OFFICE OF THE STATE CORONER

NON-INQUEST FINDINGS

CITATION:	Investigation into the death of E, aged 14
TITLE OF COURT:	Coroners Court
JURISDICTION:	Southport
FILE NO(s):	2013/1418
FINDINGS OF:	James McDougall, Coroner
CATCHWORDS:	Child suicide, Child Safety Services, Child and Youth Mental Health Service
REPRESENTATION:	Counsel Assisting: Ms Megan Jarvis and Ms Rhiannon Helsen

E was 14 years old. He was living with his paternal grandmother in Logan City and attending a local state high school (SHS). His father was in jail and his mother resided in Toowoomba. E was found at 10am on Monday 22 April 2013 hanging in a toilet cubicle at the SHS he attended as a student.

These are findings into the death of E. In publishing these findings I would like to acknowledge the assistance of Ms Megan Jarvis, Principal Researcher and Coordinator in the Office of the State Coroner.

E's Childhood.

E was born on 22 June 1998 and was the second eldest of six children born to his mother, but with the children having different fathers.

E's biological father separated from his mother when E was approximately one year old and was sent to jail when E was approximately three years old. E's father continued to move in and out of jail over the course of E's childhood but would spend time with E when he was out, including a brief period when he reunited with E's mother. E's father was in jail at the time of E's death. E's stepfather, father to two of E's younger half siblings, began living in E's home when E was approximately 10 years old.

There is evidence that E experienced significant trauma during his childhood, including chronic neglect and emotional and physical harm. A review of records held by Child Safety Services paints a picture of a child who, from a very young age, was living in a chaotic and filthy home in the care of adults with limited parenting skills and drug and alcohol issues, where the children were often left unsupervised and without basic necessities such as adequate food and clothing. As he got older, it appears E was often left in charge of his younger siblings. There were also allegations of excessive physical discipline by his mother and stepfather; ongoing psychological abuse of one of his siblings; and exposure of the children to drug use, criminal behaviours, pornography and domestic violence within the home.

In December 2011, E left his family home in Toowoomba and went to live with his paternal grandmother in a suburb in Logan City. E told his grandmother that his stepfather was 'bashing' him and making him 'score dope' for him, and that he had been smoking dope and cigarettes and drinking alcohol whilst living with his mother and stepfather. E also told a youth worker that his stepfather used to hit him and that his mother and stepfather weren't feeding him properly.

During the time that E resided with his grandmother he received only sporadic contact from his mother. In January 2013, E became aware through Facebook that his mother had given birth to a child, in circumstances where E had not been aware that his mother was pregnant. E's grandmother spoke of E being very upset over his mother not telling him about her pregnancy.

E's Health and Wellbeing

In early childhood, E was diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) and Oppositional Defiance Disorder. E was prescribed medication to treat the symptoms of ADHD, although it is unclear to what extent he took this

medication given his chaotic home life and chronic neglect by his mother. It was also suspected that E may have been suffering from Post-Traumatic Stress Disorder related to the death of a cousin and his father's imprisonment.

At 12 years of age, E was engaging in self-harming behaviours including cutting his forearm with a blade from a pencil sharpener and running hot water over his wounds because he 'liked to feel pain'.

There were also reports of other concerning behaviour including aggressive outbursts, threats of physical violence against others including whilst armed with a knife, destruction of property, break and enters, fire lighting and attempts at jumping out of windows from heights. At times E was suspended from school due to violent and non-compliant behaviours.

In February 2013, E disclosed to a school guidance officer that he was having difficulties following the recent suicide of his friend earlier that year. E also spoke of missing his father who was still in jail, of hearing voices telling him to do dangerous or mean things to other people, and of using marijuana and alcohol as a child.

E subsequently underwent a mental health assessment with the Child and Youth Mental Health Service (CYMHS). Following an interview with E on 21 March 2013, CYMHS found that he showed no evidence of pervasive mood, anxiety or psychotic disorder, and that the voices he was hearing were most likely his own thoughts and self-talk during conflicts with his peers, in the context of a significant family history of violence being tolerated and encouraged. E denied any thoughts of self-harm or suicide, and CYMHS assessed E's risk of harm to himself or others as low.

E had been identified by child protection authorities as Aboriginal. It is well established that if an Aboriginal child's needs in relation to their cultural identity are not being met, this can have a significant impact on their overall health and wellbeing. However, documentation relating to E does not give a clear picture of E's views in relation to his Aboriginality, whether he felt his needs related to his cultural identity were being met, and whether and to what extent this may have impacted on E's health and wellbeing.

E's Contact with Various Services

Child protection

E first became known to Child Safety Services in July 2002 when it was notified of concerns that E and his siblings were being neglected and that the family home was 'a pigsty'. E was four years old at the time.

Child Safety Services determined that there was no information to suggest that the children were being harmed or at risk of harm. The information was noted and no further action was taken.

Child Safety Services' involvement with E and his family from that time and up until the time of E's death is difficult to summarise given the complexity of child protection practice and the framework in which child protection services are

delivered in Queensland. As noted later, two detailed reviews were carried out for the purpose of identifying any child protection service system failures or shortcomings. For the purposes of this jurisdiction, it is sufficient to note the following:

- During the time that E lived with his mother, he and his siblings were the subject of ongoing reports to Child Safety Services concerning allegations of neglect, an unhygienic home environment, inadequate supervision and excessive physical discipline by the mother and stepfather.
- Whilst Child Safety Services did at times have concerns about possible emotional and physical harm to E and his siblings, it did not assess these concerns as sufficient to warrant removing the children from their mother's care pursuant to Child Safety Services' statutory threshold for such an intervention. Instead, Child Safety Services attempted to engage with E's mother on a voluntary basis, including by referring her to services to assist her to care for her children, and seeking her commitment to improving the level of care she was providing. This work started as early as 2008, yet similar concerns regarding neglect and emotional and physical harm continued to be reported to Child Safety Services from this time and up until at least 2011.
- Information recorded by Child Safety Services shows that it was aware of mental health concerns for E during its involvement with his family, including in relation to his self-harming and risk taking behaviours from as young as seven years of age. Child Safety Services noted the support of education and mental health services in helping E with these difficulties, and did not otherwise intervene other than through engagement with E's mother as noted above.
- At times, workloads and resource issues appear to have affected the quality of risk assessment and decision-making in relation to concerns about the mother's care of E and his siblings. One Child Safety Services senior officer involved in E's case gave evidence to the review team that, at the time of her involvement, her workload was so high that it affected risk thresholds as all the matters appeared to 'meld into one'.
- On 27 February 2013, less than two months prior to E's death, Child Safety Services was notified of concerns that E was experiencing mental health issues such as hearing voices telling him to hurt other people. Child Safety Services noted that E was now living with his grandmother and the family was receiving support from E's new school to address the mental health concerns, including through a community youth worker who was planning to speak with E's grandmother about engaging E with CYMHS. Child Safety Services assessed that the information did not indicate significant harm or risk of harm to E, and that further action by Child Safety Services was therefore unwarranted.
- On 19 April 2013, Child Safety Services was notified of concerns that E had failed to return home from school the previous day and that his grandmother had reported him missing to police, with information to

indicate E may have been intending to return to his mother. Child Safety Services noted the information but decided not to take further action at that time. The recent concerns about E's mental health were noted, however Child Safety Services assessed that there was no information to suggest E was currently experiencing any acute mental health symptoms that would indicate he might be at risk of harming himself or others.

- Child Safety Services was notified of E's death on 22 April 2013.

Education

E began attending the SHS near his grandmother's home in 2012, having moved into the area in December 2011. During the time that E attended the SHS, and particularly in the months prior to his death, E received support from various SHS staff including classroom teachers, a guidance officer, a student liaison officer and a deputy principal, as well as from external services who worked collaboratively with the SHS to provide additional social, emotional and psychological support to students.

Shortly after commencing Year 10 at the SHS in 2013, E experienced the death of a fellow Year 10 student and friend, who had suicided at home within the first few weeks of the school term. Immediately following the suicide, the SHS organised counselling for students through its student support services, with students allowed to leave class at any time to speak with counsellors including guidance officers, the school nurse and specialised counsellors trained in dealing with grief.

Around this time, on 18 February 2013, E approached one of the SHS' deputy principals in her office and told her he was upset about his friend's death. The deputy principal immediately organised support and counselling for E through the SHS' guidance officer and student liaison officer, and spoke to E's grandmother by telephone to let her know about E being upset.

E went to see the same deputy principal again on 25 February 2013, this time to disclose that he was hearing voices in his head telling him to hurt people. E also spoke of feeling sad about his friend's suicide, and disclosed information about his traumatic family background and neglect by his mother, his history of marijuana use from seven years of age (although he stated he was not using it now), and current difficulties dealing with his grandmother's rules and strictness.

E confided that he missed his father 'terribly' and wanted to live with him, but that his father would not get out of jail soon because of the seriousness of the offences he had committed including an apparently unresolved charge of armed robbery. E appeared emotional when speaking about the fact that his father would not be released from jail for a long time.

Immediately after this discussion, the deputy principal spoke to the SHS' principal to notify him about E hearing voices telling him to hurt people. The principal advised her to immediately take E to the guidance officer, which she did.

The guidance officer assessed that E needed additional support and contacted E's grandmother to seek her permission to make a referral for E to CYMHS, to which the grandmother initially agreed. However, she then phoned back and withdrew her consent. The guidance officer and deputy principal initiated a referral to Child Safety Services in relation to the grandmother 'not acting protectively' in refusing permission for a CYMHS assessment.

The guidance officer also sought the assistance of E's community youth worker to persuade the grandmother to allow E to be assessed by CYMHS, which the youth worker subsequently succeeded in doing, with E attending an appointment on 21 March 2013. CYMHS contacted the guidance officer on 22 March 2013 to advise that it had assessed E as not requiring psychological, emotional or social support, however his family could ask for another assessment later if they felt there was a need.

In the meantime, E was also receiving additional support from the SHS through its 'Xmen Youth Program', a school-based program co-facilitated by an external non-government organisation, designed to assist young male students to build resilience while engaging with them to learn about their emotions and relationships.

E was referred to this program by staff from the SHS' student support centre, who had first spoken to E in mid-February to offer support following E's discussion with the deputy principal about the suicide of his friend. At that time, E told these staff members that he was finding it hard to believe that his friend was dead and that he had taken his own life. One of these staff members, who was also a qualified counsellor, described their approach to this discussion as follows:

> *We followed Education Queensland policy and refrained from any discussion of the circumstances of [the deceased student's] death. We empathised with E's emotional state in the present moment and slowly moved the focus to his sense of wellbeing and activities he was looking forward to that day in order to enhance his wellbeing. At the conclusion of what was probably a 30 minute meeting with E, his mood had lightened sufficiently for him to return to the class room. We invited E to join the Xmen Youth group we were currently running as a means of ongoing support for him.*

The Xmen Youth Program appeared to be an important part of E's school life and something that he valued and enjoyed. E was usually first in the room for commencement of the weekly group sessions, participated regularly and meaningfully in group discussions, and was attentive and supportive towards his peers. E also appeared to enjoy the support of the SHS' student support centre, which he would visit each day at either break to touch base with staff and 'have a chat and a laugh'.

SHS staff also referred E to and supported his engagement with other support services external to the school, including a community youth worker and CYMHS. These services are discussed further below.

After E’s death, the SHS’ staff involved in supporting E stated to police that they had no knowledge of E expressing any suicidal ideation or intention to self-harm or exhibiting any such behaviours, neither generally in the school environment, nor in any interactions with staff or during Xmen Youth Program group sessions. Staff who got to know E in the months and weeks prior to his death described him as ‘outgoing’ and ‘upbeat’, that he was ‘always joking and laughing’, and that he was a ‘very likeable young man’ with a ‘real presence’ who interacted well with his peers and staff.

Mental health

As noted above, E was referred to CYMHS by the SHS in March 2013. CYMHS understood that E was being referred for assessment due to recent statements he had made to SHS staff and his community youth worker saying he was hearing voices telling him to harm others. This was therefore a particular focus of the CYMHS assessment, that is, to determine whether E was experiencing auditory hallucinations as a possible symptom of an underlying mental health issue.

The CYMHS assessment document noted E’s history of experiences with violence both within his family and school environment, and in particular of violence being tolerated and encouraged by his father and paternal uncle, who would give E messages about ‘*being tough*’ and ‘*hitting hard with the first swing*’. CYMHS concluded that the voice E was hearing was likely to be ‘*a distillation of messages he has heard from family, and experiences he has had and witnessed where indeed his physical safety was dependent on striking another*’.

As part of its assessment, CYMHS conducted a risk screen for suicide and self-harm, completing documentation that included a ‘tick box’ list of factors known to be associated with these risks. In completing this documentation, CYMHS noted E’s history of self-harming but did not otherwise identify any factors indicating an increased risk of suicide or self-harm for E at that time.

Notes made in this section record that E had denied self-harm or suicidal ideation during the interview that day, and that there was no evidence of a pervasive mood, anxiety or psychotic order. It was noted that E cried approximately once per week in private, and E was encouraged to talk with his community youth worker about what makes him sad and upset and ways to express and manage his feelings.

The overall risk assessment for suicide and self-harm was recorded as ‘low’. The focus of the overall risk assessment was in relation to E’s risk of harm to others, with CYMHS summarising as follows:

> *Overall E has significant historical information relating to emotional and behavioural disturbance but currently in his Grandmother’s care he is not presenting with these behaviours. However, he has been referred to emotion regulation programs at school and with [the community organisation] which may be related to his history or observations regarding trouble dealing with anger. He no longer sees his mother who he lived with all his life and whom he believes chose her boyfriend over him. He has a prejudicial childhood but is*

making some strong efforts to change his life and is goal directed about joining the army and staying out of trouble. The voices he spoke of in his head are phrases that he has heard his uncle and others say to him e.g. 'don't hesitate just hit him' and occur when he is in a fight or very angry. Come from within his head and are not present in other settings [sic]. Harm to self - Low. Harm to others - Low at this cross sectional review but he had numerous risk indicators in his background and thus ongoing engagement with youth worker and emotion regulation programs recommended.

The CYMHS psychologist who conducted E's assessment telephoned E's grandmother the following day to provide feedback about the assessment and recommendations. Notes of this conversation reflect that the focus of the psychologist's advice to E's grandmother was in relation to helping E stay out of trouble and reduce the risk of any violent or aggressive behaviours towards others. There is no record of any discussion with E's grandmother about possible risk of self-harm or suicide.

CYMHS notes also reflect that E spoke about his grandmother being overly strict, but that E appeared to want to abide by his grandmother's rules so that he could remain living with her and not be sent back to live with his mother. This was noted as a positive in E's life in helping him to achieve a good future for himself.

Community youth worker

After taking E into her care in December 2011, his grandmother made contact through the SHS with a local non-government community organisation to ask for assistant with re-engaging E in school. The organisation, which received Commonwealth funding to support young people at risk of homelessness, assisted E with school uniforms, school fees and obtaining a copy of his birth certificate.

The organisation also provided support to E through a youth worker, who initially met with E in February 2012 and then on a weekly and later fortnightly basis to provide additional support for E's re-engagement with the education system and with any difficulties he may be experiencing at home. These appointments continued until June 2012, when E advised that everything was going well at home and at school and that he no longer required support.

As noted above, the youth worker became involved with E and his grandmother again in 2013, when the SHS contacted him to request his assistance in engaging E with CYMHS.

The youth worker spoke to E's grandmother who explained that she was concerned that if E received mental health services, he may be disadvantaged if he later wanted to join the army. The youth worker advised the grandmother that this was not the case, and that a referral to CYMHS was in E's best interests. The grandmother subsequently agreed to the referral.

On 27 February 2013 the youth worker conducted a new intake appointment with E to re-engage him with the organisation's support services. At this meeting the youth worker spoke to E about his mental wellbeing and E explained about hearing voices and having thoughts of hurting people. The youth worker obtained E's agreement to seek counselling for this issue, and subsequently liaised with the SHS to arrange an appointment for E with CYMHS on 21 March 2013.

On 21 March 2013 the youth worker gave E a lift to and from his CYMHS appointment and also spoke with the CYMHS psychologist at the end of the appointment. The youth worker was advised that E did not have mental health issues but did have difficulties with dealing with his anger, which the CYMHS psychologist considered could be dealt with through services provided by the Xmen Youth Program at E's school.

The youth worker was not satisfied with the outcome of the CYMHS assessment, and arranged to meet with E again on 26 March 2013 to see if he would like to speak to another counsellor. E declined saying he was happy doing the Xmen Youth Program and chatting with the youth worker. The youth worker asked E about the voices in his head. E advised that he wasn't getting them and when he did he wasn't listening to them. The youth worker suggested it could be hard not to listen to the voices and again asked E if he would like to speak to a counsellor, however E declined.

The youth worker arranged to meet with E again after the upcoming Easter school holidays, and the two of them met on Tuesday 16 April 2013, just two days prior to E going missing. The youth worker's notes of that meeting were as follows:

> *Spoke with E and asked how his school holidays went. E stated that they went well. He said he went and seen his brother [sic] and they have a ball together. E also stated he chilled with some of his mates and just had fun riding and running around. I asked E how his thoughts have been with the voices in his head. E said he hasn't had any what so ever. E stated that he no longer needs my support as everything is fine at home and school and wishes to exit the program. I asked E are you sure you wish to do this. E stated yes it is [sic], I am fine and no longer require your support. E stated that everything is going well and if I need your help again I will get my gran or someone from the school to ring you and ask you to come out and see me. E thanked me for all the help he has received from the very first day he came on board with [the organisation]. I wished E all the best and told him if he needs to see me just to ring me. E case has been close [sic] 16/04/2013.*

The meeting on Tuesday 16 April 2013 was the last time the youth worker saw or spoke with E. The youth worker was notified of E's going missing on Friday 19 April 2013 by his grandmother, and offered his support to her during the time that E was missing. The youth worker was then notified of E's suicide on Monday 22 April 2013, and provided support to E's family in relation to funeral arrangements.

After E’s death, the youth worker spoke with the SHS’ student liaison officer who told him that E had stopped seeking support from her in that last week prior to his death. The youth worker and the student liaison officer discussed whether E might have planned his suicide as he appeared to have ‘cut ties’ with all his counsellors in the week leading up to his death.

The youth worker stated to police that in all his dealings with E, E was always happy, polite and smiling and there was ‘*nothing that would indicate to me that E would do something like this*’.

The Days Prior to E’s Death

E was absent from the SHS’ Xmen Youth Program group session held on the Friday prior to his death, 12 April 2013.

On Sunday 14 April 2013, E was ‘grounded’ by his grandmother for three days for not having completed his chores.

E appeared to attend school as usual from Monday 15 April 2013, with no reports of any concerns or unusual behaviour.

The last time E was seen by his grandmother was in the morning of Thursday 18 April 2013 when she said goodbye to him as he went off to school around 7:45 am.

On that Thursday, E stopped in at the SHS’ student support centre around 10.00am and said hello to the student liaison officer and asked if she was busy. The student liaison officer was busy with something else and asked E if he was okay and if it would be possible to catch up at first break. E stated ‘*yeah sure, see you then*’. He then left to attend class. The student liaison officer did not see E again after this.

School records show that E was recorded as ‘present’ for his form class and first lesson that day, however was then recorded as an ‘unexplained absence’ for the remainder of the day’s lessons.

On Friday 19 April 2013 SHS staff were advised by E’s cousin, who was also a student at the school, that E had not returned home the previous evening and that his grandmother believed he had run away.

The SHS’ deputy principal contacted the grandmother and confirmed that E was missing, and that the grandmother had reported this to police. The deputy principal also sought out and spoke with students who knew E, who advised that E had spoken of running away and catching a bus to his mother’s home.

The deputy principal was concerned that E was returning to his mother’s house when he wasn’t supposed to be in her care and reported this information, as well as her concerns about E’s mental well-being, to Child Safety Services. The SHS’ guidance officer contacted police to ensure E had been reported missing.

On Monday 22 April 2013, at the beginning of the first period for the day, a student's mother approached the deputy principal requesting a meeting, saying she had information about E. At the meeting, which was also attended by the SHS' guidance officer, the mother disclosed that her daughter was extremely anxious about E's well-being following a conversation with E in the first period of Thursday 18 April 2013, during which E told her daughter and another classmate that he was going to kill himself. The daughter had told her mother that E was acting in a strange manner in class and openly writing a will in front of her, and that he told them he had a rope in his bag and was going to do it that day. The daughter said she didn't report it as she thought E was lying and that she and her classmate had looked in E's bag and couldn't see a rope.

After this meeting the deputy principal immediately called the police to report the information and her concern that E may have taken his life in a public place somewhere. The deputy principal was not aware at this time that other staff of SHS had just discovered E's body in the school grounds.

Circumstances in Which E Was Found

At approximately 10:00 am on Monday 22 April 2013, the SHS' facilities officer was conducting a maintenance check of the male student toilets when he found that one of the toilet cubicle doors was locked from the inside. He used a screwdriver to unlock the door and went to push it open when he realised that something wasn't right, as the door felt heavy and he could only open it a little bit.

The facilities officer looked up and saw a blue rope tied to the metal mesh screen above the door. He immediately closed the main door to the toilets and went to notify the SHS' business services manager of his suspicion. They in turn notified one of the SHS' deputy principals and the principal, and the four staff members all returned to the student toilets and forced their way into the locked cubicle where they found E hanging from the blue rope tied above the door.

The staff members quickly cut the rope and laid E on the floor of the cubicle, where they performed CPR until Queensland Ambulance Service (QAS) officers arrived.

QAS received a call from the SHS at 10:10 am. QAS officers arrived at the school at 10:16 am and were taken by staff to the student toilets, where they attended to E. The QAS officers quickly identified from the condition of E's body that E was deceased and that further resuscitation efforts would not be of any use.

The QPS was notified of the death. Subsequent preliminary investigations by QPS detectives indicated that E had died by way of suicide and that there were no suspicious circumstances and no evidence to suggest that any other person was involved in his death.

At autopsy E's cause of death was found to be hanging, with evidence indicating that E had been deceased for some days before his body was found. Also at autopsy, two handwritten notes were found inside E's pockets, one of which was dated 18 April 2013 and titled '*E's Will*', setting out who was to receive what of his possessions.

SHS staff explained that cleaners were rostered to clean the student toilets at the close of every day during the school week. In the event that there was a maintenance issue, including a cubicle door that could not be opened, cleaners were asked to log a maintenance request at the end of their shift. These requests were then actioned by the SHS' facilities officer.

The toilet block in which E was found was cleaned by a casual cleaner on Thursday 18 and Friday 19 April 2013, due to the regular cleaner being away on bereavement leave from 17 to 19 April 2013 because of her father passing away. It is not known if the casual cleaner noticed a locked cubicle door within that block on those dates, however no maintenance request was logged.

When the regular cleaner returned to work for her morning shift on Monday 22 April 2013, she unlocked the external gates to the toilet block but did not go inside as she believed the toilets had been cleaned in the afternoon of the previous working day, Friday 19 April 2013.

Also on that morning of Monday 22 April 2013, the SHS' facilities officer actioned a range of maintenance requests made the previous week, including one logged by the regular cleaner on Tuesday 16 April 2013 in relation to a locked cubicle door in the *female* section of the toilet block in which E was eventually found.

In attending to this request, the facilities officer also did a general check of the rest of the toilet block, thereby discovering the locked door in the male toilets and, subsequently, E's body.

Cause of Death

An external post-mortem examination of E's body was conducted on 24 April 2013 by Queensland Health Forensic and Scientific Services. This examination confirmed that E's body was in the early stages of decomposition, consistent with initial QPS investigations indicating that E's death may have occurred several days prior to his body being found.

The cause of E's death was found to be hanging. This was supported by examination findings including an abrasion on E's neck consistent with hanging by rope, and marked lividity on the extremities consistent with his body being vertically suspended for some time. No other significant injuries were noted.

Toxicological testing of a femoral blood sample taken during the examination showed the presence of alcohol in E's blood, which could be attributed to the formation of alcohol following decomposition changes, although exogenous use of alcohol could not be ruled out. No drugs were detected in the sample taken.

During the examination, two handwritten notes were found inside E's pockets, one of which was dated 18 April 2013 and titled 'E's Will' setting out who was to receive what of his possessions, and the other with the words 'fuck you' written large and in capital letters across the entire page.

In his handwritten will, E specifically excluded his grandmother and one of his cousins, stating '*Nana can get fuck [sic] and [cousin's first name] can too*'. He otherwise left his various belongings to his father, siblings, other cousins and friends.

Findings of other Reviews and Investigations

WHSQ investigation

As E's death happened at the SHS, which is a workplace pursuant to the *Work Health and Safety Act 2011* (the WHS Act), WHSQ conducted an investigation to determine whether the school had breached any aspect of the WHS Act in connection with E's death.

The WHSQ investigation did not identify any breaches of the WHS Act related to E's death. WHSQ gave particular consideration to the issue of bullying given its prevalence amongst young people and the responsibility of schools to manage the risks to students associated with bullying, however the investigation found no evidence that E was being bullied. WHSQ further noted that, leading up to E's death, ongoing guidance and counselling support was being provided by the SHS to E to assist him in dealing with a range of personal and family issues that were impacting upon him outside the school environment.

WHSQ advised that no issues were identified by its governance group to suggest a broader work health and safety issue requiring a specific organisational response by WHSQ, and that the Office of Fair and Safe Work Queensland had decided not to commence prosecution against any duty holder in relation to this matter.

Child protection reviews

As E was known to the child protection service system in the three years prior to his death, the adequacy of child protection services provided to E and his family was initially reviewed by Child Safety Services and then subject to further independent review by the (former) Child Death Case Review Committee (CDCRC) in accordance with legislative requirements.

The reviews broadly found that there were no actions and/or inactions of the child protection service system that were directly linked to E's death. The reviews did identify a number of service system issues regarding the way in which Child Safety Services recorded and responded to concerns about E and his siblings. The CDCRC was of the opinion that:

> *…these service system issues resulted in adverse outcomes for [E] as ongoing concerns of: chronic neglect and the impact it was having on [E's] emotional wellbeing; [E's] ongoing mental health issues; and his escalating self-harm incidents remained unaddressed. Further, as [E's] indigenous status was repeatedly overlooked, this resulted in his cultural needs not being considered and decisions being made about [E] without the consultation and advice of a [Recognised Entity].*

A number of actions were taken by Child Safety Services following its review of E's death to address practice issues identified by the review. These actions were endorsed by the CDCRC. The CDCRC also noted that whilst there were a number of recurring service system issues identified in this and other cases considered by the CDCRC, these issues did not require immediate action given the significant reforms recently recommended by the Queensland Child Protection Commission of Inquiry which were, at that time, being considered by Government.

Comments

While we can attempt to make some sense of E's death and his decision to take his own life, we can never really know what was in E's mind on that day or in the days and weeks before. Even the statements E made to others and the notes he left behind only provide a snapshot of those thoughts E was able to articulate at the time, and don't necessarily speak the truth of all that he was feeling and experiencing leading up to the moment when he ended his life.

Sadly, E's death is counted amongst a growing number of deaths of children and young people by suicide in Queensland in recent years. We lost 22 children and young people to suicide in the year E died. Amongst children aged 10 to 14 years old, suicide was the leading external cause of death in that year.

There are a range of factors that appear to be associated with an increased risk of suicide among children and young people, and it is clear that many of these factors were present in E's life: a history of childhood abuse; mental health issues and behavioural problems; E's alcohol and drug use; and stressful life events including the separation of his parents, parental conflict, absence of his father, parental substance abuse, domestic and family violence, rejection by his mother, transition between schools and homes, and school issues.

E also experienced a number of events in the months leading up to his death that are known to commonly precipitate a decision by a child or a young person to take their own life; namely, the ongoing imprisonment of E's father (which E became visibly emotional about when speaking to the SHS deputy principal on 25 February 2013 about missing his father) and disciplinary problems at home (with E's grandmother having 'grounded' E in the week leading up to his death, on a background of E feeling his grandmother was overly strict).

Perhaps significantly, another risk factor present for E was the recent suicide of his friend and fellow student. E spoke to SHS staff in the months prior to his death about feeling sad and upset about his friend's death. 'Contagion', a process by which a prior suicide or attempted suicide facilitates or influences suicidal behaviour in another person, is known to be a key risk factor among children and young people who suicide.

However, despite the presence of all these risk factors, there is no evidence to suggest that those professionals who interacted with and supported E in the months prior to his death should have predicted E's state of mind and intention to suicide. As noted above, there is no evidence of E expressing any suicidal ideation or intention to self-harm or exhibiting any such behaviours in the months

and weeks prior to his death. Individuals who interacted with E during this period described him as ‘outgoing’ and ‘upbeat’, that he was ‘always joking and laughing’, and that he was a ‘very likeable young man’ with a ‘real presence’ who interacted well with his peers and staff. When E did seek help for difficulties he was having, he did not admit to any thoughts of self-harm or suicide, and appeared to be focussed on staying out of trouble so that he could remain living with his grandmother and eventually join the army. SHS staff appeared to respond appropriately when E expressed concern about his friend’s suicide, including by providing him (as well as the broader school community) with additional social and psychological support. This does not appear to be a case where relevant services or professionals failed to respond to an identifiable and imminent risk of suicide.

Tragically, on the morning of his death, E did make some very explicit statements to two of his classmates about wanting to kill himself at school that day. Understandably, those young people did not believe, and could not have known, that E intended to follow through on those statements, and this information was not passed on to anyone in authority until after E’s death.

Notes found with E’s body indicated that E felt some anger towards his grandmother. However, whilst E spoke to others of conflict with his grandmother, there is no evidence that this was anything other than normal conflict between a young person developing their independence and a caregiver concerned with setting boundaries and keeping that young person safe. In taking E into her home, E’s grandmother appeared to have had E’s best interests at heart and a genuine desire to help him create a positive future for himself.

It might be said that the earliest point for intervention in E’s life was during his early childhood, when ‘better’ tertiary, secondary and universal child protection and other support services might have helped reduce or eliminate those environmental factors, experiences and events that lead to E being at increased risk of suicide later in life. However, as noted by the CDCRC, the recent Child Protection Commission of Inquiry recognised the need for much greater investment in prevention and early intervention services and, as at the time of this file review, the Queensland Government is approximately six months into a program of reform for implementing the recommendations of the inquiry and transforming the child protection service system in Queensland. I respectfully suggest that, rather than conduct further investigations into E’s death only to come to similar conclusions, it would be more appropriate to note the current reforms underway and our shared hope that these will go some way to addressing the gaps identified by the Child Protection Commission of Inquiry for intervening earlier and more effectively in the lives of vulnerable children and young people in Queensland.

As to whether there are matters connected with E’s death that might go towards preventing deaths from happening in similar circumstances in the future as per sections 28(2)(a) and 46(1)(c) of the Act, I respectfully suggest that discerning the complex systems that interplay in the lives of people who, like E, are at increased risk of suicide, and identifying ways to intervene to effectively prevent their deaths, is a task that is difficult to achieve when examining just one death.

Fortunately, there is currently significant focus and commitment both in Queensland and nationally to reducing suicide, with the government, non-government and community sectors all contributing to various suicide prevention strategies, projects and activities.

E's life, and the lives of other children, young people and adults we have lost to suicide, will inform the growing evidence base for helping to improve our understanding of the factors that increase suicide risk, so that we can better identify ways to effectively intervene and protect the lives of other vulnerable Queenslanders in the future.

All aspects of this tragic death have been fully investigated. As I intend to publish these findings, the public interest would not be served by conducting an inquest. In publishing these findings, it is necessary that E not be identified by name. I make this decision to de-identify the findings reluctantly, however E has four siblings who are themselves involved with Child Safety and should not be identified.

James McDougall
Coroner
24 March 2015