action was taken by police. It seems unlikely this would have been acceptable had the child been caucasian and living in a major centre.

The STD detected in the sister was reported to the Department of Families by police on 23 July 2003.

A further child protection notification was made to the Department in August 2003. It related to the STD infection of the sister referred to earlier, the lack of supervision given to all three children due to the adults in the household using alcohol and concerns in relation to unproven rumours that the adoptive mother's husband sexually abused children.

The Department attempted to respond to these concerns when its officers visited Kowanyama in September and October 2003 but on both occasions the family couldn't be located. It seems they may have gone to Pormpuraaw.

The FSOs go to Kowanyama

The Department's Cape Area Office next followed up these concerns in a visit by two of its officers to Kowanyama during the week commencing 12 January 2004.

FSO's workload and training

It is important to any critique of their performance to realise that this was only one of many matters the officers were required to attend to on this visit to the community. They had to visit 29 children who had been placed in foster care as a result of previous investigations; a further 12 children who had also been the subject of substantiated child protection notifications but allowed to remain with the parents also had to be followed up. In all of these cases the Family Services Officers needed to speak with the children and their parents and/or guardians, their school teachers, police officers and/or clinic staff as appropriate. When those matters had been attended to, the officers had to try and assess 16 new child protection notifications including the one concerning the 12 year old boy and his siblings.

Before they could start work, protocol required they meet with the council and the local community justice group and the other service providers. They had five days in which to attend to these matters. They had no office or computers at their disposal: rather they took notes when to do so was not counter productive and wrote them up in more detail at night. They had no transport,

but walked from place to place. In Kowanyama in January, the temperature hovers in the high 30s and the humidity sweats in the low 90s.

Such a workload and working conditions would be extremely challenging for the most hardy and experienced professional. The officers given the job were neither. Ms Guilfoyle graduated in 2001 and commenced with the Department in December 2003. She had not received any training in the duties of an FSO and had no experience investigating child protection notifications. She had not received any cultural awareness training. Her partner on this trip, Ms Nicholas also graduated from university in 2001 and commenced with the department in 2002. She had received FSO and cultural awareness training and had been to a number of Aboriginal communities on the Cape. Neither officer had ever been to Kowanyama before.

The child protection notification is assessed

The officers arrived in Kowanyama on Monday 12 January and met with the various authorities and service providers as appropriate. They then commenced working through their case list as opportunity allowed; finding people where they could and gathering information as they moved through the community, investigating as many of the matters as they could simultaneously.

They had been briefed on the STD contracted by the 12 year old boy's sister and the suspicion that the adoptive mother's husband was the perpetrator. This suspicion was confirmed by the various people they spoke to but no one had evidence that would enable the allegation that he was responsible to be substantiated. Nevertheless, in view of the infection and the support for concerns that the 12 year old boy was not attending school and was living with his sisters in very crowded conditions among people who frequently abused alcohol, the officers understandably began looking into ways of reducing the risk of further harm to the 12 year old boy and his two sisters.

In a meeting with the Kowanyama Community Justice Group and members of the local council, the officers explored whether the adoptive mother's husband could be required to move out of the house occupied by the children, their mother, their adoptive mother (primary carer), three of her adult daughters and some of their children and a number of other foster children the adoptive mother was caring for. They were told this was not possible: that the house had been allocated to him by the council and that he could not be evicted on the basis of the child abuse rumours. The council members suggested the women and children move into a disused women’s shelter.

On Thursday 15 January, the FSOs met with the adoptive mother and most of the women from the household and two of the employees of the Kowanyama Justice Group. The FSOs explained the basis of their concerns for the safety of the children if they continued living in the house with the adoptive mother's husband. They say that the women rejected the proposal that they move into the old women’s shelter because they were not confident the council would fix the toilet as promised. The FSOs are adamant the women did accept however, that the children should not continue to live with the adoptive

mother's husband. It has been suggested that this was really a case of gratuitous concurrence or that the older family members succumbed to the pressure brought to bear by the FSOs. I readily acknowledge that there is a risk of that occurring in such a setting. Indeed the fact that towards the end of the meeting the adoptive mother apparently indicated that she would give up fostering children altogether because she was too old, is indicative of her being overborne. Conversely, two of the other indigenous women present, Ms Major and Ms Gledhill gave evidence that the family did genuinely agree to the children being moved.

The next day the FSOs spoke with a third partyand her daughter in law and they agreed that the children could come to live with them. It seems this may have been informally raised with them earlier in the week.

The move could not proceed immediately however, as there had been a death in their house and they had vacated it until it could be smoked. It was anticipated the premises would be ready for occupation on Monday 19 January.

The FSOs also had an impromptu meeting with the adoptive mother's husband who was angry that the children were being moved and angry that they were acting on the allegations that he was sexually abusing the children. They denied that he was being blamed and attempted to explain their obligation to protect the children. They invited him to go to the clinic to be himself tested for STD, an offer he did not take up.

The FSOs again met with the mother and her older daughter on Friday 16 January and explained to them that the move to third party's house would go ahead as planned on Monday.

They did not see the younger girl or the 12 year old boy before they left that afternoon.

The children move to the third party's house

The arrangement was given effect to when, on the afternoon of Monday 19 January, a group of young people including the 12 year old boy and his two sisters and perhaps their mother, went to the daughter in law's mother's place where she had been staying and helped her carry her stuff back to the third party’s house.

The third party says the girls were upset when their mother left but that the 12 year old boy seemed ok.

She says the two girls brought some clothes with them but that the 12 year old boy had nothing. The next morning he asked to go and get his things from the adoptive mother's household and was gone all day. He apparently spent the day playing around the house, fixing a bike and listening to a cassette tape or watching TV.

Towards the end of the day one of the other young people being fostered ("foster daughter") by the third party, was sent to fetch the 12 year old boy. He came back but when it was noticed he hadn't brought any of his clothes with him, he was sent back with the foster daughter to the adoptive mother's household to collect them. On this occasion he decided he didn't want to go back to the third party's house and told the foster daughter so. He said he wasn't used to the adults at the other house. She went home and told the third party.

It seems the 12 year old boy then had dinner prepared for him by the adoptive mother. Around this time the adoptive mother's husband came home. He says he was told a girl had been calling for the 12 year old boy to come out and go with her but that the boy didn't want to go. He says that the 12 year old boy was clearly distressed by being moved around against his wishes and acted out as a result.

The adoptive mother's husband said in evidence that shortly after, he drove with the 12 year old boy to the third party's house to tell them the boy was staying at his place for that night. The third party confirmed this when she gave evidence and says she was agreeable to it thinking it would be better not to force the 12 year old boy to stay at her place against his wishes.

It is unclear what transpired when the 12 year old boy and the adoptive mother's husband returned home. In her statement, the adoptive mother referred to him walking off at this stage but that is seemingly an inference by her. According to the adoptive mother's husband he was told by his granddaughter that the 12 year old boy had walked out the back door. The belatedly obtained statement of the granddaughter makes no mention of this observation and she had no particular memory of this phase of events in giving evidence.

Later in the night when it was realised the deceased was seemingly missing there was an unsuccessful search about Kowanyama conducted by members of the adoptive mother's household. The members of the household eventually retired to bed. The window in the bedroom, including the flyscreen, was left open.

The death is discovered

At or about dawn on the morning of Wednesday, 21 January 2004, the 12 year old boy was found dead, hanging inside the wardrobe of the bedroom he used to occupy at his adoptive mother's residence. The adoptive mother's husband and another male person (who is mentally disabled) also usually shared that bedroom. It was the other male person who, on the morning of 21 January, alerted the adoptive mother's husband to the fact that he had found the 12 year old boy. This was apparently when the male person had gone to the wardrobe looking for cigarettes.

The cord of a set of electric hair clippers had been tied around the 12 year old boy's neck and around the wardrobe rod from which he was hanging. The scene photographs show his knees bent, touching or nearly touching the floor of the wardrobe.

The adoptive mother's husband took hold of the 12 year old boy and tried to get him down but couldn't. He noticed that the boy was very cold and concluded he was dead.

The police were called and the investigation referred to earlier was commenced. The mother identified his body to police. A doctor from the local clinic attended and confirmed that the 12 year old boy was dead but contributed little else to the investigation. For what it's worth, both the doctor and the police constable considered the scene did not appear suspicious.

Expert evidence as to manner and cause of death

The most obvious interpretation of the known facts is that the 12 year old boy committed suicide by hanging himself. However, where the deceased has not previously manifested an intention or tendency to self harm and no note or other evidence of the deceased's intention exists, suicide should not be presumed. The need for such care is particularly acute in cases where there exists a possible motive for a suspect to have staged a killing.

In this case there is no known motive for any person to have wanted to kill the 12 year old boy. In particular there is no evidence to suggest that he was or has been identified as a victim of or witness to sexual abuse by a person who in turn may have wanted to eliminate him as a potential complainant or witness. Further there is no evidence tending to support a hypothesis that this was an unlawful killing staged as a suicide. There was no evidence of a struggle, no sign of injury potentially caused in the struggle nor was there any evidence that any person in the crowded household had seen or heard a struggle.

This Inquest both in its investigative stage and in hearing evidence went to some trouble to ascertain the factual detail of what occurred on the night in question because at first blush there were some potentially concerning aspects.

There was a degree of inconsistency in the evidence of the different witnesses about their movements on the night in question. Some of those inconsistencies appear to have been eliminated by the oral evidence. Those that remain do not appear to be indicative of any underlying dishonesty but rather are the kind to be expected when witnesses are called on to recall in fine detail events which occurred over four years ago and which were not the subject of promptly recorded written statements.

An autopsy examination was undertaken by Dr Max Stewart, an experienced pathologist. He found no suspicious injuries and nothing inconsistent with a self inflicted hanging.

The strange location of the incident, the manual dexterity that would be required to execute it and the use of an unusual ligature could raise some concerns as to whether the 12 year old boy was the sole author of his own demise. I was assisted in resolving these doubts by the expert evidence of Dr Ernest Hunter, a psychiatrist with extensive experience in attending to mental health patients in indigenous communities on the Cape and a leading scholar in suicidology.

Dr Hunter explained he had not previously encountered a suicide in a cupboard. However, Dr Hunter also explained that it was impossible to be definitive in drawing conclusions from the venue of the suicide as to whether it was suggestive of foul play. Indeed he explained that while most adult Aboriginal suicides tend to occur in a public location there is less of a pattern in that regard in respect of Aboriginal child suicide.

He explained the 12 year old boy's death was 1 of 5 apparent instances of suicide or attempted suicide by children aged between 11 and 14 between December 2003 and April 2004 in Aboriginal communities in Far North Queensland. Of those 5, 2 additional to the 12 year old boy's case involved suicide in the children's own home, 1 in a bathroom and 1 in a bedroom. Dr Hunter also explained that at that time child suicide among Aborigines was in itself uncommon but that there has been a progressive increase in the rate of Aboriginal child suicide since. He suggested the exposure of children to the unhappy fact of adult Aboriginal suicides in Aboriginal communities has led to an increase in child suicide. In that regard it is noteworthy that there had been a very large number of suicides in Kowanyama in the years leading up to the 12 year old boy's death. Against that background it is not as surprising as it may have first seemed that a 12 year old boy would commit suicide.

The likely chain of events in the early evening of the night in question appears to be that the 12 year old boy was upset at being required to return to the third party's household and even when this was postponed for a night he remained distraught. The adoptive mother's husband describes him as having been in a temperamental state. While the 12 year old boy had ended up being allowed to sleep at his preferred household that night it may readily be inferred that the disruption of the previous two days had been upsetting to him and that he was still concerned at the continuing prospect of being removed from the home in which he had grown up. He articulated to a number of witnesses that he was not "*used to*" his carers at the third party's household and wanted to remain living at the residence. These events would have been upsetting to any 12 year old boy let alone one with his intellectual and behavioural problems.

It is against that background that he went missing. It seems likely that he did not leave the house but rather hid in his bedroom cupboard. Alternatively, he may have briefly left the house and re-entered unnoticed, possibly through the window.

An unusual feature of the ensuing search is that the searchers did not double-check the third party's residence. That is somewhat less surprising than may have at first blush appeared when regard is had to the searchers' understanding that the 12 year old boy had not wanted to go to the third party's household.

The evidence as to the house itself having been searched and as to how thoroughly it was searched is not particularly clear. However if the searchers were under the impression that the 12 year old boy had actually left the house it is foreseeable that their subsequent searches of it may not have been thorough.

In summary, the circumstances in which the 12 year old boy apparently committed suicide are not so inherently implausible as to favour a conclusion,

in the absence of any evidence to support it, that another person was directly involved in his death.

Findings required by s45

I am required to find, as far as possible, who the deceased was, when and where he died, what caused the death and how he came by his death. I have already dealt with this last aspect of the matter, the manner or circumstances of the death. As a result of considering all of the material contained in the exhibits and the evidence given by the witnesses I am able to make the following findings in relation to the other aspects of the matter.

Identity of the deceased – The deceased person was a 12 year old boy.

Place of death – He died in Kowanyama in Queensland.

Date of death – He died on 20 or 21 January 2004.

Cause of death – He intentionally took his own life by hanging.

Concerns, comments and recommendations

Section 46, in so far as it is relevant to this matter, provides that a coroner may comment on anything connected with a death that relates to public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in the future.

Issues of concerns raised by the facts in this case are:-

- The standard of the police and coronial investigation
- The training and workload of the FSOs
- The appropriateness of the FSOs decisions and processes
- Collaboration among community services in remote communities

Critique not criticism

Tragic deaths such as this death must be critically reviewed to ascertain whether anything should be done differently to avoid future deaths or otherwise contribute to improvement in public health and safety. This includes a review of the performance of the various government services that interacted with the boy. Naturally, more attention will fall on perceived shortcomings and less discussion will relate to the positive achievements of those agencies.

Before commencing that critique of the issues just identified as raising concern, I want to stress that I have the greatest admiration and respect for the doctors, nurses, mental health workers, teachers, police officers and child safety officers who elect to serve in remote communities. They should be

lauded. City dwellers can't imagine the privations they endure; the social isolation; the physical hardships and the frustration of trying to deliver high quality services with insufficient resources or support from "head office". None of my comments are intended to suggest the individuals involved in this case are worthy of personal sanction. Any shortcomings that have occurred are directly traceable to systemic failings.

Investigation deficiencies

As detailed earlier, this death had a number of very troubling aspects that demanded it be rigorously investigated by specialist investigators. It seems likely the only reason this didn't happen was because of the locale in which it occurred. That is not a sufficient reason.

Since this matter, the QPS has substantially rewritten its policies concerning child death investigations. Now, all such matters are investigated with input from the Department of Child Safety and are led by a detective of at least the rank of sergeant with experience in child protection matters. The QPS Child Safety Director is responsible for over viewing all such cases and to respond to any training, policy or operational issues raised.

Accordingly, I am satisfied that if a death occurs in similar circumstances in future the mistakes made in relation to this matter will not be repeated.

I also acknowledge the deficiencies in the manner in which the coronial system responded to the death. It seems likely that was partly due to local coroners with limited experience in such matters failing to case manage the file in the absence of any reliable administrative support. Those issues have been remedied by the appointment of a full time Northern Coroner with dedicated legal and administrative assistants.

Training and workload of FSOs

The Department of Families has undergone even bigger changes than the police service or the coroners; in September 2004, it was abolished and replaced with the Department of Child Safety, an agency committed to implementing a blueprint for reform developed after a public inquiry conducted by the CMC.

One of the issues identified by the external child death review was the absence of guidance available to FSOs when working in Indigenous communities in which no recognized entity had been established; making access to reliable local information much more difficult. The reviewers recommend this policy vacuum be filled. It is alarming to learn that more than three years after that report was finalised, that has still not happened.

Further, there are no specific policies or training materials to guide and assist staff make decisions in relation to the unique circumstances prevailing in remote Indigenous communities. It can't be denied that the demand for child protection services in these communities is large and growing. Nor can it be questioned that policies developed for the provision of such services in

metropolitan or mainstream Queensland communities will in many instances be inadequate and/or inappropriate.

These shortcomings must be addressed.

Recommendation 1: Development of training and policies

I recommend, that as a matter of urgency the Department of Child Safety develop policies specific to the delivery of child protection services in Indigenous communities. Training packages to assist staff to apply these policies and to understand best practice in this context should also be developed.

I have detailed earlier the completely unrealistic caseload detailed to the two FSOs who were sent to Kowanyama to assess the notification concerning the 12 year old boy and his sisters. I am concerned that the resource shortages that caused that to occur may not have been alleviated. The Zonal Director told the Court that she has sufficient resources to properly process only 60% of the work of the Cape York Torres Strait Islands ("CYTSI") Child Safety Service Centre.

While she believes all of the most urgent notifications that require a response within 24 hours are being attended to within that timeframe, the Centre has a backlog of 169 other cases from Indigenous communities which should have been responded to within 5 or 10 days, that have not been assessed at all; that is, the subject child has not been seen by a departmental officer. Those matters include cases which under the previous policies would have been classified as priority 2, as was the notification in this instance. The prospect that children could be in as much danger as those three infants without any response from the authorities being forthcoming is untenable.

Lack of training, unclear policies and unrealistic workloads must be a major factor contributing to the high turn over of Child Safety Officers. That turnover of course exacerbates the problem as vacancies and inexperienced and untrained staff further increase the burden on others, prompting them to leave. The altruism and commitment of Child Safety Officers can not be questioned; nor can the importance of their work. It is essential that they be supported, adequately equipped, and resourced.

Recommendation 2: Resources of the CYTSI Child Safety Centre

I recommend that the resources allocated to the CYTSI Child Safety Centre be reviewed to ensure it is sufficiently funded to fill all established positions and provide the training necessary to enable the CSOs to safely and effectively discharge their functions within the mandated timeframes.

The appropriateness of the FSOs decisions and processes

The FSOs concluded that the notification that the three children were at risk of harm was substantiated. There can be no doubt that was justified in the case of the sister in view of the unexplained STD she was shown to have. The fact

that her younger sister was, a week later, also found to have been infected with an STD suggests that their assessment that she was also at risk was sound. It is less clear on what basis they determined the 12 year old boy was at risk. It seems they knew he was living in a crowded house in which alcohol abuse was common; it may have been appropriate for them to be concerned that he would be exposed to the sexual abuse of his siblings and they undoubtedly gave great weight to the suspicions that the adoptive mother's husband was abusing young girls. However, information indicating a group of young boys may have responsible for the girls STDs shows the care that has to be taken when intervening on the basis of rumour.

Undoubtedly they should have spoken with the 12 year old boy and his younger sibling before substantiating the notification; I accept however, their workload prevented this.

Reasonable minds could differ on whether the children should, in the circumstances have been left in the community rather than being taken to a place of safety. That of course requires a comparison of the alternatives. I understand the evidence to indicate that a severe shortage of foster placements in Cairns or other local communities means had they been removed, the children are likely to have been housed in a motel room in Cairns being supervised by a FSO. They could not have been removed without a court order and while urgent applications can be made over the telephone, it is by no means clear that an order would have been granted. In the circumstances, I consider the FSOs were entitled to conclude the interests of the children would be better served by their being placed in the care of the third party and her daughter in law.

I understand all parties accept that the agreement concerning the placement of the children with the third party and her daughter in law should have been recorded and a copy provided to the carers.

I also understand, all parties accept that it would have been preferable for the FSOs to have participated in the implementation of the placement but that this was impossible in the time available.

It can not be contested that the decision to move the 12 year old boy in some way contributed to his taking his life. The extent or nature of that contribution can not be gauged and speculation is not helpful. Suicide is almost always the result of the combination of many factors. Even had they known what we now know about his precarious mental and emotional state, the FSOs may still have considered moving him to a safe house with his sisters, a few hundred metres from his former home was not unduly risky. No careless disregard for the boy’s welfare or cavalier ignoring of relevant considerations contributed to the sad outcome. The FSOs should certainly bear no blame for the 12 year old boy's death; they made decisions based on limited information and with their limited skills training and experience as best they could.

The deficiencies that have been identified in this section will be ameliorated if the other recommendations I have made are accepted and acted upon.

Collaboration by government agencies in remote communities

It was disappointing to read in the statement of the DChS Zonal director, Far Northern Zone that at a local level some government agencies in remote communities seem to believe that child safety is purely a matter for her department. There was certainly evidence of a lack of collaboration in this case with a failure of education, health and police to pass on some important pieces of information about the 12 year old boy to the former Department of Families officers.

I was shocked to hear that even now Child Safety Officers are not necessarily welcome in police stations or health clinics in all communities. I am sure that is contrary to government policy which is very much focused on partnerships and whole of government responses to the incredible challenges of child welfare in remote communities. I urge the Zonal Director to take up this issue at the highest level within her department.

I am also persuaded that there may be benefit in more formal linkages and collaboration between the service agencies in the communities along the lines of what occurs in regional centres in the Suspected Child Abuse and Neglect (SCAN) teams. I consider there is a significant risk that by only bringing the various disciplines that constitute the SCAN process together at a distance from the children who are the subjects of their deliberations, crucial information will not be fed in. There is also a risk the solutions they develop will be impractical if not informed by local knowledge. I can see no reason why the same disciplines could not perform a similar task in the communities. Meetings could coincide with the visits by Child Safety Officers. In the few cases where specialist medical input was needed, the paediatrician or psychiatrist could participate by video link.

Recommendation 3: Constituting of community SCAN teams

I recommend the lead agency of the Cairns SCAN team pilot and evaluate the constituting of a multi disciplinary, multi agency meeting with the same focus and role of the SCAN team in a Cape Indigenous community

The inquest is closed.

Michael Barnes
State Coroner
Cairns
19 September 2008